

An evaluation of the development, implementation, feasibility and impact of a tailored intervention to improve the quality of care for Aboriginal and Torres Strait Islander peoples attending urban general practice.

Author:

Schutze, Heike

Publication Date:

2015

DOI:

<https://doi.org/10.26190/unsworks/18118>

License:

<https://creativecommons.org/licenses/by-nc-nd/3.0/au/>

Link to license to see what you are allowed to do with this resource.

Downloaded from <http://hdl.handle.net/1959.4/54287> in <https://unsworks.unsw.edu.au> on 2024-04-29

**An evaluation of the
development, implementation,
feasibility and impact of a
tailored intervention to improve
the quality of care for
Aboriginal and Torres Strait
Islander peoples attending
urban general practice**

Heike Schütze

School of Public Health and Community Medicine
Faculty of Medicine, UNSW Australia

A thesis presented in fulfilment of the requirements
for the degree of Doctor of Philosophy

September 2014

Originality statement

I hereby declare that this submission is my own work and to the best of my knowledge it contains no materials previously published or written by another person, or substantial proportions of material which have been accepted for the award of any other degree or diploma at UNSW or any other educational institution, except where due acknowledgment is made in the thesis. Any contribution made to the research by others, with whom I work at UNSW or elsewhere, is explicitly acknowledged in the thesis. I also declare that the intellectual content of this thesis is the product of my own work, except to the extent that assistance from others in the project's design and conception or in style, presentation and linguistic expression is acknowledged.

Signed: 

Date: *2 March 2015*

I acknowledge the Bidjigal people as the traditional owners of the land on which I work and study and pay my respects to Elders past, present and future

*“Fairness is not that each receives the same
but rather that each receives what they need.”*

(Martin Luther King, 1966)

Abstract

Background

Aboriginal and Torres Strait Islander (Aboriginal) peoples have greater health needs than other Australians. Approximately 60% of Aboriginal peoples use non-Aboriginal Community Controlled (mainstream) general practice. General practice may not provide culturally appropriate care to Aboriginal peoples, and few practices have effective systems in place to identify Indigenous status, resulting in inadequately targeted care.

Aim

To develop and evaluate a tailor-made practice facilitation model to improve the acceptability of health care provided to Aboriginal peoples who attend urban mainstream general practice.

Methods

Set in two Medicare Local Areas in Sydney, a mixed-methods multiple-site case study was used, which was informed by an interpretivist constructionist paradigm. Data collection included focus groups with the two local Aboriginal communities; interviews with Medicare local staff (n=3); interviews and surveys with GPs, nurses and practice staff (n=29); a patient medical record audit, practice systems audit and Aboriginal unannounced standardised patient (USP) assessments at two time-points at seven general practices. The triangulated data were used to tailor quality improvement activities within each practice to improve their Indigenous-status recording systems and the quality of care offered to Aboriginal patients. The implementation of the intervention was evaluated using the Normalisation Process Theory (NPT).

Findings

Feedback from the USPs, combined with education and clinical audits, enabled practices to implement an organisational response consistent with the processes described in the NPT. At follow-up most practices improved their Indigenous-status identification systems, with a doubling in Indigenous-identified patients in six practices; and there was an increase in the number of Aboriginal Health Assessments performed and enrolments into the Closing the Gap Health Initiative schemes. The method was acceptable to providers, staff and the local Aboriginal communities. A key factor in the uptake of the intervention and commitment to change by practitioners and staff was that the USPs were from the local Aboriginal communities, providing face validity to the methodology.

Conclusion

The innovative intervention used was acceptable, feasible and demonstrated some effectiveness as a quality improvement tool in general practice. It warrants further investigation and evaluation.

Acknowledgments

I extend my thanks to the following without whom this journey would not have been possible:

The participating general practitioners, practice nurses, practice managers and practice staff who generously gave their time and agreed to go "under the microscope" and share their views, and then made the effort to incorporate change into their practice;

The Aboriginal and Torres Strait Islander community members from Kurranulla Aboriginal Corporation and La Perouse for sharing their stories;

The Unannounced Standardised Patients – your insights and interpretation were invaluable;

The Kurranulla Aboriginal Corporation for allowing me to be a part of their community for the past few years, and for Aunty Yvonne Simms from La Perouse for 'adopting' me into the Custodial family. The insight into both communities was a privilege and I value the knowledge I have gained and the friendships that have grown;

The Aboriginal Health and Medical Research Council Ethics Research Committee for their guidance and support;

My supervisors, Professor Mark Harris (primary Supervisor), Associate Professor Elizabeth Harris and Professor Lisa Jackson Pulver (co-supervisors) for their belief in me, their willingness to share their knowledge and their respectful, honest feedback which has provided me the opportunity to grow and learn. I especially thank Mark for his endless patience, for the degree of time he has provided to mentor and supervise me, for always being available day, night or weekends to answer questions and for reviewing countless revisions;

Finally, thank you to my husband Bradley Traynor, for his love, encouragement and support, which keeps me together.

Table of Contents

Abstract	5
Acknowledgements.....	7
Table of Contents	8
List of Tables	16
List of Figures	18
List of Boxes	19
Glossary of Acronyms	20
Chapter 1 – Introduction	21
1.1 The health needs of Australia's Indigenous peoples	22
1.1.1 Aboriginal and Torres Strait Islander morbidity and mortality.....	22
1.1.2 Aboriginal and Torres Strait Islander morbidity and mortality according to remoteness area.....	24
1.1.3 Health service usage by Aboriginal and Torres Strait Islander peoples	24
1.2 The Australian Government's response to the health needs of Aboriginal and Torres Strait Islander peoples	25
1.2.1 Aboriginal and Torres Strait Islander primary health care services	26
1.2.2 Indigenous Chronic Disease Package.....	26
1.3 Non-Aboriginal Community Controlled primary health care services (mainstream general practice)	28
1.3.1 Barriers to access	29
1.3.2 Indigenous status identification in mainstream general practice	30
1.4 The rationale for this research	32
1.5 Research aim.....	33

1.6 Research questions	33
1.7 What led me to do this research?.....	33
1.8 An overview of the thesis	35
Chapter 2 – Assessing physician performance	36
2.1 Assessing physician performance.....	37
2.2 Literature search	39
2.2.1 The literature search research question	39
2.2.2 The search strategy	39
2.2.2.1 Unannounced standardised patients	39
2.2.2.2 Direct observation	39
2.2.2.3 Medical record abstraction	40
2.2.2.4 Vignettes	40
2.2.2.5 Survey/Questionnaire.....	40
2.2.2.6 Exit interview	40
2.2.2.7 Physician performance.....	41
2.2.4 Papers reviewed	41
2.3 Methods of assessing physician performance.....	41
2.3.1 Indirect methods	42
2.3.1.1 Medical record abstraction	42
2.3.1.2 Vignettes.....	43
2.3.1.3 Self-report questionnaires/surveys	44
2.3.1.3.1 Patient self-report postal and telephone surveys.....	44
2.3.1.3.2 Physician self-report postal and telephone surveys .	46
2.3.1.3.3 Patient and physician exit interviews.....	47
2.3.2 Direct methods.....	48
2.3.2.1 Direct observation	48
2.3.2.2 Unannounced standardised patients	49
2.4 Summary	51
Chapter 3 - Introduction to empirical work.....	53
3.1 Theoretical approach	54
3.1.1 Epistemology	55
3.1.2 Theoretical perspective (or paradigm).....	56
3.1.3 Methodology	57
3.1.4 Methodology integrity	59

3.2 Design framework	59
3.2.1 Appropriateness of a case study design framework	60
3.3 Methods	62
3.4 Study setting	62
3.5 Research Approval	62
3.5.1 Reciprocity	63
3.5.2 Respect.....	64
3.5.3 Equality	65
3.5.4 Responsibility.....	65
3.5.5 Survival and protection.....	65
3.5.6 Spirit and integrity	66
3.5.6 Ethics approval	66
3.6 Summary	66

Chapter 4 – Data collection and analysis methods 67

4.1 Sampling	68
4.1.1 Selecting the sites	68
4.1.2 Selecting the cases	68
4.1.3 Selection criteria for cases and binding of cases	69
4.1.4 General practice participants	70
4.1.5 Selecting Medicare Local participants	71
4.1.6 Selecting focus group participants	72
4.2 Data Collection	73
4.2.1 Unannounced standardised patient assessment	73
4.2.1.1 Selection of USP.....	73
4.2.1.2 Standardising USPs	74
4.2.1.3 The USP visits	79
4.2.2 Individual interviews.....	81
4.2.2.1 Interviews with 'case' members.....	83
4.2.2.2 Interviews with Medicare Local staff.....	84
4.2.3 Focus group interviews with Aboriginal and Torres Strait Islander peoples	86
4.2.3.1 Focus group participants.....	87
4.2.3.2 Recording the focus groups	88
4.2.3.3 Focus group interviews	89
4.3 Researcher notes and reflections.....	91

4.4 Practice summary and patient clinical record	91
4.5 Self-complete questionnaires with general practitioners and practice staff ..	92
4.6 Data analysis	93
4.6.1 Data management and reading	95
4.6.2 Describing, classifying, interpreting (at the respondent level)	96
4.6.3 Representing, visualising	99
4.6.4 Describing, classifying, interpreting (at the case level)	100
4.6.5 The conceptual framework for primary care	102
4.6.6 Quantitative data analysis	104
4.7 Methods to ensure rigour in qualitative data analysis	104
4.7.1 Credibility	105
4.7.1.1 Member Checks	105
4.7.1.2 Prolonged engagement	105
4.7.1.3 Persistent observation	106
4.7.1.4 Triangulation	106
4.7.1.5 Negative or Deviant Case Analysis	107
4.7.2 Transferability	107
4.7.3 Dependability	107
4.7.4 Confirmability	108
4.8 Summary	109
Chapter 5 – The intervention	110
5.1 The development of the intervention	111
5.1.1 Aboriginal and Torres Strait Islander community engagement	111
5.1.2 Background literature	111
5.1.2.1 Theories used to inform the development of the intervention	111
5.1.2.2 The need for cultural awareness training	114
5.1.2.4 Available materials for Aboriginal and Torres Strait Islander	
Cultural Awareness Training	115
5.1.2.4 A case study of a practice successfully implementing	
strategies to overcome access barriers	116
5.1.3 Results of the focus groups with Aboriginal and Torres Strait	
Islander community members	117
5.1.4 Results of the Medicare Local Interviews	118
5.2 The design and implementation of the intervention	119
5.2.1 Theoretical basis for the implementation of the intervention	119

5.2.2 Practice Summary Report	120
5.2.3 Aboriginal and Torres Strait Islander Cultural Awareness Training ..	121
5.2.4 Practice Facilitation	121
5.2.5 Making practice physical environments more welcoming to Aboriginal and Torres Strait Islander patients.....	122
5.3 Evaluation of the implementation and feasibility of the intervention.....	128
5.4 Summary	133
Chapter 6 – Case study results and analysis	134
6.1 Practice 101.....	135
6.1.1 Context	135
6.1.2 Identification of patient's Indigenous status	136
6.1.3 Assumption of literacy	138
6.1.4 Practice environment	138
6.1.5 Culturally appropriate and targeted care	140
6.1.6 Assessment by the USP	141
6.1.7 Evaluation of the implementation of the intervention	142
6.2 Practice 102.....	144
6.2.1 Context	144
6.2.2 Identification of patient's Indigenous status	145
6.2.3 Assumption of literacy	147
6.2.4 Practice environment	147
6.2.5 Culturally appropriate and targeted care	148
6.2.6 Assessment by the USP	150
6.2.7 Evaluation of the implementation of the intervention	152
6.3 Practice 103.....	153
6.3.1 Context	153
6.3.2 Identification of patient's Indigenous status	153
6.3.3 Assumption of literacy	155
6.3.4 Practice environment	156
6.3.5 Culturally appropriate and targeted care	157
6.3.6 Assessment by the USP	159
6.3.7 Evaluation of the implementation of the intervention	160
6.4 Practice 104.....	161
6.4.1 Context	161
6.4.2 Identification of patient's Indigenous status	162

6.4.3 Assumption of literacy	163
6.4.4 Practice environment	164
6.4.5 Culturally appropriate and targeted care	164
6.4.6 Assessment by the USP	168
6.4.7 Evaluation of the implementation of the intervention	170
6.5 Practice 201	171
6.5.1 Context	171
6.5.2 Identification of patient's Indigenous status	172
6.5.3 Assumption of literacy	174
6.5.4 Practice environment	174
6.5.5 Culturally appropriate and targeted care	175
6.5.6 Assessment by the USP	178
6.5.7 Evaluation of the implementation of the intervention	179
6.6 Practice 202	181
6.6.1 Context	181
6.6.2 Identification of patient's Indigenous status	182
6.6.3 Assumption of literacy	184
6.6.4 Practice environment	184
6.6.5 Culturally appropriate and targeted care	186
6.6.6 Assessment by the USP	192
6.6.7 Evaluation of the implementation of the intervention	196
6.7 Practice 203	198
6.7.1 Context	198
6.7.2 Identification of patient's Indigenous status	198
6.7.3 Assumption of literacy	200
6.7.4 Practice environment	200
6.7.5 Culturally appropriate and targeted care	202
6.7.6 Assessment by the USP	206
6.7.7 Evaluation of the implementation of the intervention	208
6.8 Between Cases and Across Cases	209
6.8.1 Identification of patient's Indigenous status	209
6.8.2 Assumption of literacy	212
6.8.3 Practice environment	216
6.8.4 Culturally appropriate and targeted care	216
6.8.5 Assessment by the USP	219
6.8.6 Evaluation of the implementation of the intervention	225
6.8.7 Summary	234

Chapter 7 - Discussion and Conclusion	237
7.1 Overview.....	238
7.2 Discussion of results in relation to the research questions	239
7.2.1 RQ1: Is the Indigenous status of patients being identified in general practice?	239
7.2.2 RQ2: What processes are in place in general practice to identify the Indigenous status of patients?	241
7.2.3 RQ3: What are the different perspectives of providers, staff and Aboriginal and Torres Strait Islander patients in regards to Indigenous status identification?	245
7.2.4 RQ4: How feasible and effective is a tailored practice facilitation model in improving <i>Indigenous status identification</i> in general practice?	248
7.2.5 RQ5: Are Aboriginal and Torres Strait Islander patients being provided with culturally appropriate health care in general practice?	252
7.2.6 RQ6: How feasible and effective is a tailored practice facilitation model in improving <i>the acceptability of health care provided to Aboriginal and Torres Strait Islander patients</i> in general practice?	257
7.3 Strengths and Limitations.....	260
7.3.1 Research Design	260
7.3.2 Sampling.....	261
7.3.3 Methods	261
7.3.4 Analysis	262
7.3.5 Rigour	263
7.3.5.1 Credibility.....	263
7.3.5.2 Transferability	265
7.3.5.3 Dependability.....	265
7.3.5.4 Confirmability.....	265
7.4 Implications of this research	266
7.5 Conclusion.....	272
 References.....	 275
 Appendices	 294
A1: Expression of Interest Circular.....	294
A2: Participant Information Sheet - General practice	295
A3: Participant Consent Form	297

A4: Participant Information Sheet (Individual/Focus Groups)	299
A5: USP Assessment Checklist	301
A6: Practice Summary and Patient Audit	306
A7: GP and practice staff self-complete questionnaire	308
A8: Example of a baseline Practice Feedback Report	312
A9: Evaluation of the implementation of the intervention (Practice 101)	320
A10: Evaluation of the implementation of the intervention (Practice 102)	323
A11: Evaluation of the implementation of the intervention (Practice 103)	327
A12: Evaluation of the implementation of the intervention (Practice 104)	331
A13: Evaluation of the implementation of the intervention (Practice 201)	336
A14: Evaluation of the implementation of the intervention (Practice 202)	340
A15: Evaluation of the implementation of the intervention (Practice 203)	344

List of Tables

Table 1: Age specific death rates (2008-2012) by Indigenous status	23
Table 2: Advantages and disadvantages of different methods to assess physician performance	52
Table 3: Demographic profile of general practitioners and practice staff	70
Table 4: Demographic profile of Medicare Local staff	72
Table 5: Demographic profile of focus groups participants	73
Table 6: Comparison of criteria for judging research	104
Table 7: Techniques to achieve trustworthiness in qualitative research	105
Table 8: Framework for operationalising the normalisation process theory	131
Table 9: Questions to consider for the NPT components when implementing or evaluating interventions	132
Table 10: Indigenous status of patients ≥18 years (Practice 101)	136
Table 11: How the USPs Indigenous status was identified and recorded (Practice 101).....	138
Table 12: Consultations and Health Assessments for Aboriginal and Torres Strait Islander patients (past 2 years) (Practice 101)	141
Table 13: Indigenous status of patients ≥18 years (Practice 102)	146
Table 14: How the USPs Indigenous status was identified and recorded (Practice 102).....	146
Table 15: Consultations and Health Assessments for Aboriginal and Torres Strait Islander patients (past 2 years) (Practice 102)	150
Table 16: Indigenous status of patients ≥18 years (Practice 103)	154
Table 17: How the USPs Indigenous status was identified and recorded (Practice 103).....	155
Table 18: Consultations and Health Assessments for Aboriginal and Torres Strait Islander patients (past 2 years) (Practice 103)	158
Table 19: Indigenous status of patients ≥18 years (Practice 104)	162
Table 20: How the USPs Indigenous status was identified and recorded (Practice 104).....	163
Table 21: Consultations and Health Assessments for Aboriginal and Torres Strait Islander patients (past 2 years) (Practice 104)	167
Table 22: Patients enrolled in the IHIPIP and/or Indigenous PBS Co-payment Measure (Practice 104).....	168

Table 23: Indigenous status of patients ≥18 years (Practice 201)	172
Table 24: How the USPs Indigenous status was identified and recorded (Practice 201).....	173
Table 25: Consultations and Health Assessments for Aboriginal and Torres Strait Islander patients (past 2 years) (Practice 201)	177
Table 26: Patients enrolled in the IHIPIP and/or Indigenous PBS Co-payment Measure (Practice 201).....	178
Table 27: Indigenous status of patients ≥18 years (Practice 202)	182
Table 28: How the USPs Indigenous status was identified and recorded (Practice 202).....	183
Table 29: Number of staff having undertaken cultural awareness training (Practice 202).....	186
Table 30: Consultations and Health Assessments for Aboriginal and Torres Strait Islander patients (past 2 years) (Practice 202)	190
Table 31: Patients enrolled in the IHIPIP and/or Indigenous PBS Co-payment Measure (Practice 202).....	192
Table 32: Indigenous status of patients ≥18 years (Practice 203)	199
Table 33: How the USPs Indigenous status was identified and recorded (Practice 203).....	199
Table 34: Consultations and Health Assessments for Aboriginal and Torres Strait Islander patients (past 2 years) (Practice 203)	204
Table 35: Patients enrolled in the IHIPIP and/or Indigenous PBS Co-payment Measure (Practice 203).....	206
Table 36: Change between baseline and follow-up: Indigenous status of patients ≥18 years (practices n=7)	209
Table 37: How the USPs Indigenous status was identified and recorded	210
Table 38: Staff responses as to whether patients' Indigenous status is recorded on the patient medical record	212
Table 39: Change in staff knowledge regarding the barriers and enablers to Indigenous status identification between baseline and follow-up	213
Table 40: Change between baseline and follow-up for visual symbols to encourage self-identification of Indigenous status	216
Table 41: Number of staff having undertaken cultural awareness training	217
Table 42: Consultations and Health Assessments* for Aboriginal and Torres Strait Islander patients (past 2 years).....	218
Table 43: Patients enrolled in the IHIPIP and/or Indigenous PBS Co-payment Measure	219

Table 44: Summary of the USPs perceptions of their interactions and experience as a patient in each practice.....	220
Table 45: Evaluation of the implementation of the intervention across practices	227

List of Figures

Figure 1: Australian population age structure by sex and Indigenous status, 2011	22
Figure 2: Age specific death rate ratios (2006-2010) of Aboriginal and Torres Strait Islander peoples compared to other Australians:	23
Figure 3: Millers Pyramid	37
Figure 4: Cambridge model for delineating performance and competence.....	38
Figure 5: Theoretical framework	54
Figure 6: GP recruitment.....	71
Figure 7: The data analysis spiral	95
Figure 8: Thematic map development.....	100
Figure 9: Conceptual framework for primary care organisations	103
Figure 10: The Social-ecological model	112
Figure 11: Theory of planned behaviour	113
Figure 12: <i>Acknowledgement to Country</i> (text-only version)	123
Figure 13: <i>Welcome</i> poster.....	124
Figure 14: <i>Are you Aboriginal</i> sign	125
Figure 15: <i>Are you Aboriginal? Torres Strait Islander?</i> ABS patient information leaflet.....	126
Figure 16: <i>One simple question could help you close the gap</i> AIHW patient information leaflet.....	127
Figure 17: Model of the components of the Normalisation Process Theory.....	130

List of Boxes

Box 1: Standardised patient scenario and instructions - Baseline	75
Box 2: Standardised patient scenario and instructions – Follow-up.....	77
Box 3: Outline of the USP assessment checklist.....	81
Box 4: Interview schedule for general practice staff and general practitioners ...	84
Box 5: Interview schedule for Medicare Local Closing the Gap Officers.....	85
Box 6: Focus group (Aboriginal and Torres Strait Islander patients) interview schedule	90
Box 7: Outline of the practice summary and patient audit	92
Box 8: Outline of the GP and practice staff self-complete questionnaire	93
Box 9: Example of initial coding	97
Box 10: Example of theme development (respondent level)	98
Box 11: Example of theme development (case level).....	101
Box 12: Outline of the practice feedback report	121

Glossary of Acronyms

ACCHS	Aboriginal Community Controlled Health Service
AMS	Aboriginal Medical Service
CPD	Continuing Profession Development
COAG	Council of Australian Governments
CtG	Closing the Gap
DGP	Division of General Practice
F/T	Full-time
GP	General Practitioner
IHIPIIP	Indigenous Health Incentive Practice Incentive Program
MBS	Medical Benefits Schedule
ML	Medicare Local
NPT	Normalisation Process Theory
PBS	Pharmaceutical Benefits Scheme
PIP	Practice Incentives Program
PM	Practice Manager
PN	Practice Nurse
P/T	Part-time
RACGP	Royal Australian College of General Practitioners
USP	Unannounced Standardised Patient

Chapter 1

Introduction

This chapter sets the scene for this research. It begins by providing an overview to the health needs of Aboriginal and Torres Islanders compared to other Australians. A description of the Australian Government's response to the problem is given along with a discussion on how this response is insufficiently proportionate to need. This is followed by a discussion on the issues Aboriginal and Torres Strait Islanders patients encounter when accessing non-Aboriginal Community Controlled Health Services (mainstream general practice). The gap in the literature is then identified, followed by the rationale for this research, the research aims and the research questions. The chapter concludes with an overview of the thesis.

1.1 The health needs of Australia's Indigenous peoples

1.1.1 Aboriginal and Torres Strait Islander morbidity and mortality

Indigenous populations worldwide continue to experience poorer health outcomes than their non-indigenous counterparts¹. Aboriginal and Torres Strait Islander peoples, the Indigenous peoples of Australia, have some of the poorest health and welfare outcomes in the Organisation for Economic Co-operation and Development²⁻⁴. The population age demographics for Aboriginal and Torres Strait Islander peoples are similar to those found in many developing countries⁵. Aboriginal and Torres Strait Islander peoples are significantly younger (median age 21 compared to 37 for other Australians), over 37% are aged under 15 years (compared to 20%), and only 3% are aged over 65 years (compared to 13%)^{4, 6} (see Figure 1).

Image not included in this publication due to copyright restrictions

Source: ABS. Estimates of Aboriginal and Torres Strait Islander Australians, June 2011⁷.

Figure 1. Australian population age structure by sex and Indigenous status, 2011

The age structure of Aboriginal and Torres Strait Islander peoples is mirrored in the age specific death rates. Aboriginal and Torres Strait Islander peoples die at higher rates and at younger ages, with a life expectancy of around 15% (11.5 years males; 9 years females)⁶ lower than that for the overall Australian

population (see Table 1 and Figure 2). It is believed that this gap may be underestimated with the true gap being around 15 years^{8,9}.

Table 1. Age specific death rates (2008-2012) by Indigenous status

Table not included in this publication due to copyright restrictions.

Source: ABS. Death Australia 2012².

Image not included in this publication due to copyright restrictions.

Source: ABS. The Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples 2010⁴.

Figure 2. Age specific death rate ratios (2006-2010) of Aboriginal and Torres Strait Islander peoples compared to other Australians

Although an underestimate⁹, Aboriginal and Torres Strait Islander peoples are said to constitute about 2.5% percent of the total Australian population⁴, yet contribute 3.6% of the total burden of disease⁴. Chronic diseases account for 80% of the difference in the burden of disease observed between Aboriginal and Torres Strait Islander peoples and other Australians¹⁰. Chronic conditions occur at much earlier ages in Aboriginal and Torres Strait Islander populations, and in the 35–54 years age group, chronic disease accounts for 75% of the mortality gap for males and 79% for females^{10, 11}.

1.1.2 Aboriginal and Torres Strait Islander morbidity and mortality according to remoteness area

The majority (75%) of Aboriginal and Torres Strait Islander peoples live in cities and non-remote regional areas: nearly one-third (32%) live major cities; 21% live in inner regional areas and 22% in outer regional areas; and only 9% live in remote or very remote (15%) areas⁶.

Mortality rates for non-Indigenous Australians are lowest in major cities and increase with measure of remoteness; in contrast, death rates for Aboriginal and Torres Strait Islander peoples are lowest in inner regional areas, higher in major cities, and then increase steadily over outer regional and remote areas before falling again in very remote areas¹². The greater proportion of studies in Aboriginal and Torres Strait Islander health research have been carried out in rural and remote areas and limited information is available in an urban context^{12, 13}. Although there is limited data on the distribution of Aboriginal and Torres Strait Islander morbidity across areas, available research shows that Aboriginal and Torres Strait Islanders are more likely to experience chronic disease at higher rates in the major city areas^{14, 15}.

1.1.3 Health service usage by Aboriginal and Torres Strait Islander peoples

Aboriginal and Torres Strait Islander peoples highly utilise community health services and public hospitals (21% and 49% respectively compared to 3.9% and 28% for other Australians), and are comparatively low users of privately provided health services such as general practitioners (GPs), specialists, dental,

pharmaceutical and other health services, which are accessed by other Australians at a rate of about 40% higher than Aboriginal and Torres Strait Islander peoples¹⁶.

Potentially preventable hospitalisations are hospitalisations that could potentially have been prevented through the timely and appropriate provision of primary care. Aboriginal and Torres Strait Islander peoples have an overall rate of potentially preventable hospitalisations 4.9 times higher than other Australians¹⁷, with individual category rate ratios of 3.8 for vaccine-preventable conditions, 2.3 for acute conditions, and 7.5 for chronic conditions¹⁷.

The data presented above clearly demonstrates the greater health needs for Aboriginal and Torres Strait Islander peoples and the need for good quality primary health care, particularly in major cities areas. The Australian Government's response to this need will now be discussed.

1.2 The Australian Government's response to the health needs of Aboriginal and Torres Strait Islander peoples

Evidence exists that access to primary care has the biggest impact on health outcomes¹⁸. Evidence from Australia, the United States and New Zealand indicates that primary health care can contribute to closing the gap in life expectancy between indigenous and non-indigenous populations¹⁹. In response to the health needs of Aboriginal and Torres Strait Islander peoples, the Australian government undertook two main activities from 2008. The first was to provide funding to 211 Aboriginal and Torres Strait Islander primary health-care services²⁰ and to increase access to mainstream primary health services. The second activity was the Indigenous Chronic Disease Package introduced as part of the Council of Australian Governments (COAG), *National Indigenous Reform Agreement*²¹. Each will be discussed in further detail below.

1.2.1 Aboriginal and Torres Strait Islander primary health care services

By 2011-12, the number of Aboriginal and Torres Strait Islander primary health care services funded by the Australian Government had increased from 211 to 226²². Included in this were approximately 150 Aboriginal Community Controlled Health Services (ACCHS), which were used by up to 50% of Aboriginal and Torres Strait Islander patients²³. In 2011-12, Aboriginal and Torres Strait Islander primary care services provided 2.6 million episodes of health care to about 445,000 clients, 79% of whom were identified as being of Aboriginal and Torres Strait Islander descent²².

The majority of Aboriginal and Torres Strait Islander primary care services are located in regional, remote and very remote areas; 15% are in major cities⁵. As one third of the Aboriginal and Torres Strait Islander population lives in the major city areas, the proportion of Aboriginal and Torres Strait Islander primary health services in these areas is disproportionate to the Aboriginal and Torres Strait Islander population in these areas.

1.2.2 Indigenous Chronic Disease Package

The second activity undertaken by the Australian Government in response to the health needs of Aboriginal and Torres Strait Islander peoples was the introduction of the Indigenous Chronic Disease Package. It is appropriate to first provide a brief overview of the National Indigenous Reform Agreement. In November 2008, COAG agreed to a partnership between all levels of government to work with Aboriginal and Torres Strait Islander peoples to close the gap in Indigenous disadvantage with aim to achieve six targets. These targets, known as the 'Closing the Gap targets' are:

- Halving the gap in mortality rates for Indigenous children under five within a decade;
- Ensuring all Indigenous 4-year olds in remote communities have access to early childhood education within 5 years;
- Halving the gap for Indigenous students in reading, writing and numeracy within a decade;

- Halving the gap for Indigenous people in Year 12 attainment or equivalent attainment rates by 2020;
- Halving the gap in employment outcomes between Indigenous and non-Indigenous Australians within a decade²¹.

The Indigenous Chronic Disease Package is the Australian Government's contribution to achieving COAG's Closing the Gap health goals. The Australian Government Department of Health and Aged Care states that, "*The Indigenous Chronic Disease Package aims to support both health services and Aboriginal and Torres Islander individuals to improve access to and outcomes of care*"²⁴ (imprint page). A core component to the package is the Aboriginal and Torres Strait Islander Health Assessment (MBS Item number 715)^{25, 26}. The MBS Item 715 was created in 2010 by merging the separate Aboriginal and Torres Strait Islander Health Assessment items for older people (MBS Item 704) created in 1999, adults (MBS Item 710) created in 2004, and children (MBS Item 708) created in 2006, into the one item number²⁷.

Research shows that health assessments for Aboriginal and Torres Strait Islander peoples have the potential for earlier diagnosis of disease and earlier intervention, which may lead to reduced health care costs²⁸⁻³⁰. Despite this the uptake of these health assessments remains low^{31, 32}. Kehoe and Lovett reviewed the number of adult Aboriginal and Torres Strait Islander Health Assessments undertaken from 2004-2008 and found that less than 10% of the Aboriginal and Torres Strait Islander population had undertaken a health assessment, with even lower rates in urban areas³¹. There has been little change in the uptake of these health assessments. In 2012, 8.8% of Aboriginal and Torres Strait Islanders aged 15-54 had undertaken an Aboriginal and Torres Strait Islander Health Assessment; in 2013 this was 10.8%^{7, 33}. The uptake is variable across Australia and is generally quite low in major cities. For example, in 2012 in the Eastern Sydney and South Eastern Sydney Medicare Local areas the uptakes were 6 and 7% respectively; in 2013, the numbers fell to 5% and 6% respectively^{33, 34}. It should be noted that the MBS Item 715 can be performed every nine months²⁶ and these figures may be an over representation of the true figures as more than one health assessment could have been performed on any individual. In addition, the statistics for Medicare Local areas cannot be broken down into age groups so the figures presented include all Aboriginal and Torres Strait Islander Health Assessments, not just those aged 15-54 years, and are an over representation of

the actual number of health assessments performed on adults. This further demonstrates the low uptake of Aboriginal and Torres Strait Islander Health Assessments for adults in urban areas.

A number of barriers to health assessments have been identified, including lack of knowledge of their existence, lack of time, and lack of Indigenous status identification systems^{31, 35-39}. These will be explored further in this research.

1.3 Non-Aboriginal Community Controlled primary health care services (mainstream general practice)

Evidence from overseas highlights the importance of the existence of Indigenous-specific services, which deliver appropriate and acceptable health services and provide indigenous patients with greater choice for their health care needs⁴⁰. However, the existence of Aboriginal and Torres Strait Islander-specific health services does not absolve mainstream general practice of the responsibility to provide high quality and culturally appropriate health services to Aboriginal and Torres Strait Islander patients. Considering that approximately 60% of Aboriginal and Torres Strait Islander patients access mainstream general practice for their health care needs⁴¹, it is essential that mainstream general practice provides quality culturally appropriate health care.

In their 2001 report, *We Can Do It!*⁴², the House of Representatives Standing Committee on Aboriginal and Torres Strait Islander Affairs stated, "*In urban areas at least, the urgent priority should be on meeting the needs of Indigenous people through better access to mainstream services...*"⁴²(p20).

The above statement has been challenged with the opposing viewpoint that the priority should be given to extending the reach of Aboriginal and Torres Strait Islander-specific health services. The focus of this research is not to compare models of healthcare but to develop and evaluate an intervention to improve the cultural appropriateness and quality of care provided to Aboriginal and Torres Strait Islander patients in mainstream general practice.

In recent years there has been a greater emphasis on 'mainstreaming' health services, particularly in urban areas. According to Medicare data, Aboriginal and Torres Strait Islander peoples access mainstream general practice at a rate similar to other Australians²⁰. However, because the health needs of Aboriginal and Torres Strait Islander peoples are higher, they should be accessing general practice at higher rates than other Australians. An indication for this is the high rate of potentially preventable hospitalisations, which as mentioned in Section 1.1.3, are 4.9 times higher for Aboriginal and Torres Strait Islander peoples than other Australians²⁰. A high rate of potentially preventable hospitalisations could reflect inadequacies in the care provided in primary care and this will be discussed in further detail in the next section. The high rates of potentially preventable hospitalisation could also indicate that the Medicare figures are an underestimate of the true figures of general practice usage by Aboriginal and Torres Strait Islander peoples. Under-identification of Indigenous status will be discussed further below in Section 1.3.2.

1.3.1 Barriers to access

Barriers to health care access can be due to problems of approachability, availability, affordability, acceptability and appropriateness^{43, 44}. In non-remote areas where primary health care services are more geographically available, 55% of Aboriginal and Torres Strait Islanders peoples reported that they experienced problems with access due to appointments not being available when needed and long waiting times, 37.5% reported cost as an issue, and 5.5% reported problems in accessing services because they were not culturally appropriate⁴⁵. A study which interviewed 55 Aboriginal and Torres Strait Islander people in south western Sydney regarding their views on health care access found the main barriers to access were: financial (cost of co-payment to the GP or medication, cost of transport); communication (low literacy levels making it difficult to read information and difficulty understanding the information GPs and receptionists gave them); and shame (in regards to their health problems and the lack of success in following the advice given to them by the GP)⁴⁶.

In their review of health care access for Aboriginal and Torres Strait Islander people living in urban areas, Scrimgeour and Scrimgeour state that acceptability

and appropriateness are particularly significant barriers to accessing mainstream general practice¹².

Analysis of focus group data in a 2012 study by Lau et al found, "Two overarching themes were identified as barriers by nearly all participants: history (of dispossession) and racism and discrimination"⁴⁷(p71). The authors go on to say that, "These may be positively transformed into facilitators if there is 'recognition and acknowledgement of history'⁴⁷(p71). This highlights not only the need for cultural awareness training, but the need for culturally appropriate practice environments. These are discussed in more detail in Chapter 5.

1.3.2 Indigenous status identification in mainstream general practice

It is recognised internationally that information on patient race and ethnicity is required to identify inequalities in health status, access to health care, differences in the quality of health care provided, and health outcomes of different populations, and to allow for the development of targeted interventions to reduce the disparities between ethnic populations⁴⁸. In order to offer targeted services to Aboriginal and Torres Strait Islander patients in general practice, effective Indigenous status identification systems are required.

In January 2009, less than half (41%) of the total Aboriginal and Torres Strait Islander population had identified themselves as Indigenous under the Medicare Voluntary Indigenous Identification program: 47% in rural areas, and 35% in urban areas¹⁶. By 2012, 59% of the total Aboriginal and Torres Strait Islander population had identified themselves⁴¹, leaving 40% of the Aboriginal and Torres Strait Islander population's Medicare claims unaccounted for. Figures derived from GP reports of their encounters show a similar picture. In 2010-2011, 1.2% of all encounters in general practice were by patients recorded by their GP as being of Aboriginal and Torres Strait Islander descent⁴⁹.

Previous research investigating Indigenous status identification in general practice in Australia have found that few general practices had established processes in place identify the Indigenous status of patients^{35, 36, 38, 50, 51}. The Australian Institute of Health and Welfare 2013 publication, 'Taking the next

steps: identification of Aboriginal and Torres Strait Islander status in general practice⁵² states:

"...only a minority of general practices have effective processes to routinely collect Indigenous status data from patients/clients, and that there are considerable barriers to implementing these processes. In addition, the structure of the general practice sector means that improving Indigenous data collection faces different challenges compared with other health settings"⁵²(p1). Furthermore, "Research studies specifically investigating general practice identification processes predate the impact of recent reforms, which have taken place largely since 2010. These studies showed only a minority of mainstream general practices had routine identification processes in place for all patients...While specific investigations have not been repeated since the reforms were implemented, overall data on general practice activity indicate little change in the proportion of patients recorded as Aboriginal or Torres Strait Islander"⁵²(p6).

Although the recording of Indigenous status is compulsory in the public sector⁵³, it is not mandatory in general practice and general practice processes are guided largely by the general practice industry standards, the *Standards for General Practices*⁵⁴, set by the Royal Australian College of General Practitioners (RACGP). Indigenous status identification was first introduced into the *Standards for General Practices (3rd edition)*⁵⁵ in July 2005. To provide more guidance on establishing Indigenous status, the RACGP released the document, *Fact Sheet: The identification of Aboriginal and Torres Strait Islander people*⁵⁶, in 2006.

In 2010, the Australian Institute of Health and Welfare released the *National best practice guidelines for collecting Indigenous status in health data sets*⁵⁷, which provided comprehensive guidance for collecting Indigenous status in the health sector overall. The RACGP released a new edition of the *Standards*, the 4th edition⁵⁴, which aligned their *Standards* with the *National Best Practice Guidelines*. In addition, the RACGP released the comprehensive document, *Identification of Aboriginal and Torres Strait Islander people in Australian general practice*⁵⁸ in 2011. Despite the availability of the abovementioned guidelines and documents, identification of Indigenous status in general practice remained low. This will be explored further in this research.

1.4 The rationale for this research

Aboriginal and Torres Strait Islander peoples have greater health needs than other Australians. Chronic disease accounts for 80% of the difference in the burden of disease observed between Aboriginal and Torres Strait Islander peoples and other Australians, with those in urban areas experiencing greater disease. Primary health care has the potential to play a significant role in closing the gap in life expectancy between Indigenous and non-Indigenous populations. Health assessments provide opportunities for earlier diagnosis of disease and earlier intervention in primary health care. Aboriginal and Torres Strait Islander primary care services provide culturally appropriate care to Aboriginal and Torres Strait Islander peoples but only 15% of these services are in the major city areas where nearly one third of the Aboriginal and Torres Strait Islander population lives. Sixty percent of Aboriginal and Torres Strait Islander peoples access mainstream general practice. Mainstream general practice may not be culturally appropriate or acceptable to Aboriginal and Torres Strait Islander peoples. Few mainstream general practices have effective Indigenous status identification systems in place, resulting in Aboriginal and Torres Strait Islander peoples missing out on health services targeted to their needs such as Aboriginal and Torres Strait Islander Health Assessments. Research specifically investigating general practice Indigenous status identification processes predates the National Indigenous Reform Agreement 2008.

In order to offer targeted services to their Aboriginal and Torres Strait Islander patients, effective Indigenous status identification systems are required in general practice. The current industry guidelines that are available to improve Indigenous status identification in general practice have had a limited impact on improving Indigenous status identification rates in general practice. Inaccurate and incomplete Indigenous data in national health data sets also impedes policy and program development for Aboriginal and Torres Strait Islander health issues. Improving Indigenous status identification systems in general practice will ensure that government, policy makers and health services have more accurate data to inform their decisions.

1.5 Research aim

This study aimed to develop and evaluate a tailored practice facilitation model to improve the acceptability and appropriateness of health care provided to Aboriginal and Torres Strait Islander patients who attend mainstream general practice in the metropolitan area of Sydney.

1.6 Research questions

This thesis addressed the following six questions:

1. Is the Indigenous status of patients being identified in general practice?
2. What processes are in place to identify the Indigenous status of patients in general practice?
3. What are the different perspectives of providers, staff and Aboriginal and Torres Strait Islander patients in regards to Indigenous status identification?
4. How feasible and effective is a tailored practice facilitation model *in improving Indigenous status identification* in general practice?
5. Are Aboriginal and Torres Strait Islander patients being provided with culturally appropriate health care in general practice?
6. How feasible and effective is a tailored practice facilitation model *in improving the acceptability of health care provided to Aboriginal and Torres Strait Islander patients* in general practice?

1.7 What led me to do this research

While I was working at a Division of General Practice in 2008-2009, although no-one in the Division was working on Aboriginal Health, a colleague and I were

discussing the very low uptake of the Aboriginal and Torres Strait Islander Adult Health Assessments. This prompted me to ask, "*Why are Aboriginal and Torres Strait Islander peoples not utilising these services which are available to them?*"

Shortly after I changed employment to the Centre for Primary Health Care and Equity, UNSW Australia. I spoke to my supervisor about my interest in pursuing research on this question. It was suggested that I should reshift my focus from the patients to the services and systems within general practice. Reflecting on my own education, I realised that my way of thinking was fairly typical of the broader population who were educated in Australia in my time. I attended a leading academic high school in Sydney, and Australian history was taught from the time of colonisation. During my TAFE course and undergraduate biomedical science degree, I learnt of disease states and a raft of communicable diseases in disadvantaged communities around the world, but Australia's Aboriginal and Torres Strait Islander peoples were never mentioned. Had I not selected an assignment on Aboriginal health in my Masters degree, my knowledge on the health inequities between Aboriginal and Torres Strait Islanders and other Australians might still be limited to, 'Indigenous Australians experience greater ill health.' Unfortunately my case is fairly typical of people educated up to the 2000's, and although not acceptable, it is understandable how many working within the western health, law and education frameworks are unaware of the extent of the health disparities between Aboriginal and Torres Strait Islander peoples and other Australians and why these disparities exist.

My previous experience working in the Market Research industry had exposed me to the shadow shopper methodology, the equivalent of unannounced standardised patients in the health industry. I was aware of the enormous value of shadow shoppers in that they showed what people actually did as opposed to what they thought they did. In general practice there exists a lack of knowledge on the existence and extent of the health disparities between Aboriginal and Torres Strait Islander Australians. By filling this knowledge gap and by showing general practice that they were not identifying their Aboriginal and Torres Strait Islander patients and thereby not offering their Aboriginal and Torres Strait Islander patients services specifically targeted for them, I hypothesised that it may be possible to improve the uptake of those services. This is the perspective from which this research was conducted.

1.8 An overview of the thesis

This chapter discussed the need for this research. It also identified the gap in the literature, and provided the rationale for this research, the research aims and questions.

Chapter 2 defines the difference between physician competence and performance. It then provides a comprehensive review of the literature regarding the suitability of the different methods available to assess performance in general practice.

The theoretical underpinnings of this research are discussed in Chapter 3, as are the ethical considerations.

The data collection methods are described in Chapter 4.

The development, implementation of the intervention and the methods used to evaluate the implementation of the intervention are discussed in Chapter 5.

The results of the case study analysis are provided in Chapter 6.

The thesis concludes with a discussion in Chapter 7.

Chapter 2

Assessing physician performance

The chapter begins by defining the difference between physician competence and performance, followed by a discussion on why physician performance should be assessed. A description of the search strategies used for the literature search is then provided, followed by a discussion on the various methods available to assess physician performance and the advantages and limitations of each. The chapter concludes by summarising why the unannounced standardised methodology was chosen for this study.

2.1 Assessing physician performance

Physician competence is defined as what a doctor is capable of doing in a testing situation and is often estimated from test scores or other standard measures, whereas performance is defined as what a doctor does in actual practice, which may be quite different to what they do in a testing situation^{59, 60}. Miller (pS63)⁶¹ described clinical competence as the degree to which a clinician can use their knowledge, skills and good judgement in an effective way in their field of practice. This stepped approach to action is conceptualised in his educational-based model, Miller's Pyramid (Figure 3), which contains four tiers: *Knows* (knowledge), *Knows How* (competence), *Shows How* (performance) and *Does* (action)⁶¹.

Image not included in this publication due to copyright restrictions

Source: Miller 1990⁶¹ (pS63)

Figure 3. Millers Pyramid

Rethans et al argue that, "*Miller's triangle implicitly assumes that competence predicts performance*"⁵⁹(p906). Furthermore, Miller's model does not account for the variations on clinical performance brought about by systemic and individual factors. Rethans et al proposed the *Cambridge Model for Performance and Competence* (Figure 4) based on an inverted form of Miller's model. This model identifies that just because a physician *Knows How* and *Shows How* does not necessarily mean that this is what the physician *Does* in real practice. The model acknowledges that performance is a product of competence as well as individual and systemic influences^{59, 60} and hence is consistent with the social-ecological

model previously discussed. This model is particularly indicative of physician performance in general practice.

Image not included in this publication due to copyright restrictions

Source: Rethans et al 2002⁵⁹ (p907)

Figure 4. Cambridge model for delineating performance and competence

Assessing performance is central to quality management. Patient outcomes and the process of care are principal measures in health care and are used to identify areas that need improvement and measure whether targets have been achieved. However, physician performance is a multidimensional construct and assessing it requires more than a checklist of adherence to guidelines, which is only one dimension of the doctor-patient relationship. Physician performance includes every aspect of how a physician interacts with their patient: the doctor-patient relationship, the physician's ability to listen to their patient as well as the physician's medical knowledge and competence.

Peabody et al state that clinical performance should be measured because, "*Practice can be improved, but only if it is measured*"⁶²(p778). While this statement may be challenged, the general argument that measuring something helps one to improve it is valid. However, whether one can *only* improve an area by measuring it is an entirely different argument. As the term *measuring* tends to lend itself to quantification, *assessing* shall be used in this thesis as it can be applied to both quality and quantity evaluations. Depending on the area being assessed, variation in physician performance requires either qualitative or quantitative assessments, or both.

2.2 Literature search

2.2.1 The literature search research question

The research question for the literature review was, “*What are the strengths and weaknesses of the different methods of assessing physician performance (including communication skills and patient satisfaction) delivered to minority populations in general practice?*” Searches were conducted in the Medline (1948 onwards), Embase (1974 onwards), Cochrane Database of Systematic Reviews (2005 onwards), Global Health (1973 onwards) and Informit databases. Google scholar was also used for the survey/questionnaire assessment area. Separate searches were conducted for each of the assessment methods as well as a search on physician performance and are described below.

2.2.2 The search strategy

2.2.2.1 Unannounced standardised patients

The initial search terms of *simulated patient OR standardi* patient AND unannounced OR incognito* yielded 214 abstracts. This was then restricted to *primary care*, which resulted in 82 abstracts remaining after duplicates were removed.

2.2.2.2 Direct observation

The initial search terms used were *direct observation AND primary care*, which yielded 1274 abstracts. This was then restricted to *physician performance*, which resulted in 48 abstracts after duplicates were removed. A different set of restrictions were also applied to the initial search to ensure important papers were not missed when the *physician performance* restriction was applied. Therefore the *direct observation AND primary care* search (1274 abstracts) was restricted by *valid* OR reliab**, leaving 730 abstracts. This was then further restricted by *standardised patient (simulated patient OR standardi* patient AND unannounced OR incognito) OR record abstraction (chart abstraction OR record abstraction OR record audit) OR exit interview OR vignette OR survey*, which left 381 abstracts.

2.2.2.3 Medical record abstraction

Two separate searches were conducted. The first search used the terms *chart abstraction* OR *record abstraction* OR *medical record audit* AND *physician performance* to yield 53 abstracts. The initial search terms used for the second search were *chart abstraction* OR *record abstraction* OR *medical record audit* AND *primary care*, which generated 802 abstracts. This was then restricted by *valid** OR *reliab**, leaving 478 abstracts after duplicates were removed.

2.2.2.4 Vignettes

Two separate searches were conducted. For the first search, the initial search terms used were *vignettes* AND *primary care*, yielding 1593 abstracts. This was then restricted by *valid** OR *reliab**, which reduced the number of abstracts from 1593 to 620 abstracts. This search was further restricted by *physician performance*, which left 19 abstracts after duplicates were removed. To ensure papers were not missed when the *valid** and *reliab** restrictions were applied, a second search was conducted using the search terms *vignettes* AND *physician performance*, which resulted in 45 abstracts after duplicates were removed.

2.2.2.5 Survey/Questionnaire

The initial search terms used were *physician survey* OR *patient survey* AND *primary care*. This yielded 1573 abstracts. This was then restricted by *valid** OR *reliab**, leaving 720 abstracts. This was then further restricted by *standardised patient (simulated patient OR standardi* patient AND unannounced OR incognito)* OR *record abstraction (chart abstraction OR record abstraction OR record audit)* OR *vignette* OR *direct observation*, which resulted in 73 abstracts remaining. Additional searches were also conducted on Google Scholar using the terms *physician survey validity* (253,000 matches) and *patient survey validity* (416,000 matches).

2.2.2.6 Exit interview

The search terms used were *exit interview* AND *primary care*, which resulted in 112 abstracts.

2.2.2.7 Physician performance

The final search conducted used the search terms *physician performance* AND *primary care*, which resulted in 186 abstracts after duplicates were removed.

2.2.3 Papers Reviewed

The titles and abstracts of the 1429 papers generated in the final searches (excluding those from Google Scholar) were screened for relevance to the research question. If the relevance to the research question was not clearly indicated in the abstract but the paper looked promising, it was included in those selected to be reviewed to ensure any important papers were not missed. All selected papers were retrieved in full text for review. The reference lists of these papers were then also carefully scanned to identify additional papers that might have been missed in the original search and the process of reviewing their reference lists was repeated in a snowball effect. A total of 98 papers were reviewed fully from these searches. The first 50 matches of the Google Scholar search were scanned and four papers were retrieved for full review. In total, the final number of papers reviewed fully was 102.

The various methods for assessing physician performance are discussed in the next section.

2.3 Methods of assessing physician performance

Performance in general practice can be assessed by either indirect or direct methods. Indirect methods include medical record/chart abstraction (also known as medical record audit), and surveys or interviews with patients or physicians after the consultation; direct methods are those where the doctor-patient interaction is heard or seen and include direct observation, video or audio recordings, and unannounced standardised patients^{63, 64}. A brief description along with the advantages and limitations of these methods are discussed below.

2.3.1 Indirect methods

2.3.1.1 Medical Record Abstraction

Record abstraction has been described as the most widely used method of assessing physician quality⁶⁵. The clinical records that are generated during consultations are retrieved at a later date by a skilled data abstractor. Skilled experts then score the data according to predetermined criteria based on clinical guidelines and/or expert panels.

Record abstraction has been used extensively to assess aspects of patient care. It has the advantage of easy accessibility⁶⁶ and does not intrude on the consultation or on the doctor's time. Record abstraction can be collected on a large sample base and also allows for the assessment of rare conditions⁶⁷. Several studies have shown that record abstraction can provide accurate assessment of some areas of service delivery, however, these are generally limited to those services that are usually also recorded in other areas of the medical record such as cancer screening notes or referrals^{66, 68}, pelvic and rectal examinations⁶⁶ and measurement of blood pressure⁶⁹.

The main limitation to record abstraction is that medical records are subject to recording bias: false negative results (actions and/or tests are carried out but are not documented in the record) result in under-reporting of performance^{65, 66, 69-73}, and false positives (actions and/or tests which have not been carried out are documented as having been performed in the record) result in over-reporting of performance^{65, 70, 73}. One study found that when compared to unannounced standardised patients and vignettes, record abstraction under-reported performance by 16%⁷⁰. Another study found that when compared to unannounced standardised patients, record abstraction over-reported performance by 19%⁷³. Mant et al demonstrated that medical records are also prone to misclassification: in their study they found that 46% of ex-smokers were recorded in the medical records as never smokers⁷⁴. With a sensitivity of 70% and specificity of 81%, record abstraction is neither a sensitive nor a specific method for assessing physician performance⁷³ and a study by Rethans et al concluded that using record abstraction was invalid method to assess physician performance in general practice⁷⁵. Other limitations of record abstraction include illegibility of medical records, incomplete or missing medical records, variations in skill levels between abstractors^{65, 67, 70} and the cost of skilled abstractors⁷⁶.

Additionally record abstraction does not control for case mix⁶⁵ (the variability due to different patients and conditions). Finally, record abstraction cannot assess patient satisfaction or physician interpersonal skills^{64, 72, 76, 77} and can therefore not be used to improve these areas of performance.

2.3.1.2 Vignettes

Vignettes are written or computerised patient case simulations that have been used widely to measure a physician's ability to assess, diagnose and treat specific medical conditions⁶². A physician is presented with a case scenario and asked to provide responses identifying areas such as history, physical examination, diagnostic testing and treatment plan⁷⁰. Skilled experts then score the completed vignettes according to predetermined criteria, based on clinical guidelines and/or expert panels. Simulations that are computerised can be set up so that physicians cannot go back to previously completed answers to modify their responses once new information becomes available, greatly improving their accuracy⁶². In a study of 7138 physicians, Veloski et al found that physicians scored much higher when they took the test using the standard five-option multiple choice questions than when they were tested on the same vignette using open-ended responses⁷⁸. The authors found that vignettes using open-ended questions more closely resemble the actual practice setting and are therefore more reflective of physician performance and they recommended that open-ended questions be used to strengthen the content validity of vignettes⁷⁸.

Dresselhaus et al concluded that vignettes are a more valid method for measuring performance than record abstraction⁷⁹. One of the main advantages of vignettes is that they control for case mix^{62, 80} because all physicians are presented with the same stimulus. This results in the ability to attribute responses to individual physicians, to assess their approach to low- or high-prevalence problems in unique patient populations and to compare results across sites⁸⁰. Other advantages of vignettes are that they are easily administered, are less costly compared to analysis of claims data, record abstraction and unannounced standardised patients^{65, 80, 81}, that they need not intrude into the practice setting and the economies of scale allow them to be administered to a large number of physicians simultaneously⁸⁰.

However, vignettes overestimate performance^{65, 71} and only reflect what physicians are competent or knowledgeable enough to do^{60, 65}. That is, they reflect physician competence not actual clinical practice. Another main limitation to vignettes is the sentinel effect in which physicians know they are being assessed: physicians will give their best answer when responding to a vignette because they are in a test situation and this may not reflect what they would actually have done in everyday practice^{59, 80, 82}. Finally, vignettes cannot assess areas of physician performance such as communication skills and the physical exam⁸⁰ and therefore cannot be used to improve these areas of performance.

2.3.1.3 Self-report questionnaires/surveys

Respondents are provided with a questionnaire which they are asked to fill out and return by mail, or alternatively self-report questionnaires can be performed over the telephone. When respondents are interviewed face-to-face directly after the event, it is referred to as an exit interview. Each of these methods are discussed below.

2.3.1.3.1 Patient self-report postal and telephone surveys

The main advantages of patient self-report postal surveys is that this method does not affect the consultation in any way⁸³, and it is a relatively efficient and low cost^{84, 85} method compared to other methods. Palonen et al compared patient surveys to medical record abstraction and found that patient surveys were significantly cheaper at US\$17 per physician compared to US\$107⁸⁵. In a review of postal surveys published in medical journals, Asch et al reported a mean response rate of 68%⁸⁶. Several tactics have been shown to be useful in increasing response rates. A systematic review of randomised controlled trials to influence postal questionnaires response rates found that the odds more than doubled when a monetary incentive was used and almost doubled when incentives were not a condition of response. Other factors that increased response rates included the use of personalised questionnaires and letters, use of coloured ink, stamped return envelopes, contacting participants before sending questionnaires, having short questionnaires, providing reminder copies of the questionnaire, follow up contact, and questionnaires originating from universities⁸⁷. Both written and telephone reminders result in a 13% increase in response rates⁸⁶, however, surveys containing questions of a sensitive nature are less likely to be returned⁸⁷.

The main disadvantages of postal and telephone self-report data is that it is subject to recall bias (resulting in highly variable results ranging from under-reporting through to over-reporting depending on the area being assessed), telescoping (recalling an event as occurring more recently than it did) and social desirability bias (resulting in over-reporting)^{67, 83, 88}. Montano et al compared patient self-reported cancer screening rates to the medical records and found a high correlation (kappa >0.70) between the two⁶⁸. [The kappa statistic (κ) measures the level of agreement that could be expected to occur beyond chance: $\kappa=1.0$ is perfect agreement, $\kappa=0$ is no agreement beyond chance]⁸⁹. A similar study by Tsubono et al also reported a high correlation (kappa=0.68), as well as a sensitivity of 100% and specificity of 75.6%⁹⁰. When looking at smoking and alcohol and counselling, Mant et al found less agreement (kappa=0.50)⁷⁴.

On the over-reporting end of the spectrum, several studies have shown that patient self-report rates of preventive services are substantially higher than those obtained from the medical records^{69, 74, 88, 91}. Considering the level of under-reporting in medical records, this is not surprising. Over-reporting is not limited to patient postal surveys and telephone surveys are similarly biased. Nicholson et al found that hospital patients reported 30% more physician preventive counselling than what was indicated in the medical record and the level of agreement between the two was very low (kappa <0.15)⁹¹. Fowles et al found that patient self-reported telephone surveys over-reported diabetes screening⁸⁸ and in a study of 9704 elderly women, Nevitt found an 11% false positive rate for self-reported fractures and a further 20% could not be confirmed in the medical records⁹². Reports obtained during telephone surveys were more accurate than reports by postal questionnaire (9% false positive versus 12%), suggesting that telephone surveys may be useful in eliminating some false-positive reports⁹².

On the other opposite end of the spectrum, under-reporting is also common in patient self-report postal and telephone surveys. Stange et al showed that the accuracy of patient recall declined with the duration of time since the event⁶⁶. Additionally, recall of a discussion or event during a consultation may be diminished if it is not of significance to the patient⁸⁸. Screening events may have been carried out by the physician but not directly discussed with the patient and will therefore not be indicated in patient self-reports⁶⁶. Flocke et al compared 2670 patient self-report questionnaires against direct observations and found that patients under-reported health behaviour advice on all items assessed⁹³. The

authors found that the duration of the advice was strongly associated with greater recall of the discussion: an additional minute discussing the target behaviour was associated with a 2.5-fold increase in recall.

Patient self-report surveys are not a suitable method to use with minority populations as one could potentially have hundreds or even thousands of surveys before finding a respondent that fit the study criteria. As such, this method was not suitable to assess physician performance for this research.

2.3.1.3.2 Physician self-report postal and telephone surveys

Physician self-report postal and telephone surveys have been widely used to elicit physician opinion on practice-related issues and the delivery of clinical preventive services⁹⁴. Like patient self-report, physician self-report surveys also do not affect the consultation in any way⁸³, and are a relatively efficient and low cost^{84, 85} method compared to other methods.

Low response rates to physician surveys are common, which may affect the validity and generalisability of results^{86, 94, 95}. The review of postal surveys published in medical journals by Asch et al reported a mean response rate of only 54% for physician surveys⁸⁶. There is little difference in the response rates of telephone and postal surveys^{94, 96, 97} and the difference is not statistically significant⁹⁷. The usefulness of a telephone interviewer includes being able to explain the value of the study, to increase the difficulty of refusal and to aid data collection when literacy levels are low or in question, hence a physician's decision to participate may not readily be influenced by an interviewer⁹⁴. Indeed, in a study by Shosteck and Fairweather, refusal to telephone contact was six times higher than that for postal contact⁹⁷. This study found that telephone contact was, however, better for screening out ineligible respondents⁹⁷. A literature review on physician survey response rates showed that factors increasing response rates included monetary incentives, the use of stamps on both outgoing and return envelopes, and short questionnaires, but pre-notification, personalising questionnaires and non-monetary incentives were not associated with increased response rates⁹⁴. Another study found no difference between responders and non-responders; the main reason for physician non-response was limited time⁹⁵.

The main disadvantages of physician postal and telephone self-report data is recall bias and social desirability bias^{67, 68, 72}, resulting in over-reporting. Montano et al compared cancer screening rates obtained through physician self-reports, medical records audits and patient surveys⁶⁸. Statistically significant differences were found between the rates assessed by different methods and there was low correlation between physician self-report rates and either patient self-report rates or those from the medical record audit. Physicians over-reported the their provision of preventive screening services and the authors concluded that physician self-report was not a reliable method for assessing the provision of preventive services. Leaf et al compared physician self-report rates to the medical records and also found that physicians over-reported preventive services⁷². Like vignettes, physician self-report may reflect provider knowledge and not necessarily performance⁶⁷. Similarly, this method cannot assess areas of physician performance such as communication skills and therefore cannot be used to improve these areas of performance.

2.3.1.3.3 Patient and physician exit interviews

Like postal and telephone self-report surveys, exit interviews do not affect the consultation in any way and are subject to recall bias (resulting in variable results from under-reporting through to over-reporting depending on the area being assessed) and social desirability bias^{67, 83}.

Hilarious et al found a high correlation between patient self-report quality of life communication compared with direct observations of oncology patients during outpatient chemotherapy visits⁸⁴. Franco et al found a range of results depending on the item being assessed and concluded that patient exit interviews may capture routine performance on some areas if they are conducted without the physicians knowledge⁹⁸. Roter and Russell compared both patient and physician exit interviews with audio recordings of the consultations⁹⁹. They also found varying results ranging from under-reporting through to over-reporting depending on the item being discussed and concluded that neither patients nor physicians provided reliable results concerning rates of preventive service discussions. Additionally, there was little correlation between patients and physicians on what was actually discussed. The authors surmised that patients and physicians had different definitions for 'counselling', or that the conversations were very brief or were regarded as being more important to one party than the other⁹⁹. These

findings are consistent with those of Fowles et al⁸⁸, Stange et al⁶⁶ and Flock et al⁹³ for patient self-report postal questionnaires. In a different study by Franco et al, they showed that physicians stated that they did more when they were interviewed even after they had been observed for up to three days, demonstrating that physician interviews are not a valid method for measuring physician performance⁶⁷. Both patient and physician exit interviews are time resource-intensive, and are influenced by the patient load in the practice⁹⁸.

As was the case with patient self-report postal and telephone surveys, patient exit interviews are not a suitable method to use with minority populations as one could potentially interview hundreds of patients before finding one that fit the study criteria. As was the case with physician self-report postal and telephone surveys, physician exit interviews may reflect provider knowledge and not necessarily performance, and cannot be used to improve these areas of performance.

2.3.2 Direct methods

The advantage that all direct methods have over indirect methods is that they provide information about the actual performance of the physician, including non-verbal communication⁶⁴.

2.3.2.1 Direct observation

This method is carried out by a skilled observer directly observing the patient-physician interaction, either by being present in the consultation, or by way of audio and/or video recordings.

Analysis of tape or video tape recordings is generally considered to be one of the most valid methods of assessing physician performance^{66, 69}. The main advantage of direct observation is that this method does not rely on patient or physician recall and therefore overcomes these biases. This method could well be a gold standard if the participants were blinded to the assessment⁶⁵. However, ethical reasons preclude truly double-blind observations, where neither provider nor patient are aware that they are being observed^{65, 100}. Franco et al showed that physicians performed better when they were observed than under normal circumstances⁶⁷. This positive behaviour change due to the effect of the

participants being observed, known as the *Hawthorne effect*^{64, 67}, results in an over estimation of performance. Additionally, providers may not necessarily perform in a consistent manner during every consultation⁶⁷. Other limitations of direct observation is that the method does not control for case mix⁶⁰, it is expensive and extremely time consuming^{66, 69} and it requires thorough training of assessors to ensure reliability⁶⁹.

As is the case with patient self-report, this method is not suitable for assessing physician performance in this research as the Indigenous status of patient's is not known¹⁶.

2.3.2.2 Unannounced standardised patients

Initially introduced by Barrows as a tool for evaluating medical education, the standardised patient remains a popular and effective tool for evaluating clinical performance⁸³. Barrows made the following differentiation between simulated patients and standardised patients: simulated patients are people trained to portray a given clinical history and presentation in a consultation in a standardised way; standardised patients are people portraying their own clinical history and illness in a standardised way¹⁰¹. However, the term standardised patient is now widely accepted in the literature to mean any trained person presenting a patient scenario to a physician in a consistent and standardised way, regardless of whether they are simulating that illness or presenting their own illness⁸³. Unannounced (or incognito) standardised patients enter the practice and doctor consultation covertly. Unannounced standardised patients then report on different aspects of the physician's performance based on pre-determined criteria.

Unannounced standardised patients offer the advantage over other methods of assessing physician quality in that they can assess the quality of case history, counselling activities and physician performance^{65, 83}, whilst controlling for biases which arise from other methods, such as memory recall, social desirability, the Hawthorne effect⁸³ and case mix^{77, 83, 102}. Additionally, they take up little physician time¹⁰³. Several studies have demonstrated that unannounced standardised patients are an accurate and effective tool for assessing the performance of doctors in the practice setting¹⁰⁴⁻¹⁰⁶ or across sites^{77, 105}. Gorter et al measured the reproducibility of the methodology and concluded it was a, "*highly authentic*

*form of performance assessment*¹⁰⁶ (p828). Tamblyn et al reported a 96% accuracy for case presentation¹⁰⁷. Rethans et al found an inter- and intra-standardised patient reliability of 0.85 and also found that compared to vignettes, unannounced standardised patients reveal more information as well as more relevant information on the performance of the doctor¹⁰⁸. Luck et al had experts independently score unannounced standardised patient assessments against covert tape recordings of the same visit and found a specificity of 85% and sensitivity of 95%¹⁰², stating that the unannounced standardised patient methodology was the validated, gold standard for measuring physician performance.

Unannounced standardised patients can provide a formative assessment with minimal interference to the doctor and practice^{82, 109}. An assessment of the effectiveness of using unannounced standardised patients in the clinical setting as a teaching intervention tool found that when combined with appropriate feedback, unannounced standardised patients significantly increased student performance by up to 25%¹¹⁰. The unannounced standardised patient methodology is also an acceptable methodology for assessing performance according to physicians. In a cross sectional study of 2000 general practitioners (GP) in England, Kinnersley et al showed that there was only a 5.5% difference in GP acceptability of using announced versus unannounced standardised patients to assess their performance, and this difference was not statically significant¹⁰³.

The unannounced standardised patient methodology is better suited to single consultation assessments (those where a clinical decision is made in one consultation) as opposed to evaluating the decision making process for chronic conditions which require more visits^{63, 64, 107}. As physician behaviour varies from patient-to-patient, ideally more than one standardised patient should be used to assess a physician's typical performance⁶⁷.

One of the main limitations of the unannounced standardised patient methodology is selection bias. About 60% of physicians have been shown to agree to participate in studies using unannounced standardised patients⁸². As physicians are required to give informed consent, the self-selection process may result in a skewed sample of highly motivated, reflective doctors that are not representative of the wider physician population^{63, 82}. Other limitations of unannounced standardised patients is the cost associated with training and

employing standardised patients, the introduction of social desirability biases and the Hawthorne effect for suspected/detected standardised patients. Franz et al showed that physicians self-reported differential treatment of suspected standardised patients¹¹¹, hence, it is essential that standardised patients remain undetected. Beaulieu et al⁸³ and McLeod et al¹¹² showed that the detection of unannounced standardised patients is reduced if the physicians selected normally examine a high numbers of new patients, if there are longer intervals between unannounced standardised patients visit⁸³, and if normal referral routes are followed¹¹².

2.4 Summary

Physician competence is defined as what a doctor is capable of doing in a testing situation, whereas performance is defined as what a doctor does in actual practice. Assessing physician performance is central to quality management. Physician performance includes every aspect of how a physician interacts with their patient: the doctor-patient relationship, the physician's ability to listen to their patient as well as their medical knowledge and competence.

There are a number of advantages and disadvantages to the various methods available to assess physician performance, which are summarised in Table 2. The main assessment area of interest in this study is physician performance (including patient satisfaction and physician communication skills) in relation to Aboriginal and Torres Strait Islander patients. Medical record abstraction, vignettes and physician postal surveys cannot assess physician performance. Self-report telephone and postal surveys are prone to recall bias and are not suitable for minority population unless the status of the patient is known. Similarly patient exit interviews and direct observation are not effective or feasible methods for capturing rare events or minority populations. Unannounced standardised patients capture normal practice (performance), not best practice (competence). The unannounced standardised patient methodology has the advantage over other methods because it assesses physician performance whilst controlling for biases which arise from other methods, such as memory recall, social desirability, the Hawthorne effect⁸³ as well as controlling for case mix^{77, 83, 102}, resulting in the method being referred to as the criterion/gold standard for assessing physician

performance. The method causes minimal interference to the doctor and practice¹⁰³ and when used as a means of formative assessment by providing feedback to physicians, it is an effective tool for improving performance^{63, 82}. The unannounced standardised patients employed in this study were of Aboriginal and Torres Strait Island background, offering a unique perspective on service delivery.

Table 2. Advantages and disadvantages of different methods to assess physician performance*

	Medical record audit	Vignette	Self-report survey	Patient exit interview	Direct observation	USP
Inexpensive	x	x	✓	x	x	x
Does not intrude on consultation	✓	✓	✓	✓	x	✓
For large sample bases	✓	-	✓	x	x	x
*Assesses performance	x	x	✓†	✓	✓	✓
Assesses rare/minority populations	✓	✓	x	x	x	✓
Controls for recording bias	x	-	x	x	✓	✓
Controls for recall bias	-	-	x	x	✓	✓
Controls for Hawthorn effect	x	x	x	✓	x	✓
Controls for case mix	x	✓	x	x	x	✓

* Performance includes patient satisfaction and physician communication skills

† patient surveys only

Chapter 3

Introduction to empirical work

This chapter begins by describing the researcher's epistemological stance and the theoretical approach which informs this research. The design framework used is then discussed. The chapter concludes with a discussion of the key ethical principles that underpinned this study.

3.1 Theoretical approach

According to Crotty¹¹³(p2), the four interrelated elements of any research study are: what *methods* will be used; what *methodology* governs the choice and use of methods; what *theoretical perspective (or paradigm)* lies behind the methodology; and what *epistemology* informs the theoretical perspective. This 'theoretical framework' is illustrated in Figure 5.

Image not included in this publication due to copyright restrictions

Source: Adapted from Crotty 1998¹¹³(p5)
Figure 5. Theoretical framework

Crotty¹¹³(p3) provides the following definition for each term:

- *“Methods: the techniques or procedures used to gather and analyse data related to some research question or hypothesis.*
- *Methodology: the strategy, plan of action, process or design lying behind the choice and use of particular methods and linking the choice and use of methods to the desired outcomes.*
- *Theoretical perspective: the philosophical stance informing the methodology and thus providing a context for the process and grounding its logic and criteria.*
- *Epistemology: the theory of knowledge embedded in the theoretical perspective and thereby in the methodology”.*

The epistemology, theoretical perspective and methodology informing this research will be discussed below. The methods are discussed in the next chapter.

3.1.1 Epistemology

Epistemology is essentially the theory of how knowledge is learnt. Crotty¹¹³ defines three epistemologies: objectivism, subjectivism and constructionism. This research lies within the constructionism epistemology. In providing a justification for this, it is appropriate to briefly outline the other epistemological viewpoints.

*"Objectivism is the epistemological view that things exist as meaningful independently of consciousness and experience, that they have truth and meaning residing in them as objects (objective truth and meaning, therefore), and that careful (scientific?) research can attain that objective truth and meaning"*¹¹³(p5).

In other words, objectivists believe that the truth is 'out there' in the world and one can find it through careful research. This epistemology is closely aligned to the theoretical underpinnings of positivism and empiricism, and has dominated the natural sciences. Positivism states that the social world exists externally to the researcher, and that its properties can be measured directly through empirical inquiry¹¹⁴. Hence the objectivist epistemology is not well suited to studying human behaviour in a natural environment, or how humans interpret things.

According to subjectivism epistemology, *"meaning does not come out of an interplay between subject and object but is imposed on the object by the subject. Here the object as such makes no contribution to the generation of meaning"*¹¹³(p9). The difficulty with applying this epistemology to human behaviour is that, *"[e]ven in subjectivism we make meaning out of something. We import meaning from somewhere else. The meaning we ascribe to the object may come from our dreams, or from primordial archetypes we locate within our collective unconscious, or from the conjunction and aspects of the planets, or from religious beliefs, or from... That is to say, meaning comes from anything but an interaction between the subject and the object to which it is ascribed"*¹¹³(p9). A theoretical perspective linked to subjectivism is postmodernism¹¹⁴. According to

Gray, postmodernism rejects social emancipation, emphasising ambiguity and fragmentation. He states, *"In terms of research, the primary task becomes the deconstruction of texts to expose how values and interests are embedded within them. The focus becomes not one of how these texts describe the 'reality' of the world, but how the social world becomes represented, and how meanings are produced"*¹⁴(p26)."

Constructionism epistemology states that knowledge and meaning is constructed between humans and their environment; there is no meaningful reality of the world apart from one's experience of it:

*"There is no objective truth waiting for us to discover it. Truth, or meaning, comes into existence in and out of our engagement with the realities of the world. There is no meaning without a mind. Meaning is not discovered but constructed. In this understanding of knowledge, it is clear that different people construct meaning in different ways, even in relation to the same phenomenon"*¹³(p8).

This study began with the assumption that the patient experience in general practice was more than just a verbal exchange between patients, staff and providers, but rather that these interactions are complex social process. This follows the constructionist epistemological view that, *"all knowledge and therefore all meaningful reality as such, is contingent upon human practices being constructed in and out of interaction between human beings and their world, and developed and transmitted within an essentially social context"*¹³(p42).

Constructionism is closely aligned with an interpretivist theoretical perspective which is based on reality being socially constructed. This will be discussed below.

3.1.2 Theoretical perspective (or paradigm)

There are a number of theoretical perspectives and providing a description of all of these is outside the scope of this dissertation. Very brief descriptions for positivism and postmodernism have been provided above. The interpretivist theoretical perspective is congruent with constructionism. Interpretivism asserts that *"all human 'knowledge' is developed, transmitted and maintained in social*

situations"¹¹⁵(p15), therefore "reality is socially constructed"¹¹⁵(p13)" through the social processes such as language, engagement and other social interactions. One person's interpretations can therefore vary according to circumstances or vary from person to person. This does not make one reality more 'true' than the other. Each person brings their personal narratives, history and culture to the social interaction. Rather than seek a universal truth, the researchers focus is on gaining a deeper understanding of each person's interpretation of reality derived from the social interaction. In order to understand this reality, researchers have to study a person's actions, objects and society from their own perspective¹¹⁴. This relies heavily on a subjective relationship between the researcher and the researched and is achieved using methods such as observation and interviews. The close collaboration between researcher and the researched whilst the researched describe their experiences is one of the advantages of the interpretivist constructionist approach¹¹⁶.

In a study attempting to improve the acceptability of general practice to Aboriginal and Torres Strait Islander patients, one must study how Aboriginal and Torres Strait Islander patients interact with general practice overall, as well as with practitioners and non-clinical staff, because it is through these interactions that meaning is constructed. Once it is understood what it means for general practice to be acceptable to Aboriginal and Torres Strait Islander patients, it becomes possible to attempt to create environments that provide the conditions for a positive patient experience.

3.1.3 Methodology

Quantitative research is used primarily to maximise objectivity, and for replicability and prediction. It uses a 'top down' approach; that is, it is deductive or confirmatory in nature. It is based on statistical analysis of quantitative data with a goal to generalising the results. Conversely, qualitative research is used primarily to explore the experiences, understanding and perspectives of participants; their reality of a phenomenon¹¹⁷. It uses a 'bottom up' approach; that is, it is inductive in nature. It is based on qualitative data which are examined for patterns, themes, and holistic attributes. The goal is not to generalise results but rather to gain an in-depth understanding. Mixed methods research involves using both qualitative and quantitative approaches in a single study and

integrating, mixing or relating the data at some stage during the research process. Both deductive and inductive methods are used. The underlying logic of using mixed methods in research is that neither quantitative nor qualitative methods alone will be sufficient to capture the phenomenon being studied¹¹⁸. It is for this reason that a mixed-methods approach was used in this study. Mixed methods research has significant advantages for policy and intervention because it can assist in understanding complex social phenomena by presenting a diversity of views and strengthen a study by either neutralising or overcoming the limitations of singular approaches¹¹⁹.

This study was conducted in two main stages. The first stage was designed to illicit and understand what general practice staff, practitioners and Aboriginal and Torres Strait Islander patients considered to be 'appropriate care' in general practice and how well Indigenous status was identified and recorded in general practice. This was conducted using a mixture of qualitative methods and quantitative methods (see Chapter 4). A collective instrumental case study methodology was chosen to provide a bounded context in which to identify and gain an in-depth understanding of any different perspectives of staff, providers and patients and what they did. This is discussed in greater detail in Section 3.2 of this chapter. The second stage was to design and implement an intervention in general practice to facilitate the correct identification of patients' Indigenous status, and acceptable and appropriate care to Aboriginal and Torres Strait Islander patients using the lessons learnt from the previous phase. This was based on the Ajzen's Theory of Planned Behaviour¹²⁰ and the Bronfenner's Social Ecological Model¹²¹ which are discussed in Chapter 5. The feasibility, implementation and impact of the intervention was then evaluated using the Normalisation Process Theory (see Chapter 5).

The first stage of this study helped to clarify if patients' Indigenous status was correctly identified in general practice, what staff and practitioners perceptions regarding Indigenous status identification and the provision of culturally appropriate care were, and how Aboriginal and Torres Strait Islander patients rated their experience as a patient in each practice. Understanding the why, when and how patients had their Indigenous status identified, and how Aboriginal and Torres Strait Islander patients experienced the interactions in general practice, informed what areas should be targeted in the intervention.

3.1.4 Methodological integrity

As mentioned earlier in this chapter, the epistemology informs the theoretical perspective, which in turn governs the methodology, which informs what methods will be used¹¹³. Hence constructionism and interpretivism also have implications for what claims can be made regarding the results. Data collection and data analysis are themselves a form of interpretive constructionism: the former occurs through the interaction between the researcher and participants; the latter through the interaction between the researcher and the data. Because reality is socially constructed, research cannot be value free. The interpretations constructed from the data by this researcher could differ from that collected by other researchers but this makes neither reality more 'true'. Therefore, it is essential that researchers make transparent their role in reporting both what has been done and what interpretations they have drawn from this. The researcher was the active agent in delivering the intervention, which was informed through the interactions between the USP and practices, the USP and the researcher, and the researcher and the participants. This also has implications on what data was collected to evaluate the intervention and how this was analysed.

3.2 Design framework

Creswell¹²²(p40) describes a case study as an exploration of "a 'case' bounded in time or place" using "extensive material from multiple sources of information to provide an in-depth picture of the 'case'". Case studies allow a detailed, intensive exploration of individuals, groups, organisations and phenomenon in context¹²³. The case study "rests implicitly on the existence of a micro-macro link in social behavio[u]r. It is a form of cross-level inference. Sometimes, in-depth knowledge of an individual example is more helpful than fleeting knowledge about a larger number of examples. We gain better understanding of the whole by focusing on a key part"¹²⁴(p1).

There are two main approaches to case studies in the health sciences, both based on a constructivist paradigm. Yin¹²³ has a positivist/empiricist approach and categorises case studies as explanatory, exploratory or descriptive and these may be either single or multiple-case studies. Explanatory case studies may be used for doing causal investigations; exploratory case studies explore any

phenomenon which serves as a point of interest to the researcher and are sometimes considered as a prelude to social research; and descriptive case studies require a descriptive theory to be developed before starting the project to support the description of the phenomenon^{125, 126}. Stake¹²⁷ has an interpretivist approach and categorises case studies as intrinsic, instrumental or collective. An intrinsic case study is chosen when the researcher wants to better understand a particular case; it does not necessarily represent other cases or have a particular trait and is therefore not used to understand generic phenomenon. An instrumental case study provides insight into a broader issue or helps refine a theory and is therefore used when a researcher wants to achieve something other than understanding a particular case. The case is of secondary interest, playing a supporting role to help the researcher pursue the broader issue or theory. A collective case study includes multiple intrinsic or instrumental cases and allows the researcher to explore differences within and between cases and replicate findings across cases^{122, 127, 128}. Because this study wanted to explore Indigenous status identification and the provision of care provided to Aboriginal and Torres Strait Islander peoples within and across general practices, and determine what affected the impact of an intervention, Stake's instrumental collective approach¹²⁷ was the case study method used in this research.

3.2.1 Appropriateness of a case study design framework

A case study design is appropriate under the following conditions: a) when the research question asks 'how' or 'why'; b) the researcher has no control over the behaviour of participants in the study; c) contextual conditions are believed to be relevant to the phenomenon under investigation; or d) the boundaries between the phenomenon and context are not clear¹²³. Although the research proposed in this dissertation meets these criteria, criteria a) and b) alone or in combination are not sufficient justification for the use of a case study for this research. The overarching research question asked 'why' do some Aboriginal and Torres Strait Islander patients find or not find general practice to be appropriate, 'how' is Indigenous status identified and recorded in general practice, and 'how' is care provided to Aboriginal and Torres Strait Islander patients? These questions could also be asked using other methods. Although the researcher had no control over how individuals acted within the general practice setting, the aim of the intervention was for the researcher to influence the actions of the general practice

staff and practitioners. However, criteria c) and d) were particularly consistent with this study. The phenomenon under investigation was the impact of the intervention in improving Indigenous status identification in general practice and the provision of appropriate care to Aboriginal and Torres Strait Islander patients. Contextual factors believed to be relevant to this included the historical context of colonisation on Aboriginal and Torres Strait Islander peoples, the health of Aboriginal and Torres Strait Islander peoples being considered a health priority area for the Australian Government, and general practice being embedded in a system which provides incentives to treat Aboriginal and Torres Strait Islander patients. The boundaries between the identification of the Indigenous status of patients and the provision of appropriate care to Aboriginal and Torres Strait Islander patients and the contextual factors above, are not clear.

A case study framework is an ideal methodology when a holistic, in-depth investigation is required¹²⁵ and can use qualitative or quantitative methods, or both¹²³. According to Creswell, "*Conducting a case study provides a picture to help inform our practice or to see unexplored details of the case*"¹²²(p95). Case studies are designed to bring out the details from the participant's viewpoint by using multiple sources of data¹²⁵, allowing the researcher to gain an in-depth understanding of peoples perspectives of issues or processes. In this study, it allowed the researcher to understand the different perspectives of general practitioners and their staff, and those of Aboriginal and Torres Strait Islander patients in relation to the appropriateness and acceptability of the care provided to Aboriginal and Torres Strait Islander patients in general practice and to assess the feasibility, implementation and impact of a tailored intervention to improve these. The multiple cases also allowed the researcher to make comparisons across cases as well as with in cases.

3.3 Methods

Mixed methods (both qualitative and quantitative methods) were employed in this research and are discussed in Chapter 4.

3.4 Study setting

The study was conducted in seven general practices in two Medicare Local Areas in Sydney, Australia. Medicare Locals are primary health care organisations that coordinate the delivery of primary health care services at a local level by linking general practice, allied health services, Aboriginal Health services, community health services, community pharmacies and local hospitals. They also provide support and services to general practice and allied health providers aimed at meeting quality standards¹²⁹.

3.5 Research Approval

Prior to conducting any research within specific ethnic or cultural group, researchers are required to demonstrate consultation and co-operation with that group. Apart from the ethical obligations which will be discussed further below, it is simply good manners to do so. The researcher first approached the Elders of the Aboriginal and Torres Strait Islander communities within the study area to introduce her ideas for the research and to find out if the communities felt this was an area of research that would benefit them. Once it was established as an area of benefit, the researcher asked permission to conduct research with the community. Conducting research *with* a community as opposed to *on* a community is an essential component of indigenous health research as will be discussed in detail further below^{130, 131}. Working with the community for this study was also required in order to carry out the research: the focus of this research was on improving the acceptability of non-Aboriginal controlled general practice to Aboriginal and Torres Strait Islander patients; hence in order to be effective, the perspectives of the local Aboriginal and Torres Strait Islander peoples had to

be provided. Being a non-Aboriginal person, the researcher could not provide this perspective herself.

Unfortunately, due to the way health research has been conducted in the past, some Aboriginal peoples consider research a "dirty" word^{132, 133}. A reform in Aboriginal and Torres Strait Islander health research has led to the development of key principles and guidelines to conduct research in this area. Key documents include the National Health and Medical Research Council's (NHMRC) *The Strategic framework for improving Aboriginal and Torres Strait Islander health through research*¹³⁴, (known as the Road Map); *Values and Ethics: guidelines for ethical conduct in Aboriginal and Torres Strait Islander health research*¹³⁵, (known as the Guidelines); and the Aboriginal Health and Medical Research Council's *Guidelines for Research into Aboriginal Health*¹³⁶. The values and principles of reciprocity, respect, equality, responsibility, survival and protection, and spirit and integrity outlined in the above documents, as well as the NHMRC's *Keeping research on track. A guide for Aboriginal and Torres Strait Islander peoples about health research ethics*¹³⁷ and the *National Statement on Ethical Conduct in Research Involving Humans*¹³⁸ have guided this research and are discussed below.

3.5.1 Reciprocity

The value of reciprocity requires the researcher to demonstrate a benefit to the community. Anderson states that it is the researched not the researchers who should be the primary beneficiaries of any inquiry¹³⁹ and suggests there are three main benefits stemming from Aboriginal and Torres Strait Islander health research. The first are immediate benefits, for example, there may be raised community awareness of a health problem or the skills of Aboriginal peoples may be enhanced through the research process. Secondly there are direct consequences of research from analyses of data, impacts of published material, and new interventions designed as a result of the research. Finally there are the delayed benefits; when the application of research findings depends on further conceptual models or intervention developments¹³⁹.

Reciprocity was demonstrated by inclusion, exchange and benefit. Immediate benefit was provided to the community by increasing the awareness of both the

local Aboriginal and Torres Strait Islander community and the participating general practices regarding the need to identify the Indigenous status of patients in order to screen for chronic disease in Aboriginal and Torres Strait Islander patients at an earlier age than other Australians. Additionally, community members joined the research team as Associate Investigators and members of the community were offered employment on the research study and were trained in research techniques. This led to subsequent employment on other research projects in the University. The direct consequences of this research included participating general practices actively seeking to correctly identify the Indigenous status of their patients in order to provide the best possible care, and addressing environmental factors within their practice in order to make Aboriginal and Torres Strait Islander patients feel welcome in their practice. In return, the community provided their local cultural knowledge and shared their experiences, all which were crucial to the study.

3.5.2 Respect

This was demonstrated by minimising difference blindness by incorporating practices and behaviours appropriate to Aboriginal and Torres Strait Islanders peoples into mainstream general practice, thereby promoting cultural distinctiveness; by recognition of contribution; and by trust and integrity. The researcher recognised that without the expertise of the members of the Aboriginal communities, without their local knowledge and shared experiences, this project would not be possible as one cannot assess and develop systems for the appropriate care of a target group without their input, interpretation and recommendations. The researcher was conscious in ensuring that the communities' perspectives were reflected throughout the project and encouraged the communities to be fully involved in the project, including the research design, data collection, data analysis and interpretation of findings. Building trusting relationships between the researcher and the researched (both Aboriginal and non-Aboriginal) facilitated honest and open communication and importantly provided the foundation for the successful uptake of the intervention. Throughout the research process the researcher placed an emphasis on maintaining communication and positive relationships with the Aboriginal and Torres Strait Islander communities and the general practice community.

3.5.3 Equality

The aim of this research was to increase the healthcare options available to Aboriginal and Torres Strait Islander peoples by improving the acceptability of general practice to them. The local knowledge and shared experiences of the Aboriginal and Torres Strait Islander peoples within the study areas were recognised as vital components of the study and key community members were invited to join the research team as equals.

3.5.4 Responsibility

This was demonstrated by doing no harm throughout the research process and/or as a result of the research outcomes, and by accountability. The researcher was conscious of the need to have all aspects of the research carried out in a culturally respectful manner and that the perspectives of the Aboriginal and Torres Strait Islander community informed the research. The research was undertaken according to the requirements for the conduct of ethical research as set by the University of New South Wales (UNSW) ethics committee, the AH&MRC Ethics committee, the NHMRC, and the participating Aboriginal and Torres Strait Islander communities. The researcher took care to negotiate sensitive issues, to respect traditions and culture, and not to make judgements about members of the local Aboriginal and Torres Strait Islander communities and the participating general practices. The emphasis of the research was to find ways of improving the acceptability of general practice to Aboriginal and Torres Strait Islander peoples, not to discredit either general practice or the Aboriginal and Torres Strait Islander communities, and the research was conducted accordingly.

3.5.5 Survival and Protection

A guiding principle to this research was to minimise difference blindness by promoting the identity and cultures of Aboriginal and Torres Strait Islander peoples in general practice. The values, beliefs and cultural traditions of Aboriginal and Torres Strait Islander peoples differ from 'colonised' Australians. In order for general practice to provide more culturally appropriate healthcare to Aboriginal and Torres Strait Islander patients, this difference was drawn upon to inform and evaluate the research.

3.5.6 Spirit and integrity

This overarching value binds all the values together into a coherent whole. Spirit and integrity reflects that past, present and future generations are bound up in a continuum and in behaviour that maintains coherence of Indigenous values and cultures¹³⁷. By drawing on the knowledge, values, culture, traditions and experiences of the local Aboriginal and Torres Strait Islander communities to improve the acceptability of general practice to future users, past, present and future generations of the community are acknowledged. By conducting the research from the perspectives of the Aboriginal and Torres Strait Islander communities and not the researchers own western perspective, the researcher did not diminish the values and coherence of Aboriginal and Torres Strait Islander cultures.

3.5.7 Ethics approval

Ethics approval for this study was granted by the University of New South Wales Human Research Ethics Committee (HREC No: 11222), and the Aboriginal Health and Medical Research Council Ethics Committee (AH&MRC No: 796-11).

3.6 Summary

This chapter described that the theoretical framework which underpinned this research lies within an interpretivist paradigm and constructionism epistemology and that the research was based on a mixed methods methodology using a collective case study framework. As a non-Aboriginal Australian conducting research into Aboriginal and Torres Strait Islander health, the researcher was acutely aware of the past history of conducting health research in this population and for the need to make the researched the primary beneficiaries of the inquiry. The success of the study relied on the considered approach of the researcher to remain in-keeping with the with the values of reciprocity, respect, responsibility, equality, survival and protection, and spirit and integrity, as outlined in the NHMRC guidelines for conducting Aboriginal and Torres Strait Islander research.

Chapter 4

Data collection and analysis methods

This chapter discusses the data collection and analysis methods used in this research. The chapter begins by describing the various sampling strategies and data collection methods. This is followed by a discussion on the data management and analysis techniques used. The chapter concludes with a discussion on the strategies used to increase the rigor of the research.

4.1 Sampling

4.1.1 Selecting the sites

As mentioned in the Chapter 1, the greater proportion of studies in Aboriginal and Torres Strait Islander health research have been carried out in rural and remote areas and limited information is available in an urban context¹². This research aimed to help fill this gap and the focus was therefore in urban general practice. Sydney, Australia was chosen for convenience as the researcher was based there. Geographic locations with known substantial Aboriginal and Torres Strait Islander populations were then identified. Locations which had or were conducting other studies which could influence the results were excluded. The researcher then approached the Elders of the local Aboriginal and Torres Strait Islander communities to find out if they felt that the research topic was an area of benefit to them and to gauge their level of interest. Two Aboriginal communities in separate Medicare Local regions (the Eastern Sydney Medicare Local and the South-eastern Medicare Local) readily expressed an initial interest. The researcher then spent several months building a relationship and trust with the communities - a key factor in the success of this study. The researcher was very fortunate in that she was readily accepted by the Elders and Aboriginal Corporation Chairpersons in both communities. She was welcomed into homes, asked to join in weekly women's groups as well as other community events, and helped out at Naidoc events and art exhibitions. This allowed both formal and informal communication and the establishment of trusting relationships.

4.1.2 Selecting the cases

Miles and Huberman suggest 16 types of purposeful sampling¹⁴⁰, any of which are suitable for case studies¹²². The sampling method used in this study included criterion sampling, where cases are included if they meet some predetermined criteria; and snowball sampling, where people identify information-rich people. Opportunistic criterion sampling was used to recruit general practitioners. Their practice was the 'case' and hence the unit of analysis in this study. If more than one practitioner from the same practice participated in the study, they were considered to be part of the 'case'. The selection criteria are detailed in the following sections.

An *Expression of Interest* was circulated to all general practices via the Medicare Locals and the researcher then followed up on any responses, initially by telephone and then in person. A copy of the *Expression of Interest* circular is attached as Appendix 1. Eight general practitioners from separate practices (three from the South-eastern Sydney Medicare Local area and five from the Eastern Sydney Medicare Local area), responded to the *Expression of Interest*. Two general practitioners in the Eastern Sydney Medicare Local area that expressed interest in the study were not recruited: one declined to participate after receiving more information regarding the study, stating that he didn't have time for patient record audits and visits from unannounced standardised patients; the other practitioner stated that her books were closed to new patients and the researcher did not recruit this practitioner because, although the practitioner was willing to open her books to receive the study patient, practitioners who accepted few new patients are more likely to detect unannounced standardised patients⁸³. Thus six practices were initially recruited to become the 'cases'.

4.1.3 Selection criteria for cases and binding of cases

A practice was considered eligible if it fell within the boundaries of the Medicare Local areas in the study, a general practitioner agreed to participate, and the practice was not currently engaged in a similar or related study. Because the study involved access to the practice patient database, consent was required from the Practice Principal if the participating general practitioner was not the Principal.

Case study boundaries indicate what will and will not be considered to be within the scope of the research project. They are similar to the inclusion and exclusion criteria used for sample selection in a quantitative study, but they also outline the breadth and depth of the study. Cases can be bound by time and place¹²², by time and activity¹²⁷ and by definition and context¹⁴⁰. Placing boundaries on a case ensures that the scope of the study remains manageable and reasonable. The cases in this study were bound by time (baseline and post intervention), place (each general practice), and by context (patient experience during a consultation visit).

4.1.4 General practice participants

All staff in the participating seven practices (the 'cases') were invited to participate and one allied health professional, two practice nurses, three practice managers and 16 reception staff agreed. Participant demographics are provided in Table 3. Participants excluded after baseline data collection or lost to follow-up are indicated with a hash “#” symbol.

Table 3. Demographic profile of general practitioners and practice staff

Case	Participant ID	Role	Age Group (Years)	Gender
101	101102	GP	35-44	Male
	101501#	Allied Health	45-54	Female
	101502#	Reception	55-64	Female
	101503#	Reception	35-44	Male
	101504#	Reception	55-64	Female
	101505#	Reception	55-64	Female
	101506#	Reception	<25	Female
102	102101	GP	55-64	Female
103	103101	GP	35-44	Female
	103501	Reception	<25	Female
	103502	Reception	25-34	Female
	103503	Reception	<25	Female
104	104101	GP	25-34	Female
	104301	Practice Manager	25-34	Male
201	201101	GP	55-64	Male
	201301	Practice Manager	45-54	Female
	201501	Reception	25-34	Female
202	202101	GP	55-64	Male
	202102	GP	45-54	Male
	202301	Practice Manager	35-44	Female
	202401	Nurse	55-64	Female
	202402	Nurse	<25	Female
	202501#	Reception	25-34	Female
	202502	Reception	<25	Male
	202504#	Reception	45-54	Female
	202505#	Reception	55-64	Female
	202506	Reception	<25	Female
203	203101	GP	55-64	Male
	203301	Practice Manager	45-54	Female
	203501	Reception	45-54	Female
	203502	Reception	>65	Female

Participants excluded after baseline data collection or lost to follow-up

Participation was voluntary and participants were free to refuse participation or revoke their consent at any time without prejudice. All participants were provided with a *Participant Information Sheet* outlining the study aims and what their participation would involve. Written consent was obtained from all participants prior to participation in the study. Copies of the *Participant Information Sheet* and *Participant Consent Form* are attached as Appendices 2-3 respectively.

Shortly after baseline data collection, the general practitioner in Practice 101 moved to another practice. This practitioner asked if she could continue in the study at her new practice. This resulted in an additional 'case'. The Practice Manager from this additional case asked to participate in the study and was also recruited. To keep Practice 101 in the study another GP from that practice was recruited. The general practitioner in Practice 202 was uncertain whether he would be available for the follow-up data collection. The Practice Manager was keen for the practice to remain in the study and an additional general practitioner was recruited in this practice. The GP recruitment is outlined in Figure 6.

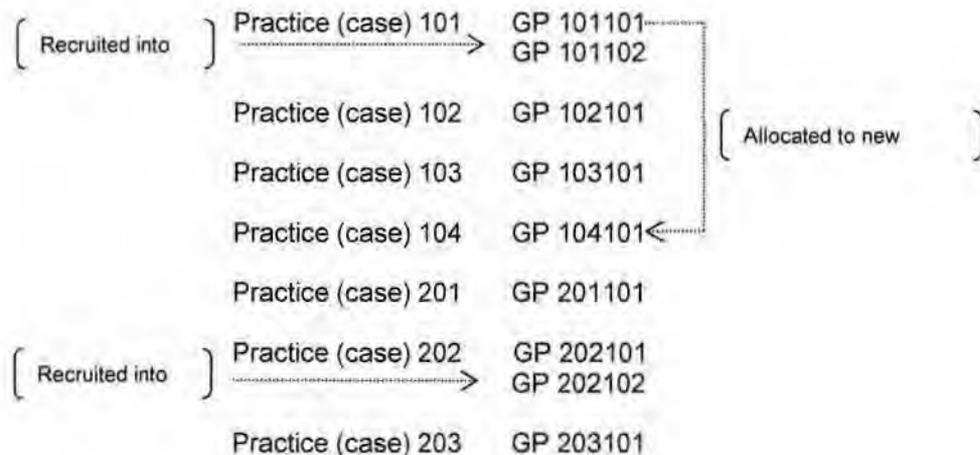


Figure 6. GP recruitment

4.1.5 Selecting Medicare Local participants

Criterion sampling was used to select the Closing the Gap (CtG) Officer at the two participating Medicare Locals and both Closing the Gap Officer's agreed to participate. Snowball sampling was used to identify Medicare Local employees who could provide rich and accurate information regarding Practice Accreditation for general practices. The Practice Support Officer at one Medicare Local agreed

to participate; the one at the other Medicare Local was unavailable. The demographic profile of the Medicare Local participants is provided in Table 4.

Table 4. Demographic profile of Medicare Local staff

Participant ID	Role	Age Group (Years)	Gender
100	Closing the Gap Officer	35-44	Female
100-2	Practice Support officer	<25	Female
200	Closing the Gap Officer	35-44	Female

Participation was voluntary and participants were free to refuse participation or revoke their consent at any time without prejudice. All participants were provided with a *Participant Information Sheet* outlining the study aims and what their participation would involve. Written consent was obtained from all participants prior to participation in the study. A copy of the *Participation Information Sheet* is provided as Appendix 4. A copy of the *Participant Consent Form* is attached as Appendix 3.

4.1.6 Selecting focus group participants

Opportunist purposeful sampling was used to identify Aboriginal and Torres Strait Islander peoples for the focus group interviews: Elders of the respective Aboriginal communities either directly invited community members to attend the focus group interviews or identified a person to act in their stead. Six participants were recruited from the Kurrunulla Aboriginal Corporation (South Eastern Sydney Medicare Local area) and five from the La Perouse/Botany Bay Aboriginal Corporation (Eastern Sydney Medicare Local area). The demographic profile of these participants is provided in Table 5.

Participation was voluntary and participants were free to refuse participation or revoke their consent at any time without prejudice. All participants were provided with a *Participant Information Sheet* outlining the study aims and what their participation would involve. Written consent was obtained from all participants prior to participation in the study. A copy of the *Participation Information Sheet* is provided as Appendix 4. A copy of the *Participant Consent Form* is attached as Appendix 3.

Table 5. Demographic profile of focus groups participants

Focus Group ID	Participant ID	Age Group (Years)	Gender
FG 100	FG 100-1	45-54	Female
	FG 100-2	45-54	Female
	FG 100-3	>65	Female
	FG 100-4	25-34	Female
	FG 100-5	55-64	Female
	FG 100-6	45-54	Female
FG 200	FG 200-1	>65	Female
	FG 200-2	55-64	Female
	FG 200-3	35-44	Female
	FG 200-4	>65	Female
	FG 200-5	55-64	Female

4.2 Data Collection

As mentioned in Section 3.2 of Chapter 3, case studies provide an in-depth picture of the case through the collection and analysis of extensive material from multiple sources of information. The data collected in this study involved a mixed methods approach using five different methods of data collection: unannounced standardised patients assessments, in-depth individual interviews, focus group interviews, surveys and patient clinical record audit. The data collection and analysis techniques for each will now be discussed.

4.2.1 Unannounced standardised patient assessment

This section will discuss the selection and training of the unannounced standardised patients (USP), and how the USPs assessed the actual behaviour of general practice staff and practitioners, as well as their overall experience as a patient in each participating general practice. A literature review discussing the choice of this method of data collection was discussed widely in Chapter 2.

4.2.1.1 Selection of USP

The Elders in each Aboriginal community were asked to suggest potential candidates to be employed as USPs. As Aboriginal and Torres Strait Islanders peoples represent a small proportion of the patient population in many general

practices, the researcher requested candidates 'not look obviously Aboriginal' to decrease the possibility that the USP would be detected. Four candidates were suggested to the researcher, two from the Kurrunulla Aboriginal Corporation (South Eastern Sydney Medicare Local area) and two from the La Perouse/Botany Bay Aboriginal Corporation (Eastern Sydney Medicare Local area). All four were offered the position as a casual research assistant and all four accepted; however, one candidate from the La Perouse/Botany Bay Aboriginal Corporation had to withdraw from training due to personal and health reasons and the second from this community was not available at baseline data collection. After discussions with the Elders in both communities, it was decided that as all candidates were familiar and known in both communities, that the Kurrunulla Aboriginal Corporation community candidates would be used for the baseline data collection and the La Perouse/Botany Bay Aboriginal Corporation candidate would be used for the follow-up data collection.

4.2.1.2 Standardising USPs

The researcher gave the three USP candidates an initial introduction and overview of the USP roles at their local Aboriginal Corporation meeting place and left a copy of the standardised patient scenario case with them so they could begin to familiarise themselves with the presentation (see Boxes 1-2). The scenario was based around the family and clinical history of the USPs so that there was less reliance on the USPs mastering the biographical details of the roles. The scenario included a 'cover story' to explain why the patient was seeking a new practitioner. The clinical presentation part of the scenario was developed in consultation with the Chief Investigator of this study, a Professor of General Practice and a practising general practitioner. The clinical presentation was chosen as it was clinically credible and manageable within the context of an acute presentation in a new general practice consultation. For example, at baseline, the clinical history and presentation of the USP was that they had recently been diagnosed with high blood pressure and had been placed on Coversyl 2.5mg six weeks previously, and they were presenting for the consultation due to a persistent dry cough that had developed in the past two weeks.

The researcher then developed an USP assessment in consultation with the Chief Investigator which focused around describing the USP's own perceptions

and experiences when they presented at the practice. This approach has been found effective in other studies^{141, 142} and when using USPs for a formative or needs assessment, less stringent guidelines are required than when developing checklists for summative assessments¹⁴³.

The USPs then attended a half day training session at the UNSW Centre of Primary Health Care and Equity (the Centre) to learn the skills necessary to present the standardised patient scenario. The training session addressed how to respond to various scenarios and what was required in the USP assessment. The USPs practiced their encounter by doing role plays with the researcher and then having a number of mock visits at the Centre. This was done to expose the USPs to more realistic encounters. The USPs were asked to enter the Centre as if it were a surgery and report to reception just like they would at a general practice. The Centre front office staff played the roles of reception staff and the Chief Investigator played the role of general practitioner. A number of mock visits were carried out with reception and the USPs, including both 'good' and 'bad' behaviour in terms of how the staff treated the USP. The USP performances were discussed between the USPs, the researcher and the Chief Investigator and refined until all parties reached consensus.

Box 1. Standardised patient scenario and instructions - Baseline

INSTRUCTIONS ON ARRIVAL

At reception and in the waiting room

- When given a form at reception when registering, pause a moment and look at the form as if you are going to say something, fidget and state you have forgotten your glasses. Take a mental note regarding if someone asks if you need help filling in the form.
- If asked if you need help to fill out the registration form, reply that you are, "Okay."
- If there is a question regarding your Aboriginality status, leave it blank. USP is not to fill in question at reception if the question is on the form. Wait to see if reception or the doctor asks.
- If staff notice that you haven't answered the Indigenous status question and ask you the question, take a mental note of exactly how they asked you your Indigenous status and then quietly and politely ask, "Why?" Take a mental note of their response and then answer that you are Aboriginal.
- Take note of waiting room – Aboriginal identification posters, pamphlets, other Aboriginal-specific health promotion material, Koori flag or other symbols of welcome?
- If you are asked at reception if you are the 'standardised patient' or the 'patient in the Closing the Gap Study' or the 'patient in the Aboriginal Study' or the 'patient in the University study' or anything similar, do not react but simply say, "I'm sorry, what? I'm here about my cough."

- If you hear someone at reception say that you are the patient in the study, cancel your appointment by pretending that you have been called home urgently.

INSTRUCTIONS FOR THE CONSULTATION

Family history

- Father alive, 70 years – diabetes, stroke (70)
- Mother alive, 65 years – arthritis
- Stroke paternal grandmother

Patient history

- Female, 43, overweight
- Partner, 4 kids [David 16, John 18, Sarah 20, Susan 7]
- Home-maker
- Recently moved from country - Casino
- Generally fit and healthy (patient self-description)
- Smoker 20+ years, 10-15/day
- Alcohol, 2 drinks 2-3x per week
- Limited exercise. Walks dog 3 times per week around 10 minutes.
- Eats well. Two pieces of fruit per day. Toast breakfast, sandwich lunch. Meat and 2 vegetables at dinner. Last doctor said to watch diet because of mum and dad's history. After last blood test doctor told you to cut out cholesterol and sugary foods. Have tried a little, but not sure why.
- Recently had a few high blood pressure results when the doctor checked. Was put on Coversyl 2.5mg 6 weeks ago.
- If asked about nationality, state you are Australian. If asked specifically about Aboriginality status, answer you are Aboriginal.

Medication

- Coversyl 2.5mg
- Sometimes forget to take medication

Presentation

- Developed a persistent cough 2 weeks ago. Sometimes get shortness of breath, wheezing. No phlegm. Sometimes feel dizzy. Was given puffer once to use a few years ago but haven't used one recently (can't remember the name).

Possible scenarios during the consultation

- If the doctor asks for a blood test, say you have eaten and want to leave it for another day. If they say you don't need to be fasting, say you wouldn't mind a cholesterol check up at the same time so would prefer only one blood test.
- If doctor tries to write a new script for Coversyl, state you still have several repeats from the script your last doctor gave you.
- If doctor suggests new medication, act concerned and ask about price
- If doctor tries to refer you onto another health care profession (apart from AMS or other ACCHS), act concerned and ask about price and location (i.e. access).
- If doctor has asked about your Indigenous status, and asks you if you have had the Indigenous Health Check, ask them to explain what it is. Then answer that you have not had one. If they want to perform one, insist on another appointment as you don't have time today.

- If they ask about signing on to the Closing the Gap initiative, ask for an explanation and state you will think about it. Then ask about getting signed on for cheaper scripts.
- If you get to this part of the consultation, and have not been asked about your Aboriginal status, ask about getting cheaper scripts. Do not say you are Aboriginal unless asked.
- If during the consultation, you believe you have been detected as the standardised patient, continue with the consultation if you are unsure. However, if at any time the doctor openly discloses that you are detected, or acts in a way that makes you believe strongly you have been detected, then end the consultation.
- If your doctor asks you to sign the Medicare consultation slip at the beginning, during or at the end of the consultation, do so. Inform the Researcher immediately upon leaving the practice that you signed a Medicare slip. The Researcher will organise to have the bulk-bill claim destroyed and the University to be invoiced.

INSTRUCTIONS AFTER THE CONSULTATION

- If you have not been asked to sign the Medicare consultation slip by the doctor, proceed to the reception area as you normally would at the end of the consultation. If the practice is a bulk-billing practice, sign the necessary paperwork and inform the Researcher immediately upon leaving the practice. The Researcher will organise to have the bulk-bill claim destroyed and the University to be invoiced. If the practice gives accounts, get them to give you an account as normal. The Researcher will then organise to have this bill cancelled and one made out to the University.

Box 2. Standardised patient scenario and instructions – Follow-up

INSTRUCTIONS ON ARRIVAL

At reception and in the waiting room

- When given a form at reception when registering, pause a moment and look at the form as if you are going to say something, fidget and state you have forgotten your glasses. Take a mental note regarding if someone asks if you need help filling in the form.
- If asked if you need help to fill out the registration form, reply that you are, "Okay."
- If there is a question regarding your Aboriginality status, leave it blank. USP is not to fill in question at reception if the question is on the form. Wait to see if reception or the doctor asks.
- If staff notice that you haven't answered the Indigenous status question and ask you the question, take a mental note of exactly how they asked you your Indigenous status and then quietly and politely ask, "Why?" Take a mental note of their response and then answer that you are Aboriginal.
- Take note of waiting room – Aboriginal identification posters, pamphlets, other Aboriginal-specific health promotion material, Koori flag or other symbols of welcome?
- If you are asked at reception if you are the 'standardised patient' or the 'patient in the Closing the Gap Study' or the 'patient in the Aboriginal Study' or the 'patient in the University study' or anything similar, do not react but simply say, "I'm sorry, what? I'm here because I feel sick."

- If you hear someone at reception say that you are the patient in the study, cancel your appointment by pretending that you have been called home urgently.

INSTRUCTIONS FOR THE CONSULTATION

Family history

- Father alive, 42 years – diabetes, high BP
- Mother alive, 43 years – high BP
- Paternal grandmother – breast cancer, all other grandparents have high BP

Patient history

- Female, 19, overweight
- Partner, 6mo baby
- Home-maker
- Generally fit and healthy (patient self-description)
- Smoker 2+ years, 5-10/day
- Alcohol - socially but binge drinks also
- Nil exercise.
- Poor diet, never eats breakfast, ham sandwich for lunch, cooked dinner, has lots of soft drinks and junk food
- Was staying at parents place over January holidays and their family doctor prescribed Duramine 30mg for weight loss.
- If asked about nationality, state you are Australian. If asked specifically about Aboriginality status, answer you are Aboriginal.

Medication

- Duramine 30mg since for past 2 months
- Micronor (take at bedtime)

Presentation

- Feeling of nausea, dry mouth, can't sleep, moody.
- Also need repeat for Micronor

Possible scenarios during the consultation

- If the doctor asks for a blood test, say you have eaten and want to leave it for another day. If they say you don't need to be fasting, say you wouldn't mind a cholesterol check up at the same time so would prefer only one blood test.
- If the doctor suggests stopping Duramine, ask what you will do about weight gain
- If doctor suggests new medication, act concerned and ask about price
- If doctor tries to refer you onto another health care profession (apart from AMS or other ACCHS), act concerned and ask about price and location (i.e. access).
- If doctor has asked about your Indigenous status, and asks you if you have had the Indigenous Health Check, ask them to explain what it is. Then answer that you have not had one. If they want to perform one, insist on another appointment as you don't have time today.
- If they ask about signing on to the Closing the Gap initiative, ask for an explanation and state you will think about it. Then ask about getting signed on for cheaper scripts.
- If you get to this part of the consultation, and have not been asked about your Aboriginal status, ask about getting cheaper scripts. Do not say you are Aboriginal unless asked.

- If during the consultation, you believe you have been detected as the standardised patient, continue with the consultation if you are unsure. However, if at any time the doctor openly discloses that you are detected, or acts in a way that makes you believe strongly you have been detected, then end the consultation.
- If your doctor asks you to sign the Medicare consultation slip at the beginning, during or at the end of the consultation, do so. Inform the Researcher immediately upon leaving the practice that you signed a Medicare slip. The Researcher will organise to have the bulk-bill claim destroyed and the University to be invoiced.

INSTRUCTIONS AFTER THE CONSULTATION

- If you have not been asked to sign the Medicare consultation slip by the doctor, proceed to the reception area as you normally would at the end of the consultation. If the practice is a bulk-billing practice, sign the necessary paperwork and inform the Researcher immediately upon leaving the practice. The Researcher will organise to have the bulk-bill claim destroyed and the University to be invoiced. If the practice gives accounts, get them to give you an account as normal. The Researcher will then organise to have this bill cancelled and one made out to the University.

4.2.1.3 The USP visits

The USPs scheduled their own appointments with the general practitioners over the telephone. The researcher was listening to the calls and then immediately asked the USP to complete the *Making the appointment* section of the *USP assessment* in order to reduce recall bias. For each appointment, the researcher transported the USP to the appointment and waited nearby. This was to facilitate USPs transport to the appointments and to deal with billing issues after the consultation.

The USP attended the appointments without disclosing that they were the study patient. For the purposes of this research, fake Medicare Cards were not possible. The USPs presented their own or another Medicare Card at initial registration at reception, and gave their own address details if the surgery was close to their home address or a fake address if the surgery was not close. This was done to reduce detection of the USP as a patient presenting out of area may have raised suspicion in the practice. USPs were instructed to end the visit if they felt they were detected. Whilst waiting for the general practitioner, USPs discreetly jotted down notes regarding their perception of their encounter with reception, their views on the physical environment of the practice, and how they felt walking in to the practice, in the waiting room and at reception. Once in the

consultation, the USPs were trained to decline any intrusive physical examinations; examinations such as the measuring of blood pressure and listening to the chest with a stethoscope were deemed an acceptable part of the scenario. USPs could accept pathology requests for blood tests but were to refuse offers of immediate blood collection, citing non-fasting or being pressed for time as reasons.

After the consultation, USPs were instructed to report back to reception to finalise their accounts. On completion of the consultation and visit, they were instructed to obtain an account from reception and refuse automatic lodgement for the Medicare rebate if offered. If the practice was a bulk-billing practice, the USPs were instructed to sign the Medicare Form and, once they left the practice, to inform the researcher who was waiting nearby outside. The researcher then went to the practice and advised the reception staff that the patient was the study patient and instructed reception to destroy the Medicare bulk-bill claim and invoice the University. At the same time the researcher would check if any staff member had suspected or detected the USP.

Immediately after the visit, the USP completed the USP Assessment. Again this was done to minimise recall bias. An outline of the USP template is provided in Box 3; the full version of the assessment is provided in Appendix 5. The researcher then interviewed the USP, verbally asking the questions in the USP Assessment and probing for further information when areas required further clarification or description to obtain a richer picture of the encounter and the USP perceptions of the experience. Immediately or as soon as was practical after the USP visit, the researcher obtained a copy of the clinical notes for the consultation and ensured the USP was recoded as "UNSW Study Patient" and that all personal identifying information including name, address, telephone numbers, Medicare and Health Care Card numbers were deleted so that the USP consultation could not be linked back to an individual in the future. When the researcher next saw the GP she checked if they had detected or suspected the USP at any time during the consultation.

Box 3. Outline of the USP Assessment Checklist

1. *Identification*: was the USP asked their Indigenous status? If so, how?
2. *Literacy*: Was literacy assumed?
3. *Practice environment*: description of posters, brochures, artwork and other material encouraging self-identification of Indigenous status
4. *Nurse*: What the nurse did and how the USP felt.
5. *GP*: What the GP did and how the USP felt.
6. *Other health professional*: What any other health professional did and how the USP felt.
7. *Indigenous PIP*: Was the USP asked to register for it and was it explained properly?
8. *Indigenous PBS Co-payment Measure*: Was the USP asked to register for it and was it explained properly?
9. *How the USP felt*: making the appointment, walking in, at reception, in the waiting room and during the consultation
10. *Continuing care*: Would the USP return if given the choice?
11. *Other Comments*

4.2.2 Individual interviews

Interviews are conversations with agendas¹⁴⁴. Kvale describes the interview as, "an inter-view where knowledge is constructed in the inter-action between the interviewer and the interviewee"¹⁴⁴(p1). Hence from a social constructionist perspective, the interview is itself an interaction where meaning is constructed. The aim of in-depth interviews is to gain a deep understanding of people's perceptions, views and/or experiences in their own words¹⁴⁵. Interviews were the method of choice here as observation could reveal a person's behaviour but not their perspectives; and surveys would not permit the researcher to probe further for richer explanation or a deeper exploration without having to revisit the respondent.

Interviewing requires the researcher to ask questions, listening actively, and probe the respondent for further information to ensure they have a clear understanding of the phenomena being explored from the respondent's viewpoint. Researchers also need to pay attention to what is not being said, so that they can attempt to elicit a response from the respondent or gain an understanding of why the respondent is not comfortable with the question¹⁴⁵.

In-depth interviews require a rapport between the researcher and the respondent. Prior to beginning an interview, the researcher should engage in small talk with the respondent and explain the process of the interview to help the respondent

relax and to produce a more natural setting. Accurate recording during the interview is vital. It is recommended that all researchers take notes during interviews to highlight areas that need to be explored further by asking probing questions without interrupting the respondent. Respondents should be allowed to finish their stories, regardless of how irrelevant it may be to the research question¹⁴⁵. The entire interview session should be audio-recorded. This is so that the researcher can concentrate on what the respondent is saying and how they are saying it (or not saying it); the free flow of the respondent's answer is not disrupted with concerns that they are speaking too fast or offering too much information and that the researcher does not have enough time to write it all down; and so that the entire conversation can be transcribed verbatim at a later date so that a detailed and accurate analysis on its content may be performed¹⁴⁴.¹⁴⁵ Audio-recordings permanently capture words, tones, pauses, enabling the researcher to return to them again and again. When the researcher has asked all the questions they are interested in, it is recommended that the final interview question they ask respondents is if they would like to add anything. This ensures that respondents feel that they have had the opportunity to discuss any matters important to them also¹⁴⁴.

The researcher took all these factors into consideration when conducting the interviews. Prior to interviewing the participants, the researcher spent time with the respondents explaining the interview process and allowed them time to review the interview questions. This was done to ensure the respondents were fully informed, to help the respondents relax and to help the flow of the interview. During the interview, the researcher encouraged respondents to offer as much information as they could. The researcher made a conscious effort to remain neutral and facilitate the discussion without challenging the respondent's opinions. The last question in each interview was an open question which asked respondents, "*What other comments would you like to make?*" All interviews were audio-recorded with a digital voice recorder with the prior permission of the respondents. The researcher made field notes immediately or as soon as practicable following each interview, including a description of the interview setting and the researcher's impressions about the interview process. The specific interview process with 'case' members and Medicare Local staff are discussed in detail separately below.

4.2.2.1 Interviews with 'case' members

To understand the current knowledge, attitudes and behaviours, as well as their perception of the barriers or enablers to Indigenous status identification and providing culturally appropriate care in general practice, semi-structured interviews were conducted with practitioners and practice staff at baseline and at follow-up.

At baseline 30 interviews were conducted (general practitioners n=8, practice nurses n=2, practice managers n=4, allied health provider n=1, and reception staff n=15); at follow-up 22 interviews were conducted (general practitioners n=8, practice nurses n=2, practice managers n=4, and reception staff n=8). Baseline interviews were performed between May and September 2012 and follow-up interviews were conducted between April and May 2013. The average interview length at baseline was 12 minutes 16 seconds (range 3 minutes 55 seconds to 30 minutes 25 seconds). The average interview length at follow-up was 13 minutes 0 seconds (range 4 minutes 49 seconds to 32 minutes 35 seconds).

All interviews were conducted face-to-face by the researcher with the exception of the baseline interview with the allied health provider which was conducted over the telephone. All the face-to-face interviews were conducted in the practice where the participant worked, with the exception of one practitioner who was interviewed in his office which was external to the practice.

The interview questions followed a series of standard questions that allowed for flexibility around the responses. Participants were asked 12 broad questions about their knowledge, attitudes and skills regarding identifying patient's Indigenous status, the provision of culturally appropriate care and service delivery to Aboriginal and Torres Strait Islander patients in general practice, their knowledge and attitudes regarding the Indigenous-specific Medicare Benefits Item Numbers and Pharmaceutical Benefits Scheme Co-payment Measure, as well as practice accreditation and the Indigenous Health Incentives Practice Incentive Payments (IHIP). A copy of the interview schedule is provided in Box 4.

Box 4. Interview schedule for general practice staff and general practitioners

This project is looking at improving the acceptability of general practice to your local Aboriginal community. The purpose of this interview is to find out your views on what (if anything) is required to enhance the acceptability of this practice to Aboriginal patients.

Questions:

1. What do you think the barriers to Indigenous status identification in general practice are?
2. What do you think the enablers to Indigenous status identification in general practice are?
3. What do you think the barriers to providing culturally appropriate care to Aboriginal and Torres Strait Islander patients in general practice are?
4. What do you think the enablers to providing culturally appropriate care to Aboriginal and Torres Strait Islander patients in general practice are?
5. What are your views on the Aboriginal and Torres Strait Islander-specific MBS item numbers available for Aboriginal and Torres Strait Islander patients?
6. What are your views on the new PBS Co-payment Measure available for Aboriginal and Torres Strait Islander patients?
7. (If the practice is accredited) What are your views on the practice guidelines and requirements for the Indigenous Health PIP and the PBS Co-payment Measure?
8. What are your attitudes, understanding and skills in the area of providing culturally appropriate service delivery for Aboriginal and Torres Strait Islander peoples?
9. What activities does the practice engage in to be more welcoming for Aboriginal and Torres Strait Islander patients?
10. In your opinion, is the physical environment of the practice inviting to the Aboriginal and Torres Strait Islander community? Why/Why not?

Baseline only

11. In what ways do you think this study could improve the acceptability of your practice to Aboriginal and Torres Strait Islander patients?

Next two questions for follow-up interviews only

12. In what ways has this study improved the acceptability of your practice to Aboriginal and Torres Strait Islander patients?
13. What suggestions do you have for improvement?

Both baseline and follow-up

14. What other comments would you like to make?

4.2.2.2 Interviews with Medicare Local staff

Unstructured in-depth interviews were conducted with Medicare Local Closing the Gap Officers to gain an understanding of their perceptions and experiences regarding the implementation of, and the effectiveness of the existing Closing the Gap Health Initiatives programs that had been introduced in general practice. The

researcher conducted two interviews face-to-face between April and May 2012. The Closing the Gap Offices were asked one broad question: what programs currently exist to enhance culturally appropriate care for Aboriginal and Torres Strait Islander patients in general practice, what did the participants feel were the barriers and facilitators to these programs, and what were their perceptions of what was and was not working. A copy of the interview schedule is provided in Box 5. The average interview length was 1 hour 27 minutes 37 seconds (range 1 hour 13 minutes 59 seconds to 1 hour 40 minutes 45 seconds).

Box 5. Interview schedule for Medicare Local Closing the Gap Officers

The purpose of this session is to find out your views on the any programs available to general practice that you are aware of to improve the health outcomes of the local Aboriginal and Torres Strait Islander community.

Questions:

- What programs/facilities are available?

For each program mentioned have respondent:

- Explain the program
 - Discuss what is working, what isn't working, what can be done better/differently
 - Discuss what the major barriers or facilitators of these programs are
- What other comments would you like to make?

A theme that arose from the above interviews was Practice Accreditation (see Section 5.1.4, Chapter 5). In order to further explore this theme, the researcher then interviewed the Practice Support Officer at one Medicare Local (the Practice Support Officer at the other participating Medicare Local was not available) and asked her to explain the process of Accreditation and what the barriers and facilitators to Accreditation were. Prior to interviewing this participant, the researcher explained the theme that had emerged in the previous interviews and explained that she wanted a deeper understanding of the Accreditation process. This helped the flow of the interview by focussing the participant. This unstructured in-depth interview was conducted over the telephone and occurred in May 2012, with an interview length of 22 minutes 20 seconds.

4.2.3 Focus group interviews with Aboriginal and Torres Strait Islander peoples

In order to understand Aboriginal and Torres Strait Islander peoples experiences of care in general practice and understand their perspectives and views on what appropriate care in general practice was, focus groups were conducted with Aboriginal and Torres Strait Islander community members in the two study areas.

Focus groups interviews are group discussions used to explore people's realities, that is, their understandings, perceptions, views and/or experiences on a specific phenomenon¹⁴⁵⁻¹⁴⁷. Before moving on to describe the suitability of the research method and its use in this study, a clear distinction must be made between group interviews and focus group interviews. A group interview involves interviewing a number of people at the same time, with the emphasis being on the responses of individual participants to questions by the researcher¹⁴⁸. The unit of analysis is each individual participant. Focus groups are a form of group interviewing but the emphasis is on the group interaction to produce the data. Topics are provided by the researcher who usually takes on the role of moderator. Morgan states, "*the hallmark of focus groups is their explicit use of group interaction to produce data and insights that would be less accessible without the interaction found in a group*"¹⁴⁹(p2). The unit of analysis is the group, not the individual participants within the group.

Focus group interviews are a suitable research method when an in-depth knowledge is required about what the participants think and why they think the way they do, and is particularly important when the researcher is exploring people's perspectives and experiences from different social and cultural backgrounds to their own, such as was the case in this study. Focus groups are also suitable to explore sensitive issues or to research sensitive, marginalised or hard-to-reach populations, because people often feel more at ease discussing issues when they are with others who have similar views or experiences^{145, 150}.

There are essentially three different ways in which focus groups can be used^{145, 149}.

- As a self-contained method, in which case the focus group is the main source of data collection. This method is used as opposed to individual interviews

because it can reveal participant's perspectives and experiences which may not be possible without the group interaction.

- As a supplementary source of data. In this method the focus group is used as a source of preliminary data in quantitative research and is most often used to generate survey questions, or it is used to develop a program or intervention, or it can be used to validate aspects of quantitative research findings such as survey findings when they survey itself cannot provide a deep understanding on the participants' perspective.
- In mixed or multi-method studies where it contributes something unique to the researcher's understanding of the phenomenon under study. This method is used for triangulation of data - to enhance the understanding of each method by the other.

This research used focus groups as a self-contained method to understand Aboriginal and Torres Strait Islander peoples experience in general practice as well as for triangulation of data.

4.2.3.1 Focus group participants

The emphasis of a focus group is the group discussion; hence the composition of the group is important. To ensure maximum interaction within the group can be achieved and to avoid individuals dominating, participants should have something in common. There are three points of commonality to consider.

Group homogeneity/heterogeneity: participants coming from similar social and cultural backgrounds may feel more comfortable talking with one another allowing for more free and open conversation among the participants, whereas participants from different backgrounds can restrict the openness of the discussion¹⁴⁵. A heterogeneous group is useful if researchers want to "*maximize the possibility of exploring subjects from different perspectives*"¹⁵⁰(p300).

Shared experiences: Focus group participants who have shared experiences are more likely to talk openly with each other because they feel that others in the group can better understand them because they have a common experience.

Familiarity of participants: In some cases, for example when discussing culturally sensitive topics, group anonymity facilitates free and open discussion between

participants in a focus group. However, recruiting strangers may not be practical or possible. Conversely, free and open discussion between participants may be facilitated by participant familiarity. For example, women may talk openly with their friends and family but may not talk openly in front of strangers. Focus groups conducted with acquaintances allows participants to share their experiences as well as disclosing personal information; deeper levels of disclosure can be obtained the more the participants interact. Kitzinger described the benefit of using participants known to each other in a focus group: *“By using pre-existing groups we were able to tap into fragments of interactions which approximated to ‘natural occurring’ data (such as might have been collected by participant observation). The fact that research participants already knew each other had the additional advantage that friends and colleagues could relate each other’s comments to actual incidents in their shared daily lives”*¹⁴⁶(p104).

The focus group participants in this study met all the above requirements. Focus groups were comprised of a homogenous group of participants (female Aboriginal and Torres Strait Islander peoples), with shared experiences (attendance at non-Aboriginal controlled general practice), with familiar participants (members from their local community). In Aboriginal and Torres Strait Islander culture, it is customary to keep ‘women’s and men’s business’ separate. As the focus of the discussion was attendance at general practice, the researcher was informed that it was not appropriate to have a gender mix in the focus groups. Being female, and because of time and financial constraints, the researcher was limited to conducting focus groups with women.

4.2.3.2 Recording the focus groups

An essential component to a focus group is the note-taker. The note-taker allows the moderator to concentrate on facilitating the focus group without having to divert their attention to taking notes. The note-taker makes a short note each time a new participant in the focus group is speaking as this can often be difficult to distinguish in audio recordings. Additionally, note-takers record non-verbal responses like facial expressions and shows of emotion such as tears or boredom for example¹⁴⁵. As is the case with individual interview, the focus group should be audio-recorded to enable a verbatim transcript to be made for detailed and accurate analysis. The verbal responses (and silences) captured on the audio-recordings together with nonverbal responses recorded by the note-

taker¹⁴⁵ are combined to help add richness and context to the focus group data¹⁴⁵,

Each focus group was audio-recorded using a digital voice recorder with the prior permission of the participants. An Associate Investigator (themselves a member of the local Aboriginal and Torres Strait Islander community) acted as note-taker for each focus group. Hence, a different note-taker was present for each focus group. The researcher feels that having 'an insider' as note-taker facilitated the openness and flow of the focus groups as a stranger was not introduced into the mix.

4.2.3.3 Focus group interviews

Focus groups best take place in a setting where participants feel comfortable enough to engage in a dynamic discussion for one or two hours¹⁴⁵. In this respect the focus groups were held at the Aboriginal Community Centres for each respective Aboriginal community. One focus group was conducted in each community, with five and six members respectively.

The researcher asked participants to share their experiences in general practice, including making the appointment; how they felt when they walked in, at reception and in the waiting room; and how they felt during the consultation. The interview schedule is provided in Box 6. Positive and negative experiences were explored to understand what Aboriginal and Torres Strait Islander patients wanted and expected in general practice. The researcher acted as moderator to keep the interview on topic and to allow participants who might have been dominated by other participants to share their experiences. During the focus groups the researcher made a conscious effort to remain neutral and facilitate the discussion without challenging the participant's opinions. Before concluding the focus group, the researcher asked the participants, "*What other comments would you like to make?*" This ensured that all participants had the opportunity to discuss any matters important to them also¹⁴⁴.

The average focus group interview length was 1 hour 7 minutes 8 seconds (range 1 hour 12 minutes 2 seconds to 1 hour 22 minutes 7 seconds). Focus group participants were given a \$30.00 gift card to compensate for their time.

Box 6. Focus group (Aboriginal and Torres Strait Islander patients) interview schedule

The purpose of this session is to find out your views and experiences when you have attended a doctors surgery in this area, and for you to tell me what was right, what was wrong and what can be done to make the service better for you.

Questions:

Thinking about the/some doctor's surgeries or medical centres you have been to.

Appointments:

- What was your experience when calling to make appointments?
 - How did that make you feel?
 - What was right, what was wrong, what can be done better/differently?

When you walk in the door:

- What was your experience when you walked in the door (i.e. Did you feel welcome, safe)?
 - How did that make you feel?
 - What was right, what was wrong, what can be done better/differently?

Registration and front desk staff:

- Were you asked if you needed help with the paperwork?
 - How did that make you feel?
 - What was right, what was wrong, what can be done better/differently?
- Were you/have you been asked if you are Aboriginal or Torres Strait Islander?
 - Why do you think you have/have not been asked that question?
 - How was it asked?
 - How did that make you feel?
 - What made you feel that way? What was right, what was wrong, what can be done better/differently?
- How did/do the staff speak to you/treat you?
 - How did that make you feel?
 - What was right, what was wrong, what can be done better/differently?

Seeing the doctor:

- Were you/have you been asked if you are Aboriginal or Torres Strait Islander?
 - Why do you think you have/have not been asked that question?
 - How was it asked?
 - How did that make you feel?
 - What made you feel that way? What was right, what was wrong, what can be done better/differently?
- How did/does the doctor speak to you/treat you?
 - How did that make you feel?
 - What made you feel that way? What was right, what was wrong, what can be done better/differently?
- Did/does the doctor spend enough time with you or do you feel rushed?
- What do you know of Closing the Gap regarding health outcomes?
 - What is the difference between signing on to the Closing the Gap and getting cheaper scripts?
 - Does your doctor offer this? If no, do you know why not?

– Tell us your experiences regarding this?

Other Comments:

- What other comments would you like to make?

4.3 Researcher notes and reflections

As well as keeping a communications diary, the researcher kept a reflective journal of all conversations and encounters with participants, paying particular attention to any comments or other issues that stood out, were of interest, or could help add richness and context to the interactions. The reflexive journal was informal and in notebook form in a Microsoft word document, and entries were made either immediately after conversations and/or interactions took place or as soon as was practical.

4.4 Practice summary and patient clinical record audit

The researcher made appointment with the Practice Manager or Principal to conduct the Practice Summary and Patient Clinical Record Audit. The information for the practice summary was obtained verbally from the Practice Manager or Principal and included the demographics of the practice staff (role, gender and full-time or part-time status), whether the practice was accredited with the Royal Australian College of General Practitioners, and whether any staff had undertaken Aboriginal and Torres Strait Islander Cultural Awareness Training in the past.

The researcher then conducted a deidentified audit of the patient clinical records. All patients aged 18 years or over that had attended the practice within the past two years were included in the audit. From these patients, the researcher searched the records for the number of patients identified as Aboriginal, Torres Strait Islander, Aboriginal and Torres Strait Islander, neither, or Indigenous status not identified. For any Indigenous-identified patients, the researcher then counted the total number of consultations within the past two years, as well as the number of health checks performed, follow up services provided by a practice nurse or

registered Aboriginal Health Worker for a patient who has received a health assessment, and the number of referrals for health services provided by an eligible Aboriginal health worker. An outline of the Practice Summary and Patient Clinical Record Audit is provided in Box 7; the full version is provided in Appendix 6.

Box 7. Outline of the Practice Summary and Patient Audit

1. Staff Demographics
2. Practice Software
3. Pip registered
4. No. of staff having undertaken Cultural Awareness training
5. Indigenous-status recording for patients aged 18 or over
6. Total. Indigenous-identified patients aged 18 years or over
7. No of consultations for Indigenous-identified patients (past 2 years)
8. No. of health checks in the past 6 months for Indigenous-identified patients
9. No. of patients enrolled in IHPIP and/or Indigenous PBS Co-payment Measure

4.5 Self-complete questionnaires with general practitioners and practice staff

After the USP had visited each practice and after each participant had been interviewed, all GPs and practice staff were asked to complete a self-complete mail-questionnaire. As well as covering the areas of interest for this study, the questions also covered various aspects of care that had been identified by Aboriginal and Torres Strait Islander patients in the literature as being important for culturally appropriate care^{47, 151}. The questionnaire included demographics and the participant's knowledge and perceptions on: the Indigenous status identification methods used in the practice for new and existing patients; the barriers and enablers to providing care to Aboriginal and Torres Strait Islander patients; the level of involvement with Aboriginal organisations and health services; and the knowledge and views of the Indigenous-specific Medicare Benefits Item Numbers, Pharmaceutical Benefits Scheme Co-payment Measure, and the Practice Incentive Payments. Some of the questions covered topics that were also asked in the individual interviews. There were two main reasons for this. Firstly the researcher wanted to capture as many different respondent views as possible and understood that some participants might elect to participate only in the interview or the survey and not both; secondly the two methods were used

for triangulation of data purposes. An outline of the self-complete questionnaire is provided in Box 8; the full version is provided in Appendix 7. At baseline 29/31 respondents returned their surveys (94% response rate); at follow-up 21/22 respondents returned their surveys (95% response rate).

Box 8. Outline of the GP and practice staff self-complete questionnaire

1. *Demographics*
2. *Indigenous status identification*: how are patients identified, who does Indigenous-status identification, how effective is the method, is Indigenous status recorded on the medical record?
3. *Engagement*: with AMS/ACCHS and Aboriginal community
4. *Participant views*: on the barriers and enablers to the provision of culturally appropriate care to Aboriginal and Torres Strait Islander patients, and the Indigenous-specific MBS item numbers, PBS Co-payment Measure and PIP.

4.6 Data analysis

Case study analysis involves either an holistic analysis of the entire case or an embedded analysis of a specific aspect of the case¹²². A typical format for analysis of collective case studies is to perform a within-case analysis and then a cross-case analysis. Analysis involves a detailed narrative description of the case situated within its contextual setting, and analysis of themes and interpretations. According to Stake, “meanings in case studies are reached through direct interpretation of the individual instance and through aggregation of instances until something can be said of them as a class”¹²⁷(p74). In other words, the focus is on the development of themes and aggregating the data into larger clusters of assertions or interpretations.

Stake describes four techniques for case study analysis:

- *Direct interpretation*: draws meaning from a single instance. It involves pulling the data apart and putting it back together again in more meaningful ways.
- *Categorical aggregation*: draws meaning across multiple instances. A collection of instances (or repetition of the phenomena) in the data are studied searching for emergent themes. This process is known as open coding in grounded theory.

- *Correspondence and patterns*: are similarities across multiple instances of data. It involves searching for relationships or correspondence (consistency within certain conditions) between categories and can be done during data collection, or through coding the data and aggregating the frequencies, or through a mixture of both. Patterns may be known in advance based on previous literature or can emerge from the analysis.
- *Naturalistic generalisations*: are the interpretations of the case in order to make it understandable. This understanding could be the lessons learnt about this case or those that could apply to other cases. Stake describes naturalistic generalisations as "*conclusions arrived through personal engagement in life's affairs or by vicarious experience so well constructed that the person feels as if it happened to them*"¹²⁷(p85). He suggests that a descriptive narrative account with an "*emphasis on time and place provide rich ingredients for vicarious experience*"¹²⁷(p87).

Before performing within-case and cross-case analyses, it is appropriate to provide an overall description of the analysis techniques used. Qualitative analysis can be roughly separated into two groups: those that are tied to or stem from a particular theoretical or epistemological approach; and those that are independent of the theoretical or epistemological approach. The first group contains a broad range of analysis methods ranging from phenomenological and conversation analysis which Braun and Clarke describe as having "*limited variability in how the method is applied*" and where essentially "*one recipe guides analysis*"¹⁵²(p78); to others such as grounded theory and narrative analysis where "*there are different manifestations of the method*"¹⁵²(p78). The second group includes thematic analysis, which is compatible with the constructionist paradigm. Thematic analysis is used to identify, analyse and report patterns (or themes) within data. According to Boyatzis¹⁵³, it can go further than this and also interpret various aspects of the research.

Creswell¹²² describes the overall analytical process as conforming to an analytic spiral (see Figure 7) rather than a linear approach, and identifies four loops in the process. The first loop is data management where files are converted into text and organised into a retrievable system such as index cards or a computer program. The next stage is reading and memoing. In this stage, the researcher becomes familiar with the entire database, reading the transcripts several times and immersing themselves in the detail. The next loop in the process is the

describing, classifying and interpreting loop. Here the data is categorised into themes through a process of coding, condensing and providing an interpretation of the data in light of their own views or those presented in the literature. The final loop involves presenting the data in text, tables or figures.

Image not included in this publication due to copyright restrictions.

Source: Creswell 1998¹²² (p143).

Figure 7. The data analysis spiral

Creswell's spiral analysis process was the overall analysis process used for the qualitative component of this research and is described in detail below.

4.6.1 Data management and reading

All interviews were audio recorded using a digital recorder and were transcribed verbatim by the researcher at baseline, and using a combination of the researcher and a transcribing service at follow-up. Researchers transcribing interviews themselves is an excellent way for the researcher to start familiarising themselves with the data^{152, 154}. Bird argues that this is also a key phase of data analysis as it allows for a more thorough understanding of the data¹⁵⁴. It is important for researchers who do not transcribe their own interviews to familiarise themselves with the interviews by listening to the audio-recordings whilst reading the transcripts¹⁵². This also serves as a method for checking the accuracy of the transcripts. To ensure anonymity, all names identifying individuals, organisations or locations were suppressed in the transcriptions. Each participant was assigned a unique numerical number to enable demographic description. As transcripts

have been described as decontextualised conversations which do not capture non-verbal communication¹⁴⁴, a number of steps were taken to overcome or minimise the decontextualisation. Audio-recordings of the interviews allowed a permanent capture of words, tones and pauses which could be referred back to again and again. Sighs, pauses and any notable changes in tone were noted on the transcripts. The notes the researcher made of the individual interviews and the note-takers notes for the focus group interviews also helped add richness and context to the transcripts. After the interviews were transcribed, the researcher listened to each interview again whilst reading the transcript to ensure the transcript accurately represented the interview. All transcripts and any other relevant documents (such as those collected during the course of the USP visits for example) were then uploaded into QSR Nvivo 9.2¹⁵⁵, a qualitative software computer program which assists with coding and organising data. The researcher's observational notes and reflexive notes were also uploaded into QSR Nvivo.

4.6.2 Describing, classifying, interpreting (at the respondent level)

This part of the analysis spiral is where Stake's first three analysis techniques (direct interpretation, categorical aggregation, correspondence and patterns), are carried out. These processes rely on thematic analysis. The first part of thematic analysis is coding. Put simply, codes are labels or tags attached to chunks of data of any size to assign units of meaning¹⁵⁶. Codes refer to *"the most basic segment, or element, of the raw data or information that can be assessed in a meaningful way regarding the phenomenon"*¹⁵³(p63). But coding is more than labelling; it is the part of analysis that *"involves how you differentiate and combine the data you have retrieved and the reflections you make about this information"*¹⁴⁰(p56).

The first level of coding performed was descriptive coding, which is used to store things known about the data sources, such as respondents, places and events. It *"entail[s] little interpretation. Rather you are attributing a class of phenomena to a segment of text"*¹⁴⁰(p57). This coding was applied to the individual data sources to provide demographic data and to facilitate the description of the cases and for pattern seeking.

The next level of coding began classifying the text. After reading through the transcripts, initial concepts that appeared to be relevant to the study were identified and were used to generate the initial coding categories. Text was coded inclusively using a broad brush approach. The broad brush approach meant that surrounding text which captured the context of the content was coded and an inclusive approach meant that the same information could be coded multiple times under different categories. New codes that emerged during the analysis were added as required. The Chief Investigator reviewed the coding of five interviews to identify differing or additional insights or meanings from their reading of the transcript, which then informed the subsequent analysis. Examples of initial coding from baseline interviews are provided in Box 9 below.

Box 9. Example of initial coding

Text	Coding
<i>"Often people want to not stand out from the crowd...They don't want to identify uh for whatever reason because, because I guess they're a minority and they want to be like everybody else..."</i>	Patients don't identify
<i>"To be honest I don't know if there's anyone who comes in that is really, Aboriginal or Torres Strait Islander."</i>	Assumes little or no Aboriginal patients
<i>"We ask people to identify if they wish to on paper so it's up to them to decide....I'm just happy for them to fill in the form and identify themselves that way."</i>	Patients responsibility to identify
<i>"We do have a section on our um new patient listing that um where we do but honestly I don't ask. I have not asked you know, ever."</i>	Patients not asked Indigenous status
<i>"Maybe uh the receptionist may not want to offend by asking are they um an Indigenous person."</i>	Staff think patients will be offended if asked
<i>"I think doctors are too sc-, uncomfortable asking the question..."</i>	Staff not comfortable asking the question
<i>"We don't have anything on the walls to encourage, like there's no um Aboriginal art...I guess it would make it seem like they're more welcome here...it shows that we're um happy for them to come in and we're encouraging them to come in and it shows that we want them here I think."</i>	No artwork or signage

Once all transcripts were coded, the focus of analysis was diverted to developing broader themes according to the process described by Braun and Clark¹⁵². This process "involves sorting the different codes into potential themes, and collating all the relevant coded data extracts within the identified themes. Essentially, you

are starting to analyse your codes and consider how different codes may combine to form an overarching theme"¹⁵²(p89). An example of theme development for the coding is provided in Box 10.

Box 10. Example of theme development (respondent level)

Text	Coding	Theme
<i>"Often people want to not stand out from the crowd...They don't want to identify uh for whatever reason because, because I guess they're a minority and they want to be like everybody else..."</i>	Patients don't identify	Staff attitudes/ beliefs
<i>"To be honest I don't know if there's anyone who comes in that is really, Aboriginal or Torres Strait Islander."</i>	Assumes little or no Aboriginal patients	Staff attitudes/ beliefs
<i>"We ask people to identify if they wish to on paper so it's up to them to decide....I'm just happy for them to fill in the form and identify themselves that way."</i>	Patients responsibility to identify	Identification routines
<i>"We do have a section on our um new patient listing that um where we do but honestly I don't ask. I have not asked you know, ever."</i>	Patients not asked Indigenous status	Identification routines
<i>"May be uh the receptionist may not want to offend by asking are they um an Indigenous person."</i>	Staff think patients will be offended if asked	Staff training
<i>"I think doctors are too sc-, uncomfortable asking the question..."</i>	Staff not comfortable asking the question	Staff training
<i>"We don't have anything on the walls to encourage, like there's no um Aboriginal art...I guess it would make it seem like they're more welcome here...it shows that we're um happy for them to come in and we're encouraging them to come in and it shows that we want them here I think."</i>	No artwork or signage	Unwelcoming practice environments

Theme development is an ongoing iterative process of reflection, which requires re-coding, refining and reorganising the data several times until the relationships between and within themes fit accurately. As such, the next step in this process was refining the themes. This was performed by first reviewing all the coded data extracts within each theme to see if they formed a coherent pattern and if distinctions could be made between the themes. If the data did not fit within the theme, the theme itself was reviewed to see if the coded extracts would fit within another existing theme, whether new themes needed to be created to house those codes that did not fit, or whether the codes would be discarded because

they were not pertinent to analysis. Hence some themes were collapsed together into the same theme while other themes were separated out into further themes. The process was then repeated at the level of the entire data set. Here each theme was considered on its validity in relation to the data set and whether they accurately represented the data as a whole. The final step was defining what aspect of the data each theme captured. While 'identifying the story' within each theme and subtheme, the researcher considered how each theme fit within the overall story the data was telling in relation to the research question.

4.6.3 Representing, visualising

Braun and Clarke recommend using visual aids such as thematic maps to help sort codes into themes and to identify possible relationships and associations between themes¹⁵². The first few interviews coded seemed to indicate that Indigenous status identification and the provision of care to Aboriginal and Torres Strait Islander patients were dependent upon staff awareness and practice environments that promoted identification of Indigenous status. As coding progressed and more themes emerged, it became more apparent that the Indigenous status identification processes within a practice were dependent upon a complex interplay between staff training, staff attitudes and awareness, the practice environment, and practice factors. The thematic map development is depicted in Figure 8.

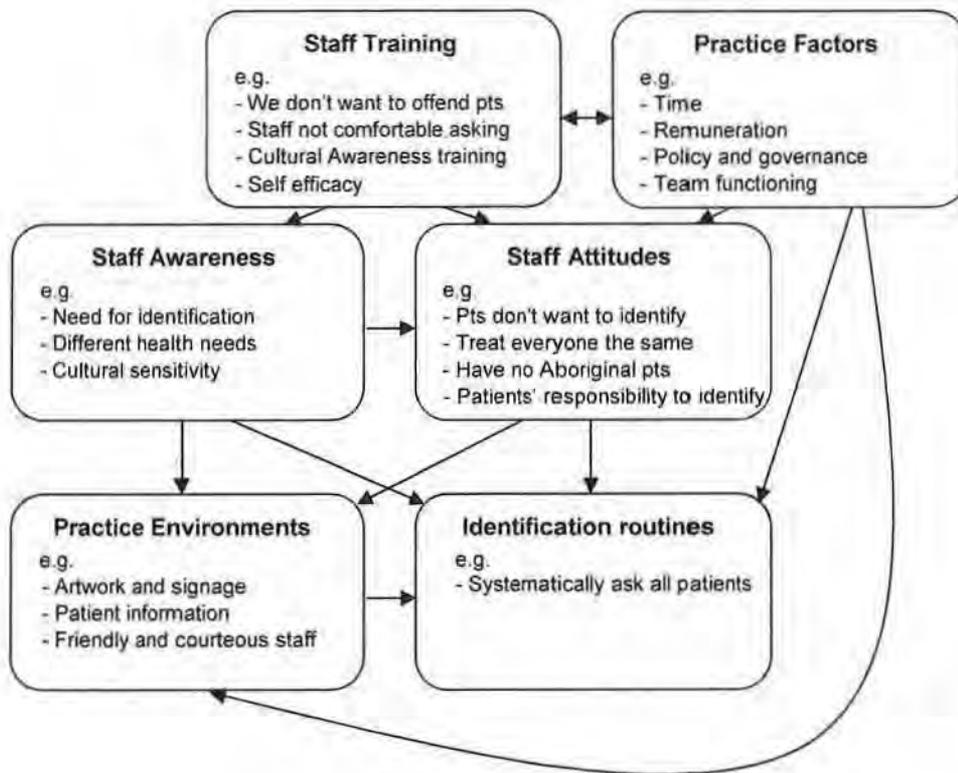


Figure 8. Thematic map development

4.6.4 Describing, classifying, interpreting (at the case level)

Once thematic analysis had been performed at the individual respondent level, it was performed at the higher case level (at the practice level). This involved pulling out the interviews for members of the cases, grouping them within their cases and examining themes within and across cases (see Box 11). In order to do this, factors that influenced performance at the practice level needed to be considered and this was done using Hogg's Conceptual Framework for Primary Care¹⁵⁷ (discussed in the next section).

At the practice level, data was collapsed into two main themes: a belief that issues with Indigenous status identification were external to the practice, (for example, there were no Aboriginal patients at the practice, or patients did not want to disclose their Indigenous status or would be offended if asked their Indigenous status; and a belief that issues with Indigenous status identification were due to internal practice factors, (for example, staff attitudes, having effective

systems in place to identify the Indigenous status of patients and the necessary tools and training to do this, and having practice environments that promoted Indigenous status identification).

Box 11. Example of theme development (case level)

Text	Coding	Sub Theme	Theme
<i>"Often people want to not stand out from the crowd...They don't want to identify uh for whatever reason because, because I guess they're a minority and they want to be like everybody else..."</i>	Patients don't identify	Staff attitudes/ beliefs	Identification issues externalised e.g. due to Pt
<i>"To be honest I don't know if there's anyone who comes in that is really, Aboriginal or Torres Strait Islander."</i>	Assumes little or no Aboriginal patients	Staff attitudes/ beliefs	Identification issues externalised e.g. due to Pt
<i>"We ask people to identify if they wish to on paper so it's up to them to decide....I'm just happy for them to fill in the form and identify themselves that way."</i>	Patients responsibility to identify	Identification routines	Identification issues externalised e.g. due to Pt
<i>"We do have a section on our um new patient listing that um where we do but honestly I don't ask. I have not asked you know, ever."</i>	Patients not asked Indigenous status	Identification routines	Identification issues internalised e.g. practice systems
<i>"May be uh the receptionist may not want to offend by asking are they um an Indigenous person."</i>	Staff think patients will be offended if asked	Staff Training	Identification issues internalised e.g. practice systems
<i>"I think doctors are too sc-, uncomfortable asking the question..."</i>	Staff not comfortable asking the question	Staff Training	Identification issues internalised e.g. practice systems
<i>"We don't have anything on the walls to encourage, like there's no um Aboriginal art...I guess it would make it seem like they're more welcome here...it shows that we're um happy for them to come in and we're encouraging them to come in and it shows that we want them here I think."</i>	No artwork or signage	Practice Environments	Identification issues internalised e.g. practice systems

4.6.5 The Conceptual Framework for Primary Care

As discussed in Chapter 2, variation in individual performance is affected by a number of factors including an individual's state of mind on the day, their knowledge and attitudes, and environmental factors (such as time, resources, organisational constraints, policies and initiatives)¹⁵⁸. As each practice in this study was considered the unit of analysis, factors that affected performance at the practice level also needed to be considered. This was achieved using organisation science. The Conceptual Framework for Primary Care developed by Hogg et al¹⁵⁷ (Figure 9) was used when describing each case to provide context on how it functioned as an organisation and what factors affected teamwork. The framework is comprised of two main domains, the Structural Domain and the Performance Domain. According to Hogg et al, *"The Structural Domain includes the organizational and environmental features likely to influence primary care service delivery,"* and *"These structural attributes align with the individual and collective capacity to provide services"*¹⁵⁷(p310).

Hogg et al describe this domain as being divided into three main components: 1). The Health Care System and factors at the system level that can influence primary care organisations; 2). The Practice Context (factors at the community level that can influence the organisation of the practice and the delivery of care); and 3). The Organisation of the Practice (structures and processes at the practice level). The Organisation of the Practice refers to the individual practices and internal factors which may affect performance, such as the characteristics and training of the team members, staff decision-latitude, culture of the organisation, and team collaboration. The organisation of the practice was an important consideration for this study.

Image not included in this publication due to copyright restrictions

Source: Hogg et al¹⁵⁷ (p311).

Figure 9. Conceptual Framework for Primary Care Organisations

4.6.6 Quantitative data analysis

Numerical data from the practice audits and self-complete questionnaires were entered into the Statistical Package for the Social Sciences (SPSS) Version 21¹⁵⁹, a computer software application that provides statistical analysis of data. Data analysis involved descriptive statistics using univariate (a single variable as the unit of analysis) and bivariate analysis (analysis between pairs of variables)¹⁶⁰.

4.7 Methods to ensure rigour in qualitative data analysis

Four trustworthiness assessment criteria are widely accepted as better reflecting the underlying assumptions involved in qualitative research¹⁶¹ and are listed alongside their 'analogous' quantitative criteria in Table 6 below.

Table 6. Comparison of criteria for judging research

Quantitative Research	Qualitative Research
Internal validity	Credibility
External validity	Transferability
Reliability	Dependability
Objectivity	Confirmability

It should be noted that the procedures outlined for achieving trustworthiness are *one* way of achieving trustworthiness, not *the* way, and researchers should utilise and build on these guidelines as required in their research¹⁶¹. Each criterion is discussed below. A description of how each criteria was specifically applied to increase rigour in this study is discussed in Section 7.3.5 of Chapter 7.

Lincoln and Guba describe a series of techniques that can be employed to achieve the criteria, outlined in Table 7.

Table 7. Techniques to achieve trustworthiness in qualitative research

Qualitative research	Technique
Credibility	<ul style="list-style-type: none">• Prolonged Engagement• Persistent Observation• Triangulation• Peer debriefing• Negative case analysis• Referential adequacy• Member-checking
Transferability	<ul style="list-style-type: none">• Thick description
Dependability	<ul style="list-style-type: none">• Inquiry audit
Confirmability	<ul style="list-style-type: none">• Confirmability audit• Audit trail• Triangulation• Reflexivity

4.7.1 Credibility

This is one of the most important factors of trustworthiness. Member checks, prolonged engagement, persistent observation and triangulation of data were used to increase credibility in this research and are outlined below.

4.7.1.1 Member checks

These are considered to be "*the single most critical technique for establishing credibility*"¹⁶¹(p239). Member checks establish that the results are 'true' from the perspectives of the research participants. It involves taking the data analysis and interpretations back to the participants so they can judge the accuracy of the findings, and to provide alternative interpretations if required¹⁶¹.

4.7.1.2 Prolonged engagement

This involves spending sufficient time in the field to understand the culture of the respondents/settings, or the phenomena of interest¹⁶¹. The researcher should be engaged long enough so that the context of the situation is understood, so that the researcher begins to blend in and respondents feel comfortable disclosing information, the researcher can rise above their preconceived ideas, and so that rapport and trust is built between the researcher and the respondents. The latter is particularly important as rapport and trust aid the understanding and co-construction of meaning between the researcher and the respondents.

The researcher collected data over two time points over a year and remained engaged with the practices between the two time points by providing feedback and training.

4.7.1.3 Persistent observation

This identifies the "*characteristics and elements in the situation that are most relevant to the problem or issue being pursued and focusing on them in detail. If prolonged engagement provides scope, persistent observation provides depth*"¹⁶¹ (p304). Persistent observation provides an accurate, credible account of a phenomenon. For example, if observing a group of people on one day only, they are likely to behave in a different way to the way they normally behave due to the Hawthorne effect. However, this can be minimised by having a long term observation period where the participant gets used to the observer. This study used unannounced standardised patients as an alternative to prolonged observation.

4.7.1.4 Triangulation

A number of triangulation methods exist including source, data collection and researcher triangulation. Each of these were used to increase the credibility of the methods and findings in this study and are discussed below.

Data collection and source triangulation: involves using multiple collection techniques and a multiple sources of data. It is considered a key strength of the case study method and the technique ensures a rich, comprehensive and well-developed account^{161, 162}. Data sources can include interviews, observation, documentation review, surveys, and physical artefacts. Triangulation of data serves a number of purposes. Firstly, gathering data using different data collection techniques overcomes the inherent weaknesses found when using one technique alone. Secondly, triangulation of the data may develop converging lines of inquiry, for example, observation data may corroborate or contradict interview data. Thirdly, research findings are stronger when multiple data sources lead to the same conclusion. Finally, triangulation of data is particularly important in research where the primary data source is the individuals within an organisation but the unit of analysis is the organisation. For example, data from individual interviews reflect the individual's perceptions, they do not reflect organisational events which are obtainable by document review or observation¹²³.

Researcher triangulation: involves using multiple researchers to analyse and/or review the findings. This increases the number of ways in which the data can be viewed and reduces the likelihood that the data analysis is biased by individual interpretation^{161, 162}.

4.7.1.5 Negative or Deviant Case Analysis

This involves searching for and examining the 'exception to the rule cases'; that is, the cases that appear to contradict patterns or explanations emerging from the data analysis. Analysis of negative or deviant cases is a process for refining the analysis until it can explain the majority of cases, and may help with building a broader explanation for the majority of cases and confirm the patterns emerging from data analysis^{161, 162}.

4.7.2 Transferability

This refers to the degree to which the results can be generalised or transferred to other contexts and settings. Lincoln and Guba state that although it is not the researchers "*responsibility to provide an index of transferability; it is his or her responsibility to provide the data base that makes transferability judgments possible on the part of potential appliers*"¹⁶¹(p316). Therefore, researchers can enhance transferability by providing sufficient description and context as well as implicitly stating the assumptions that underpinned the research.

4.7.3 Dependability

This is analogous to reliability and relates to the extent that the findings can be replicated in similar situations with similar subjects. However, reliability is problematic in interpretative constructionism because human behaviour is not static and changes continually according to contextual factors. As the focus is on understanding and explaining the world as others have experienced it, and assuming that multiple realities exist, there is no benchmark against which to measure repeatability in interpretative constructionism. As such, the focus of dependability in qualitative research is determined by whether the results are sensible and consistent with the data collected¹⁶³. Dependability is usually achieved by external audit where details of the processes used to define the study, and collect, analyse and report the findings are made available¹⁶⁴.

Triangulation and a detailed account of the data collection and analysis methods, and the theory underlining these can also be used to assess dependability¹⁶³.

4.7.4 Confirmability

This refers to the degree to which the results could be confirmed or corroborated by others. Methods to achieve this include external audits, triangulation and reflexivity¹⁶¹. Triangulation of data has been described above. Reflexivity is concerned with the researcher's awareness of the effect that their own theoretical assumptions and behaviour may have on the construction of knowledge (the research). In other words, it is the recognition that the researcher's perspective shapes all research.

*"A researcher's background and position will affect what they choose to investigate, the angle of investigation, the methods judged most adequate for this purpose, the findings considered most appropriate, and the framing and communication of conclusions"*¹⁶⁵(pp483-4).

Although researcher bias is undesirable in some research, particularly quantitative research, it is entirely appropriate for an interpretive constructionist study. Different researchers will approach a study from different perspectives, which may lead to different, although equally valid, understandings of a phenomenon. However, neither reality is more 'true'. Reflexivity can be demonstrated by designing research that uses multiple investigators to develop complementary or divergent interpretations; by developing a reflexive journal where the researcher records methodological decisions and the reasons for employing them and their own effect on the research; or by making explicit the researcher's perspectives throughout the research.

4.8 Summary

This chapter discussed that the data collection methods used for this research included direct observation by unannounced standardised patients, in-depth individual semi-structured interviews, focus group interviews, observations, surveys and document review. Purposive sampling strategies were employed. The case study data analysis techniques of direct interpretation, categorical aggregation, correspondence and patterns, and naturalistic generalisations were employed following Creswell's spiral analysis procedure. Strategies to increase rigor in qualitative analysis included triangulation of the data from multiple data sources, prolonged time in the field, member checks, transparency and reflexivity.

Chapter 5

The intervention

This chapter discusses the development, implementation and evaluation of the implementation of the intervention. The chapter begins by providing the background literature which informed the development of the intervention. This is followed by the results of the Aboriginal and Torres Strait Islander focus group interviews and the Medicare Local staff interviews. A description of the various methods used to implement the intervention is then provided. The chapter concludes with a description of the analysis methods used to evaluate the implementation of the intervention.

5.1 The development of the intervention

There were four main activities which informed the development of the intervention: 1. Engagement and involvement of the local Aboriginal and Torres Strait Islander communities; 2. A review of background literature; 3. Analysis of the local Aboriginal and Torres Strait Islander community focus group interviews in relation to the literature; and 4. Analysis of the views of the Medicare Local staff interviews in relation to the effectiveness of Closing the Gap Indigenous Health Initiative. Each are discussed below.

5.1.1 Aboriginal and Torres Strait Islander community engagement

Researchers are required to demonstrate consultation and co-operation with a specific ethnic or cultural group prior to conducting any research on that group. Apart from ethical and moral considerations, this is essential for ensuring the right to self-determination for Aboriginal and Torres Strait Islander peoples.

Section 3.5 in Chapter 3 outlines in detail how this research was conducted with the local Aboriginal and Torres Strait Islander communities and in accordance with the values and principals outlined in *The Strategic framework for improving Aboriginal and Torres Strait Islander health through research*¹³⁴ (the Road Map), *Values and Ethics: guidelines for ethical conduct in Aboriginal and Torres Strait Islander health research*¹³⁵ (the Guidelines), *Guidelines for Research into Aboriginal Health*¹³⁶, and the *National Statement on Ethical Conduct in Research Involving Humans*¹³⁸.

5.1.2 Background literature

5.1.2.1 Theories used to inform the development of the intervention

There is considerable variation in what physicians do in everyday practice compared to what they are supposed to do¹⁶⁶. What determines how health professionals behave? The *Social-ecological Model* recognises that behaviour is influenced by the individual, their environment, the community and policy^{121, 167}.

Bronfenbrenner described these influences as a series of layers like Russian dolls, where each layer had a resulting impact on the next¹²¹ (see Figure 10).

Image not included in this publication due to copyright restrictions.

Figure 10. The Social-ecological Model

Consistent with this model, physician behaviour is influenced by a number of internal and external factors. Internal factors include the physicians state of mind at the time of the consultation, their knowledge and attitudes (lack of agreement with guidelines, lack of outcome expectancy, motivation and/or self-efficacy¹⁵⁸) [self-efficacy is an individual's belief that they can successfully carry out a behaviour; the greater ones perceived self-efficacy, the greater their success¹⁶⁸]; external factors include the patient, guidelines and environmental factors (such as time, resources, organisational constraints and government policies and initiatives)¹⁵⁸.

Ajzen's *Theory of Planned Behaviour*¹²⁰ is a psychological theory that may explain variation in behaviour and has been used in previous applications to study physicians' behaviour regarding sexually transmitted disease counselling¹⁶⁹ and prescribing behaviour¹⁷⁰⁻¹⁷². The *Theory of Planned Behaviour* (Figure 11) proposes that the most important predictor for behaviour is an individual's intentions to act on that behaviour. In turn, intentions are predicted by three variables: attitude, subjective norm and perceived behavioural control. Attitude is determined by an individual's belief based on knowledge and experience that a desired outcome will result if said behaviour is carried out. Subjective norm relates to what the individual believes is socially desirable and the social pressure

to carry out the behaviour. Perceived behavioural control refers to an individual's perception of the ease or difficulty in successfully carrying out the behaviour based on constraints such as time, support and budget. The more positive a person's attitude towards a given behaviour, the more pressure from society to behave in this way and the more control an individual feels they have over the situation, the stronger the intention will be to carry out that behaviour^{120, 173-175}.

Image not included in this publication due to copyright restrictions

Source: Ajzen 1991¹²⁰ (p182)

Figure 11. Theory of planned behaviour

The Social Ecological Model and the Theory of Planned Behaviour were used to inform the development of the intervention as follows. The intervention was designed to influence physician and practice staff behaviour drawing together facets of individual behaviour, the practice environment, and both internal practice policy and industry guidelines. As well as targeting individual physician knowledge and attitudes, the knowledge and attitudes of the practice staff, the physical environment of the practice and the practice policies regarding Indigenous status identification were also targeted. Practitioners and staff were taught the health needs of Aboriginal and Torres Strait Islander peoples and that in order to provide targeted care to their Aboriginal and Torres Strait Islander patients they needed to know the Indigenous status of their patients (attitude toward the behaviour). Subjective norms were targeted during the practice facilitation visits by providing participants with the *National best practice guidelines for collecting Indigenous status in health data sets*⁵⁷, and by providing them with feedback on the literature, the focus groups with the local communities

and direct feedback of an Aboriginal person's experience as a patient at their practice. Practices also received training on how to embed Indigenous status identification as part of the usual routine and were assisted in improving their physical environments to one that actively promoted identification of Indigenous status. These helped target perceived behavioural control as participants could see that they were able to effectively carry out the behaviour within the normal operational constraints of their work.

Each of the activities mentioned above are described in detail in Section 5.2 of this chapter. The implementation of the intervention was influenced by the Normalisation Process Theory^{176, 177} and is discussed in Section 5.3 of this chapter.

5.1.2.2 The need for cultural awareness training

A number of different types of racism exists: cultural racism refers to a widespread acceptance of stereotypes concerning different ethnic or racial groups; interpersonal racism is discriminatory attitudes and behaviour of individuals; and institutional racism refers to specific policies and/or procedures of organisations, including governments, which consistently result in unequal treatment for particular groups. In the health care setting racism usually occurs at the individual level (attitudes and behaviours of staff) and the institutional level^{178, 179} (for example, the systemic failure of the organisation to meet the needs of Aboriginal and Torres Strait Islander peoples). Research shows that experience with racism or perceptions of racism have been associated with poorer health outcomes^{178, 180-182}. Perceived experiences with discrimination have also been associated with a greater concern by patients in providing their ethnicity data¹⁸³. As such, culturally safe health care settings are essential.

The term cultural safety was first used by Māori nurses to describe their working practices from their own viewpoint as the indigenous minority in New Zealand¹⁸⁴. Cultural safety and cultural security are often used interchangeably. It is an environment in the health care setting where patients can recognise their own culture, language, customs, attitudes, beliefs and preferred ways of doing things. Williams defines it as, "*An environment that is safe for people: where there is no assault, challenge or denial of their identity, of who they are and what they need.*"

*It is about shared respect, shared meaning, shared knowledge and experience, of learning, living and working together with dignity and truly listening*¹⁸⁵(p213).

Cultural awareness and cultural sensitivity are considered the building blocks of cultural safety. Cultural awareness refers to learning about the culture of a specific ethnic or cultural group, and is a reflective, awareness raising activity¹⁸⁶. The next building block is cultural sensitivity, which investigates the influences of personal experiences, attitudes and prejudice on the lives of others, particularly in the health care setting^{186, 187}. Cultural safety cannot be reduced to a checklist, and cultural education will always be a first step only. However, improved knowledge of the patient's cultural context when combined with respectful attitudes and a whole of practice approach to cultural safety, can improve the patient experience and the effectiveness of healthcare delivery¹⁸⁸.

The next section provides a brief overview of the background literature and materials used to develop the cultural awareness training used in this study.

5.1.2.3 Available materials for Aboriginal and Torres Strait Islander Cultural Awareness Training

In June 2010 the RACGP, together with the National Faculty of Aboriginal and Torres Strait Islander Health and external stakeholders, developed the *Introduction to Aboriginal and Torres Strait Islander Cultural Awareness Online Training*¹⁸⁹ to assist GPs with cultural awareness training. *Respecting the Difference: Aboriginal Cultural Training*¹⁹⁰ was developed for the New South Wales (NSW) public sector by NSW Health. Using the *RACGP Checklist of Adjudicating Cultural Awareness Training Education*¹⁹¹ as a guideline, the Aboriginal and Torres Strait Islander Cultural Awareness Training offered in this study was informed by the both RACGP and NSW Health cultural awareness training packages, as well as background literature on the health disparities experienced by Aboriginal and Torres Strait Islander peoples (see Section 1.1 of Chapter 1) and the *National Best Practice Guidelines for collecting Indigenous status in health data sets*. The local content was developed using population data available from the Australian Bureau of Statistics Census of Population and Housing data and information provided by the Elder of the La Perouse / Botany Bay Aboriginal Corporation, who also checked the overall content for culturally appropriateness. Cultural education using Aboriginal and Torres Strait Islander

community mentors has been shown to be an important factor in improving patient safety and to assist GPs to work more effectively with their Aboriginal and Torres Strait Islander patients¹⁸⁸. The delivery of the cultural awareness training will be discussed later in Section 5.2.4 of this chapter.

5.1.2.4 A case study of a practice successfully implementing strategies to overcome access barriers

Following feedback from focus groups with Aboriginal and Torres Strait Islander peoples in the Brisbane suburb of Inala in Australia, the Inala Health Centre implemented five key strategies to improve access to the centre for Aboriginal and Torres Strait Islander peoples¹⁵¹:

1. Employment of an Indigenous person as health worker, receptionist or liaison officer;
2. Create culturally appropriate waiting rooms by displaying culturally appropriate health posters and other artwork, playing the local Aboriginal radio station on occasions;
3. Provision of cultural awareness training to all staff within the centre;
4. Informing the local Aboriginal and Torres Strait Islander community about the services available at the centre;
5. Promoting intersectoral collaboration by liaising with the local ACCHS and local Aboriginal and Torres Strait Islander organisations.

As a result 899 new Aboriginal and Torres Strait Islander patients attended the centre between 1995 and 2000, with new patient consultations remaining constant at 180 per year. In addition, second or subsequent patient consultations increased from 720 in 1995 to 2546 in 2000.

The successes of the strategies used in the above case study were drawn upon and influenced the strategies employed in the intervention in this research, which are described in Sections 5.2.2-5.2.5 of this chapter.

5.1.3 Results of the focus groups with Aboriginal and Torres Strait Islander community members

It is well recognised that Aboriginal and Torres Strait Islander culture is polycultural and therefore programs need to be localised. As such, it was important to see if the views of the provision of appropriate care for the local Aboriginal and Torres Strait Islander communities were similar to or different to those identified more broadly in the literature.

There were a number of factors that were considered important in the patient journey:

- Visual symbols of welcome (such as the Aboriginal and Torres Strait Islander flags, or artwork or signage that demonstrated that the practice acknowledged Aboriginal culture). Participants stated that the visual symbol could be anything at all that demonstrated that Aboriginal and Torres Strait Islander peoples were welcome at the practice.
- Some participants felt that having to wait several days or longer to get an appoint with their GP was a barrier to receiving health care and resulted in people not attending a GP for their health needs.
- Personal interactions were important: the experience in the waiting room and at reception was just as important as the consultation with the doctor, and staff attitudes and behaviours played an important role in making the patient feel welcome as a patient at the practice.
- Aboriginal and Torres Strait Islander patients often felt like they were less important than non-Aboriginal patients because they felt that they were being rushed through the consultation and information was often not explained to them in a way that they could understand.

Several participants stated that their GPs were not aware of the 'Closing the Gap' scripts (Indigenous PBS Co-payment Measure), and one participant described the process by which she had to go from practice to practice until she found one that could provide the scripts. A number of participants were not aware of why

their Indigenous status was collected and some believed it was for Census purposes or was somehow linked to their social security payments.

These factors were all taken into consideration when designing and implementing the intervention and are discussed in Sections 5.2.2-5.2.5 of this chapter.

5.1.4 Results of the Medicare Local Interviews

The Medicare Local staff felt that the Indigenous-specific MBS item numbers were good for preventive health and for early disease detection, but felt that they were underutilised. They felt that Aboriginal and Torres Strait Islander Health Assessments and other related item numbers were not an effective measure of the uptake of the Closing the Gap Indigenous Health Initiative. They also highlighted that the Indigenous-specific MBS Item Numbers showed only the number of items billed and did not demonstrate the acceptability and appropriateness of general practice for Aboriginal and Torres Strait Islander patients and felt that this was an important factor that needed to be considered.

Participants strongly felt that practice accreditation was a barrier for both general practices and for Aboriginal and Torres Strait Islander patients. They felt that the cost and time involved for practice accreditation prevented many small and/or solo practices from becoming accredited, which meant that they were not able to provide their Aboriginal and Torres Strait Islander patients with Closing the Gap scripts. They stated that many eligible patients were either forced to get their scripts from a GP other than their usual GP, or they had to go without the benefit of the reduced cost scripts.

Participants also felt that PIPHI registration did not guarantee best patient care, and that the requirement for only one GP and one other member of staff to undertake cultural awareness training as part of PIPHI registration, regardless of the size of the practice, was tokenistic. Participants felt that Aboriginal and Torres Strait Islander Cultural Awareness training should be compulsory for all practitioners and that a refresher course should be required either yearly or each triennium.

Participants also commented on the low level of awareness of the various schemes available in the Indigenous Health Initiatives by both practitioners and the local Aboriginal and Torres Strait Islander community.

The intervention could only address some of the issues raised above: the Aboriginal and Torres Strait Islander Cultural Awareness Training (see Section 5.2.3 of this chapter), and practitioner awareness of the Indigenous Health Initiative schemes (see Section 5.2.4 of this chapter).

5.2 The design and implementation of the intervention

As discussed earlier in this chapter, the intervention was informed by the views of the local Aboriginal and Torres Strait Islander communities, the back ground literature and the results of the interviews with the Medical Local staff. The intervention included Practice Feedback Reports for baseline and follow-up data collection; practice facilitation in regards to Indigenous status identification and recording, Indigenous MBS Item number usage, the Indigenous PBS Co-payment measure and the Indigenous Health Incentives PIP; help making practice physical environments more welcoming to Aboriginal and Torres Strait Islander patients; provision of patient health information regarding identification of Indigenous status; and an optional component of Aboriginal and Torres Strait Islander Cultural Awareness Training. Each area will be described in further detail below, after first introducing the theoretical basis for the implementation of the intervention.

5.2.1 Theoretical basis for the implementation of the intervention

Normalisation Process Theory (NPT)^{176, 177} was used to inform the implementation of the intervention. NPT not only provides a framework for understanding why healthcare interventions work and for evaluating interventions, but also for planning the implementation of interventions¹⁹². NPT is discussed in detail in Section 5.3 of this chapter.

5.2.2 Practice Summary Report

Research shows that cultural knowledge alone is not sufficient to facilitate culturally safe care¹⁹³, but programs that encourage participants to reflect on their own culture and personal biases can help lead to an understanding of how their behaviour impacts on people from different cultural backgrounds¹⁹³⁻¹⁹⁶. This was provided using the reflexive activity of the Practice Feedback Report at both baseline and follow-up.

The Practice Feedback Report comprised a combination of the results from the Practice Summary/Patient Records Audit and the USP Assessments. An outline of the areas covered in the Practice Feedback Report is provided in Box 12; an example of a full version of the report is provided in Appendix 8. The report was structured in a way to highlight any deviation from what practices thought and said they did in regards to identification of Indigenous status and the provision of culturally acceptable care and what happened when a patient presented to their practice. Best Practice Guidelines were presented with the data wherever applicable. The results were expressed in a way so that each practice was represented as a case as opposed to individual staff members, with the exception of the GP consultation section. For this reason, two variations of the hard copy report were made available: the participating GPs received the entire report but where there was more than one participating GP in the practice, each GP received the report which dealt with only their consultation with the USP; the participating Practice Manager received the report minus the section covering what occurred in the consultation and any comments that related specifically to the GP consultation(s) with the USP. This was done to ensure the confidentiality of all participants. In order to allow GPs and practice staff to reflect on their performance in comparison to other practices, individual practice results were presented alongside the average of all participating practices wherever possible.

Reflecting on how one's own behaviour can impact on a different culture can be confronting as participants may realise that their unconscious prejudices and stereotypes^{195, 197} could actually be part of the problem. Due to the possible confronting nature of the report, prior to releasing the report, the researcher secured appointments to discuss the results with each practice and this formed an integral part of the intervention. The researcher saw each GP on their own, and then organised to walk through the results with the rest of the practice staff in

groups at times which were convenient to each practice. To allow for all staff to participate in the feedback session the researcher allowed for up to three sessions with each practice. Each session was held at the individual participating practices.

Box 12. Outline of the Practice Feedback Report

- Asking and recording Indigenous status
- PBS Co-payment Measure
- The practice environment
- How the USP felt
- Health assessments
- The GP consultation
- Other comments

5.2.3 Aboriginal and Torres Strait Islander Cultural Awareness Training

Each GP and practice staff member was offered RACGP accredited Aboriginal and Torres Strait Islander Cultural Awareness Training. The training was delivered face-to-face by the researcher and was usually provided at the same time the researcher was discussing the results of the Practice Feedback Report with participants in order to contextualise the training. It also facilitated less disruption to the practice as staff had to attend fewer sessions. The researcher allowed up to a maximum of three separate visits to each practice. The cultural awareness training was not a compulsory component of the study, and all participants with the exception of two GPs elected to receive this training. Both GPs who chose not to receive the training had previously undertaken or were currently undertaking Aboriginal and Torres Strait Islander Cultural Awareness Training elsewhere.

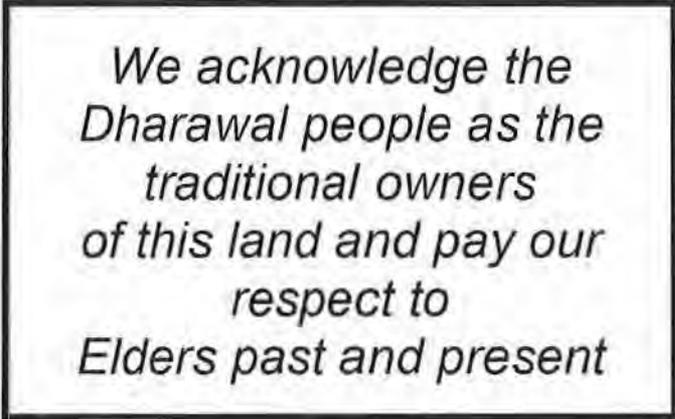
5.2.4 Practice Facilitation

Each practice was offered practice facilitation according to their needs. For example, some practices required assistance redesigning their New Patient Registration Form so that patients were asked their Indigenous status according to Best Practice Guidelines; other practices needed training on how to enter patients' Indigenous status on the practice software or where to look on the patient record to see if the Indigenous status was recorded. Other practices

wanted ideas on how to update the Indigenous status of existing patients in a discreet manner; in these instances, the researcher offered techniques for updating the Indigenous status of patients whilst checking a number of other information such as current address and contact details. For GPs, the researcher also discussed the availability of the various Indigenous-specific MBS Item Numbers. In addition, all GPs and Practice Managers were offered a visit by the Medicare Local Closing the Gap Officer to reinforce the Indigenous-specific MBS Item Numbers and to discuss patient enrolment and eligibility criteria in the Indigenous Health Initiative PIP and the Indigenous PBS Co-payment Measure. It should be noted that the researcher had previous experience working in a general practice and also worked as a Project Officer at former Division of General Practice. This gave her unique insight into some of the administrative processes in general practice and some of the issues encountered in general practice, as well as experience in facilitating change within general practice.

5.2.5 Making practice physical environments more welcoming to Aboriginal and Torres Strait Islander patients

Each practice was offered a series of patient health information leaflets, Aboriginal artwork poster and other visual symbols of welcome. Recognising that each practice environment is different, the researcher offered a number of different resources and some of these could be customised to a practice's requirements. For example, some practices had a no-poster policy and only displayed information in black-and-white signs. For this reason, the *Acknowledgement to Country* was offered in two versions: a coloured version which included both the Aboriginal and Torres Strait Island flags and a text only black-and-white version (see Figure 12). The researcher recommended that the sign be placed in a prominent position at the practice such as the entrance of the practice or at reception.



*We acknowledge the
Dharawal people as the
traditional owners
of this land and pay our
respect to
Elders past and present*

Figure 12. *Acknowledgement to Country* (text-only version for South-Eastern Sydney Medicare Local area practices)

Some participants had expressed that although they wanted to make their practice environment more inviting to Aboriginal and Torres Strait Islander patients and wanted to highlight that the practice welcomed Aboriginal and Torres Strait Islander patients, they had concerns about singling out one ethnicity and stated that they would be more accepting of artwork that reflected Australia's multiculturalism. As a result, the researcher sourced material that was developed with NSW Health and Aboriginal artist Bronwyn Bancroft. The artwork entitled *Celebrating Diversity*¹⁹⁸, is accompanied by the word 'welcome' in 32 languages, and acknowledges Aboriginal Australia and Australia's post-colonisation multiculturalism (see Figure 13). The researcher recommended that this poster be placed at the front door of the practice so that passers-by could see that the practice welcomed all ethnicities whilst also specifically highlighting that it welcomed Aboriginal and Torres Strait Islander patients. If the practice did not want to display the poster on the front door/window of the practice, the researcher recommended that it be displayed in a prominent position at reception and/or in the waiting room area.

Image not included in this publication due to copyright restrictions

Source: NSW Health¹⁹⁸

Figure 13. Welcome poster

A theme that emerged during the interviews and focus groups was that some GPs and practice staff were not aware why they asked patients their Indigenous status and some were not comfortable asking the question. As mentioned in Section 5.1.3 above, several of the Aboriginal and Torres Strait Islander focus group participants were also not aware of the reason why they were being asked their Indigenous status. The researcher developed a simple A4 size sign (Figure 14) to serve a number of purposes: to serve as a prompt to practice staff to ask both new and existing patients their Indigenous status; to support practice staff to ask the question; to help patients understand why they were being asked the question; and to serve as a prompt for patients to disclose their Indigenous status. Recognising that some patients might prefer to disclose their Indigenous status in the privacy of the consultation room, in addition to recommending that the sign be placed in a prominent position at reception, the researcher also recommended that this sign be placed in each consulting area in a position where it was directly in the both the patient's and GP's line of sight.



Figure 14. Are you Aboriginal? sign (black and white version)

The final standard items offered to each practice were the Australian Bureau of Statistics (ABS), *Are you Aboriginal or Torres Strait Islander* patient information leaflets¹⁹⁹ (Figure 15) and the Australian Institute of Health and Welfare (AIHW), *One simple question could help you close the gap* patient information leaflet²⁰⁰ (Figure 16). These items were also available in A3 size poster form. For practices that did not have dedicated stands for patient information leaflets, the researcher recommended that the leaflets be placed on the reception desk or in the waiting room area. Some practices also elected to attach one of these brochures to the clipboard given out to patients when filling in a New Patient Registration Form.

Some practices requested additional material such as more general-health posters that were inclusive to Aboriginal and Torres Strait Islander patients. These practices were offered the NSW Cancer Institute's *Live strong and healthy - Have a pap test every two years*²⁰¹ poster.

Prior to offering any of the abovementioned visual materials to practices, the researcher checked that both local Aboriginal and Torres Strait communities deemed the materials appropriate and acceptable.

Image not included in this publication due to copyright restrictions

Source: ABS¹⁹⁹

Figure 15. *Are you Aboriginal? Torres Strait Islander?*
ABS patient information leaflet

Image not included in this publication due to copyright restrictions.

Source: AIHW²⁰⁰

Figure 16. *One simple question could help you close the gap*
AIHW patient information leaflet

5.3 Evaluation of the implementation and feasibility of the intervention

The Normalisation Process Theory^{176, 177} (NPT) is a middle-range theory that *“focuses on the work of embedding and of sustaining practices within interaction chains, and helps in understanding why some processes seem to lead to a practice becoming normalized while others do not”*¹⁷⁶(p535). The theory is *“concerned with the social organization of the work (implementation), of making processes routine elements of everyday life (embedding), and of sustaining embedded practices in their social contexts (integration)”*¹⁷⁶(p538).

Put another way, Murray et al¹⁹² state that NPT is a theory that, *“...identifies factors that promote and inhibit the routine incorporation of complex interventions into everyday practice. It also explains how these interventions work, looking not only at early implementation, but beyond this to the point where an intervention becomes so embedded into routine practice that it ‘disappears’ from view (i.e., it is normalised)”*¹⁹²(p2).

May and Finch¹⁷⁶ summarise NPT by three statements:

- “a) Material practices become routinely embedded in social contexts as the result of people working, individually and collectively, to implement them;*
- b) The work of implementation is operationalized through four generative mechanisms (coherence, cognitive participation, collective action, reflexive monitoring);*
- c). The production and reproduction of a material practice requires continuous investment by agents in ensembles of action that carry forward in time and space”*¹⁷⁶(p540).

The four components of the NPT (coherence, cognitive participation, collective action and reflexive monitoring) are described below.

Coherence: is the meaning and sense-making by the participants. Participants need to be able to define a practice and give it meaning. If participants cannot define the practice and do not see it as meaningful, it will not be embedded into practice.

*"Embedding work is shaped by factors that promote or inhibit actors' apprehension of a practice as meaningful"*¹⁷⁶(p542).

Cognitive participation: is the level of participant engagement and commitment. Engagement and commitment is required by all participants involved in a practice. A practice is unlikely to become embedded if some participants involved in the practice do not become engaged.

*"Embedding work is shaped by factors that promote or inhibit actors' participation"*¹⁷⁶(p543).

Collective action: is the work done by the participants to enable the practice to happen. The work done by participants in order to enable a practice to happen is dependent upon factors such as the ease or difficulty of the practice, the comfort a participant feels in carrying out the practice, and the level of disruption the practice will cause. Complicated, uncomfortable and disruptive practices are unlikely to be embedded.

*"Embedding work is shaped by factors that promote or inhibit actors' enacting it"*¹⁷⁶(p544).

Reflexive monitoring: is the formal and informal appraisal of the utility and effectiveness of the practice. Appraisal of a practice plays an important role in the meaningfulness and coherence of a practice. Both individual and communal appraisal may lead to the reconfiguration of the practice so that a better fit can be achieved between the practice and the organisation's work¹⁹². Practices that can fit with other work practices are more likely to be embedded than those that do not.

*"Embedding work is shaped by factors that promote or inhibit appraisal"*¹⁷⁶(p545).

The four components of the NPT are depicted in Figure 17. May¹⁷⁶ stresses the figure “...is a map of the relations between the core concepts of the theory rather than an empirical map of normalization processes, and relations between the core concepts are not linear”¹⁷⁶(p542). Murray et al describe the components as being “in a dynamic relationship with each other and the broader context of the intervention, such as organisational context, structures, social norms, group processes and conventions”¹⁹²(p2). According to the theory, all four domains of NPT must be met in order for an intervention to be effectively implemented.

Image not included in this publication due to copyright restrictions

Source: May and Finch¹⁷⁶ (p541).

Figure 17. Model of the components of the Normalisation Process Theory

Table 8 sets out the four components of the NPT in summary format, always beginning with the question, ‘*What is the work?*’

Table 8. Framework for operationalising the normalisation process theory

Table not included in this publication due to copyright restrictions

Source: May and Finch¹⁷⁶ (p549).

Murray et al provide a list of questions to consider for each of the four components of the NPT when implementing and evaluating interventions, shown in Table 9. These questions formed the framework used to implement and evaluate the intervention.

Table 9. Questions to consider for the NPT components when implementing or evaluating interventions

Table not included in this publication due to copyright restrictions

Source: Murray et al¹⁹² (pp9-10).

5.4 Summary

This chapter described that the four main activities that informed the development the intervention were: 1. Engagement and involvement of the local Aboriginal and Torres Strait Islander community; 2. A review of background literature; 3. Analysis of the local Aboriginal and Torres Strait Islander community focus group interviews in relation to the literature; and 4. Analysis if the views of the Medicare Local staff interviews in relation to the effectiveness of the Closing the Gap Indigenous Health Initiative. The theories which informed the intervention were the Social Ecological Model and the Theory of Planned Behaviour. The intervention involved the researcher personally discussing the results of the Practice Feedback Report with each participant; tailored practice facilitation; helping practices promote a more welcoming environment for Aboriginal and Torres Strait Islander patients by providing Aboriginal artwork, patient information leaflets and other resources; and Aboriginal and Torres Strait Islander Cultural Awareness Training. Hogg's Conceptual Framework for Primary Care was used when describing the organisational context of each practice to determine factors which may influence performance at the practice level. The Normalisation Process Theory informed the implementation of the intervention and was used to evaluate the feasibility and implementation of the intervention.

Chapter 6

Case study results and analysis

This chapter provides an analysis of the results found in the case studies in this research. A summary case analysis for each of the seven practices is provided, followed by a cross case analysis. The chapter concludes with a summary of the findings.

6.1 Practice 101

6.1.1 Context

Practice 101 was situated within a small local shopping complex in a suburban area of Sydney. The practice was comprised of two consulting rooms and an additional room for basic pathology collection, which was manned part-time by an external pathology company. There was no back-office area or staff area.

Organisation of the practice: Practice 101 was owned by non-medical based corporation which had several practices. The practice was a non-accredited practice and all patients were bulk-billed. Two full time GPs and seven part-time reception staff were employed; there was no nurse employed. Some staff were also rotated in the other practices owned by the corporation. Demographics of participating staff members have been provided in Table 3 (p70).

Practice 101 priorities were set by the Practice Manager who was in charge of several practices and was seldom present. Quality improvement was not a priority area for the Practice Manager and he was resistant to change. There were no general staff or clinical staff meetings. When changes needed to be made, the usual process was for the Practice Manager to telephone and leave a directive with the receptionist on duty, who would then leave a note for the rest of the reception staff. Staff did what they were told and did not have input into any decisions regarding the practice. This lack of decision latitude appeared to have resulted in a low level of staff morale and there was no feeling of a team environment to the observer. The Practice Manager agreed for the practice to take part in the study because a GP had expressed interest and said that it would result in an increase in patient numbers. The Practice Manager did not see Aboriginal and Torres Strait Islander health as a priority and was adamant that there were no Aboriginal and Torres Strait Islander patients at the practice and would not enrol in the study himself. There was a general apprehension amongst the staff regarding whether or not the Practice Manager would know their individual responses. The Practice Manager did not interfere with the GPs; they were hired to see patients and make money for the practice.

One GP left this practice during the baseline data collection and moved to another practice (Practice 104) and the data for this GP have not been used in

this case's analysis. As the study progressed, there were a number of changes to the reception staff. Two female receptionists left and the remaining female receptionists had their allocated shifts reduced, with their shifts being given to the one male receptionist. This resulted in further workplace dissatisfaction amongst many of the female staff. After baseline data collection and once the practice facilitation (intervention) commenced, the Practice Manager refused to allow his staff to take part in the intervention. He stated that he felt that there were no Aboriginal patients at the practice and his staff did not need any training because as far as he was concerned they weren't doing anything wrong and he was happy with what they were doing. He said that the GPs were free to undertake any training they desired as he only supervised the reception staff. As a result, all the reception staff in the practice were excluded from the study. By this time, one receptionist had already received Aboriginal and Torres Strait Islander Cultural Awareness Training, as well as receiving some training as part of the intervention and the researcher had explained the results of the baseline Practice Feedback Report to her.

6.1.2 Identification of patient's Indigenous status

All new patients were asked to fill out a patient registration form at reception, asking their name, date of birth, contact details, Medicare details and Indigenous status; the latter question asked, "Are you an Aboriginal or Torres Strait Islander? Y/N." The question was not asked according to Best Practice Guidelines but the GP had no control over change in this area and so could not ask to have it corrected. The Indigenous status of all patients in the practice from the clinical records audit is shown in Table 10.

Table 10. Indigenous status of patients ≥18 years (Practice 101)

Indigenous status	Baseline (%)	Follow-up (%)
Aboriginal	0	0.08
Torres Strait Islander	0	0
Both Aboriginal and Torres Strait Islander	0	0.04
Neither	41	38.9
Refused / Inadequately stated	59	60.9
Unidentified	0	0.08

When asked why the 'Refused/Inadequately stated' percentage was so high, the researcher was informed that since the time the Indigenous status question had been introduced in the practice, all existing patients had automatically been assigned this code and any new patients who did not mark that they were Aboriginal and/or Torres Strait Islander on the Patient Registration Form were coded as 'Inadequately stated.'

At baseline, reception staff did not verbally ask patients their Indigenous status and relied solely on the registration form. There was little consensus amongst staff in regards to how new and existing patients were identified. The GP was not aware how new or existing patients were identified and some reception staff assumed that the GP also checked. At follow-up the GPs awareness as to how patients were asked their Indigenous status had increased and he was also aware that the only receptionist who prompted patients to complete the Indigenous status question on the registration form if this had not been completed by the patient was the one receptionist that received some training as part of the intervention prior to them being excluded from the study.

At baseline the USP was not asked her Indigenous status and the receptionist incorrectly recorded the USP's Indigenous status on the medical record as non-Indigenous based on the USP's physical appearance (Table 11). At follow-up the receptionist that was on duty was the receptionist that had received some training as part of the study prior to being excluded. This receptionist asked the USP to return to the reception desk and discreetly pointed out that she had not answered the question. When the USP asked why she was being asked the question, the receptionist answered, "*Because Aboriginal people can get different services under Medicare and cheaper medication*". The USP identified as being Aboriginal and her Indigenous status was correctly recorded in the medical record.

Table 11. How the USPs Indigenous status was identified and recorded (Practice 101)

	Baseline	Follow-up
USP asked Indigenous status	Yes	Yes
Yes - asked on registration form	Yes	Yes
Yes - asked by reception	No	Yes
Yes - asked by GP	No	No
Indigenous status question asked according to Best Practice Guidelines	No	No
USP Indigenous status correctly recorded in medical record	No	Yes

At baseline, there was little awareness amongst the staff regarding barriers or enablers to the identification of Indigenous status, with many answering, “*Don’t know.*” One receptionist was concerned that she would offend patients if she asked them if they were of Aboriginal or Torres Strait Islander descent, another felt that patients may be reluctant to identify. The GP replied, “*What’s the problem with identification, you just look at them and then you know if they’re Aboriginal?*”, GP 101102. At follow-up the GP was aware that staff confidence, practice routines and the practice environment as a whole were some of the factors that played a role in Indigenous status identification, and had gained an awareness that patients could not be identified on physical appearance.

At baseline the GP and one receptionist did not know that the patient’s Indigenous status was recorded in the patient medical record; at follow-up the GPs knowledge had improved and he was aware that Indigenous status was recorded in the medical record. The other staff were excluded from the study and their knowledge at follow-up was not assessed.

6.1.3 Assumption of literacy

The practice staff assumed all patients were literate and did not ask patients if they needed help with any forms or paperwork.

6.1.4 Practice environment

The practice was modest and unremarkable. The waiting room area allowed for nine patients to be seated in an L-shape along one wall and a shop-front style

window. There was a 'personal space' gap between each chair. There was enough space between the reception desk and the waiting area to afford patient's some privacy when at reception. However, not all reception staff asked patients to come to the reception desk when addressing them and openly discussed their information across the waiting room whilst other patients were present. Some gossip/entertainment magazines were available for patients to read and there was a television which appeared to be turned on whenever the practice was open. It was loud enough to give patients privacy when speaking to reception staff, although at times when certain members of reception staff were on duty, the television could be quite loud resulting in patients and reception staff competing with the television to be heard. At these times, all patients in the waiting room could hear what was being discussed at reception.

The walls were bare except for two small paintings and a sign regarding pick up of x-rays. There were a few posters displayed under the reception counter. Reception staff were not allowed to put up posters or information without first running it past the Practice Manager and some staff expressed that the Practice Manager did not take note of anything the staff said so they were therefore very reluctant to ask. The consultation rooms were similarly modest, comprising a GP desk, two chairs for patients to sit on, an examination table and cupboards. The GPs had more decision-latitude regarding what was displayed within their consulting rooms.

At baseline, the posters displayed under the reception counter were all general health posters and none either mentioned or depicted Aboriginal and Torres Strait Islander peoples or encouraged self-identification of Indigenous status. No other patient health information was available. The practice did not engage in any activities to be more welcoming to the Aboriginal or Torres Strait Islander community. At follow-up, a 'Welcome' poster was displayed under the reception desk (it had been placed there by a staff member without asking the permission of the Practice Manager), and the GP had the 'Are you Aboriginal' sign in his office.

6.1.5 Culturally appropriate and targeted care

At baseline, no staff had undertaken any cultural awareness training, although one receptionist reported receiving some awareness as part of her University degree some years earlier. At follow-up, the GP had received cultural awareness training as part of the study and one receptionist had received training before she and the remaining reception staff were excluded from the study.

At baseline, the GP had no knowledge on Aboriginal and Torres Strait Islander Australia and asked where the Torres Strait Islands were and why Torres Strait Islanders were part of the study; he thought the Torres Strait Islands and the Pacific Islands were one and the same. After having the location of the Torres Strait Islands explained to him, the GP asked why Torres Strait Islanders were relevant to the study because the Torres Strait Islands were not on mainland Australia. Once the GP learned that Torres Strait Islanders were one of the Indigenous populations of Australia and that Torres Strait Islanders could be found all over Australia, and that both Aboriginal and Torres Strait Islander peoples were present in the local community, he concluded, *“Well I guess I am a good person for this study because I don’t know anything about this, these people”*, GP 101102.

The staff were not aware of the practice having any engagement with the local Aboriginal Community, Aboriginal Medical Service (AMS) or Aboriginal Community Controlled Health Service (ACCHS). At baseline several staff members replied that they believed culturally appropriate care meant treating everyone equally. At follow-up, the GP was more aware that in order to provide targeted care to Aboriginal and Torres Strait Islander patients, he needed to know their Indigenous status, and that visual symbols of welcome and staff attitudes played important roles in creating welcoming practice environments.

The GP and staff were not aware of any Indigenous-specific MBS services available to Aboriginal and Torres Strait Islander patients, hence no Aboriginal and Torres Strait Islander or other health assessments were performed (Table 12).

Table 12. Consultations and Health Assessments for Aboriginal and Torres Strait Islander patients (past 2 years) (Practice 101)

	Baseline	Follow-up
Aboriginal and Torres Strait Islander Patients	0	3
No of consultations past 2 years	0	7
Aboriginal and Torres Strait Islander Health Check Assessments: (MBS Item 715)	0	0
Other Health Check Assessments: (MBS item numbers 703, 705, 707, 10986, 10987, 81300)	0	0

The practice was not accredited practice and was therefore not eligible to register for the IHIP, hence no patients were enrolled to the IHIP or the Indigenous PBS Co-payment Measure.

6.1.6 Assessment by the USP

The USP had two visits to this practice at baseline, one for the participating GP and one for the GP that moved to Practice 104. Although the USPs encounter with the latter GP will not be discussed here, her experience with reception will be. The USP reported that the level of service provided by the reception staff was variable. At baseline, the USP reported that when she telephoned to make an appointment she found the receptionist polite and helpful on both occasions. On her first visit, the USP found the receptionist on duty to be very rude and dismissive. This particular receptionist embarrassed and humiliated her by asking her personal and confidential information from where she was seated in the waiting room whilst other patients were present. The USP reported that the waiting room environment was very unwelcoming on this occasion, and that other patients also shared her discomfort. She stated that she would not return to the practice again if given the choice because of this encounter.

On her next baseline visit, the USP reported that the waiting room had a more welcoming air because a different receptionist was manning the desk and there was chatting amongst the patients which made her feel more comfortable. The USP stated she would have been more comfortable as a new patient entering the practice, at reception and in the waiting room if she would have seen a visual symbol of welcome or any health-related pamphlets or other information for Aboriginal patients.

At follow-up, the USP reported that when she telephoned to make the appointment the receptionist was abrupt, rude and arrogant, and that he just hung up on her after the appointment was made without saying goodbye or anything else to indicate that the discussion was closed. The USP reported she wasn't sure if the appointment had even been made and sought confirmation from the researcher if it had been made. The USP reported that when she first entered the practice to attend her appointment, the receptionist seemed to be "*in her own world*". The USP reported that the receptionist was very nice, and explained why she needed to fill in the Indigenous status question, and that she was friendly. The USP reported that she was comfortable in the waiting room because she saw the 'Welcome' poster which put her at ease and made her feel welcome in the practice.

At baseline the USP spent 25 minutes waiting for her appointment and four minutes with the GP; at follow-up she spent 10 minutes waiting and 30 minutes with the GP. There was little change in the content of the consultation and no referrals to dieticians or lifestyle change services were made at either time point. The USP felt that the GP explained things well and stated that she would return to the practice again if given the choice because she had had a positive encounter with both reception and the GP.

The GP and staff stated that they did not suspect that the USP was the study patient at either time point.

6.1.7 Evaluation of the implementation of the intervention

Despite the considerable restraints imposed by the Practice Manager, the GP and the receptionist that had received training as part of the intervention demonstrated positive responses across all four domains of the NPT. In terms of coherence, the GP understood that the practice needed to change its Indigenous status identification systems and the physical environment needed to be made more welcoming to Aboriginal and Torres Strait Islander patients, and that he and the staff needed to increase their awareness in regards to providing appropriately targeted healthcare to Aboriginal and Torres Strait Islander patients. In terms of cognitive participation, both the receptionist and GP felt that the intervention was a good way of learning about how to provide the best possible care to any

Aboriginal and Torres Strait Islander patients that may become patients of the practice and they were willing to learn of ways to do this and committed to improving the quality of service they offered. Both the receptionist and the GP demonstrated collective action as they made conscious efforts to remember to ask patients their Indigenous status, despite being the only people in the practice to do so, and even though the Practice Manager did not allow her training to finish, the receptionist correctly identified the USPs Indigenous status at the follow-up visit by prompting the USP to complete the Indigenous status question on the Patient Registration Form. In terms of reflexive monitoring, the GP saw the positive impact the intervention had had on both himself and the receptionist and how this would in turn benefit Aboriginal and Torres Strait Islander patients. However, as only two people in the practice participated, the four domains of NPT were not met at the practice level which limited the impact of the intervention. The full analysis of the implementation of the intervention using the NTP framework is provided in Appendix 9.

6.2 Practice 102

6.2.1 Context

Practice 102 was situated in a suburban street in Sydney. The practice was comprised of two consulting rooms, a nurse's room, a treatment room, a back-office area and a staff area.

Organisation of the practice: Practice 102 was one of two medical practices owned by the Practice Principal. The practice was an accredited practice and a private billing practice but some patients were bulk-billed at the discretion of the GPs. The Practice Principal was employed full time over both his practices. Five part time GPs worked across both sites and there was a full time Practice Manager who managed both premises. One full time nurse was employed as well as nine part-time reception staff, most of who were also rotated in the other practice.

The Practice Manager was quite involved in the day-to-day running of the practice, and although she would not join the research study herself, she was very helpful facilitating the medical records audits. The Practice Principal did not see Aboriginal and Torres Strait Islander health as a priority and the general consensus amongst staff and GPs was that the practice did not have any Aboriginal and Torres Strait Islander patients. None of the staff except one part-time GP were keen to learn of ways to improve their level of knowledge and service delivery to Aboriginal and Torres Strait Islander patients and would not sign on to the study. The GPs motivation for participating in the study was that she was interested in doing some volunteer work in a rural Aboriginal Medical Service. Demographics of the participating GP have been provided in Table 3 (p70).

The practice priorities were set by the Principal and the Practice Manager. Clinical staff meetings were held once a quarter, as were staff meetings. If there was a major change or something important came up beforehand a meeting could be pulled forward. Information at other times was transferred to the staff in writing from the Practice Manager, usually via email, and the Practice Manager would at times follow up verbally with individual staff afterwards if they have not undertaken or understood the instructions. Change was accepted within the

practice but was generally viewed as being more work for both the Practice Manager and staff. During recruitment, the staff were very apprehensive as to whether or not the Practice Manager and Practice Principal would know their individual responses. When reassured that all interview and survey responses would remain confidential, one receptionist laughed and said, "Yeah right". Some reception staff perceived the study as a method to monitor them over the year. There appeared to be an overall high level of stress amongst reception staff in regards to their work loads and at various times several staff members openly expressed their dissatisfaction with the lack of staff input into decision-making. At times, the practice was very busy and staff were under a lot of pressure and there was also a certain level of dissatisfaction amongst some of the staff members in regards to remuneration rates versus workload. The lack of decision latitude combined with heavy workloads appeared to have resulted in a low level of staff morale and there was no feeling of a team environment to the observer.

6.2.2 Identification of patient's Indigenous status

The practice had some well-established Indigenous status identification systems in place which were driven by Practice Accreditation. All new patients were given a New Patient Information Pack which contained various information about the practice in it. They were also asked to fill out a New Patient Registration Form which asked their name, date of birth, contact details, Medicare details, medical history, social history (smoking, alcohol and drug use), family history and Indigenous status; the latter question asked, "To assist with health initiatives - *Are you of Aboriginal or Torres Strait Islander (TSI) origin? Aboriginal Yes / No, Torres Strait Islander Yes / No*". Although the researcher informed the Practice Manager that the Best Practice Guidelines recommended a 'both Aboriginal and Torres Strait Islander' option, the form was not updated by the time the follow-up data was collected. The Indigenous status of all patients in the practice from the clinical records audit is shown in Table 13.

The practice was also effectively working through identifying the Indigenous status of existing patients: patients were given a form which started by explaining that the question was being asked in order to plan and provide the best possible health services. The form stated that answering the questions were optional and asked, "*Are you of Aboriginal or Torres Strait Islander (TSI) origin?*" Tick boxes

were then provided for, "Aboriginal, Torres Strait Islander, both Aboriginal and Torres Strait Islander, neither (Aboriginal or TSI), [and] other (please specify)". This form asked the Indigenous status question according to Best Practice Guidelines. At baseline, the GP believed that all new and existing patients were asked the Indigenous status question on a registration form, but not verbally by reception, the GP or nurse. At follow-up, the GP stated that reception staff verbally asked all patients as well.

Table 13. Indigenous status of patients ≥18 years (Practice 102)

Indigenous status	Baseline (%)	Follow-up (%)
Aboriginal	0	0.1
Torres Strait Islander	0	0
Both Aboriginal and Torres Strait Islander	0	0
Neither	14	56.3
Refused / Inadequately stated	0	0.1
Unidentified	86	43.5

At both the baseline and follow-up visits, the receptionists on duty discreetly pointed out to the USP that she had not completed the Indigenous status question. At baseline the receptionist offered an explanation to the USP according to Best Practice Guidelines; at follow-up the receptionist pointed to the 'Are you Aboriginal' sign on the wall by way of explanation, stating that it would really help them (the practice) if the patient answered the question. The USPs Indigenous status was correctly recorded on the medical record as Aboriginal at both time points (Table 14).

Table 14. How the USPs Indigenous status was identified and recorded (Practice 102)

	Baseline	Follow-up
USP asked Indigenous status	Yes	Yes
Yes - asked on registration form	Yes	Yes
Yes - asked by reception	Yes	Yes
Yes - asked by GP	No	No
Indigenous status question asked according to Best Practice Guidelines	Yes*	Yes*
USP Indigenous status correctly recorded in medical record	Yes	Yes

* New Patient Registration form did not ask the Indigenous status according to Best Practice Guidelines, form for existing patients did.

At baseline, the GP felt some that barriers to Indigenous status identification were not having it as part of the usual routine in general practice and that one could not rely on appearances and felt that self-identification was an enabler. At follow-up, the GP felt that the barriers to Indigenous status identification included reception staff not asking patients their Indigenous status and patients being reluctant to disclose their Indigenous status. The GP felt that GP personality was an important enabler to Indigenous status identification. The GP relied solely on the reception staff to identify patient's Indigenous status, so it is unclear to the researcher how the GP's personality could be perceived as an enabler to identification. The GP was confident that the patient's Indigenous status was recorded in the patient medical record.

6.2.3 Assumption of literacy

The practice staff assumed all patients were literate and did not ask patients if they needed help with any forms or paperwork.

6.2.4 Practice environment

The waiting room area for Practice 102 was very small, with room for ten patients to be seated. Chairs were lined around two walls and a shop-front style window in a u-shape, with about one meter in between opposite facing chairs. Chairs on one side of the room abutted the reception desk. There was no gap allowing for personal space between each chair, and the chairs abutted each other. There were two small paintings on one wall and a quit smoking poster and another poster regarding heart health on a side wall. Near the reception desk there was a large pamphlet rack which contained health information pamphlets. Some gossip/entertainment magazines were available for patients to read and there was a television on the wall behind reception which appeared to be turned on whenever the practice was open. Due to the size of the waiting room, the television did not afford patient's privacy when speaking to reception staff. Regardless, some reception staff made no attempt to lower the volume of their voice when speaking to patients and actually spoke quite loudly for such a small area. There was also another television monitor behind the reception desk which had no sound and was devoted to displaying information regarding the practice.

The researcher observed some reception staff notably ignoring patients standing in front of them at the reception desk for several consecutive minutes. The researcher also observed some reception staff members speaking to patients whilst never once turning their heads to face to patients. The reception staff could be quite busy at times and were often visibly stressed by this.

The consultation rooms were small but functional, comprising a GP desk, two chairs for patients to sit on and an examination table. The Principal GP had his own room which appeared neat and orderly; the part-time GPs shared the other consulting room, and the desk in this room was crowded and appeared dishevelled.

At baseline, the practice did not engage in any activities to be more welcoming to the Aboriginal or Torres Strait Islander community and there were no posters, signs, pamphlets or other information that either mentioned or depicted Aboriginal and Torres Strait Islander peoples or encouraged self-identification of Indigenous status. Although the GP was aware that visual symbols of welcome were important factors for improving the physical environment of a practice for Aboriginal and Torres Strait Islander patients, she felt it was not as important as the attitude of the staff. *"So um I know, I've read some recent things I was, I was reading um yeah one of these cultural training was, you know Aboriginal paintings and things like that but I, I think it's more the attitude when a patient gets there you know how they're treated you know things like that..."* GP 102101. At follow-up, some pamphlets regarding self-identification of Indigenous status were in the pamphlet rack, and the 'Are you Aboriginal' sign was displayed behind the reception desk.

6.2.5 Culturally appropriate and targeted care

When recruited in to the study the GP had not previously undertaken any Aboriginal and Torres Strait Islander Cultural Awareness Training, and no other staff within the practice had received any training either. Many staff appeared to be unaware of the effect that their manner had in creating a welcoming environment for patients, nor of the importance of this. After the baseline USP assessment but before the interview and the self-complete mail questionnaire, the GP enrolled in a volunteer position in a rural Aboriginal Medical Service

(AMS) and stated that she had started the online cultural awareness training course offered by the Royal Australian College of General Practitioners (RACGP). The GP's motivation for taking part in this research study was because she was considering doing some remote volunteer work. Very shortly after the initial recruitment visit, the GP stated, *"You know your visit inspired me. After I spoke to you, it got me moving. I got in touch with the Division...and I will be volunteering now. I think this sort of thing will be good for me to do"*, GP 102101. Although she felt she had no knowledge on the provision of culturally appropriate care, the GP felt she had the right attitude and was willing to learn: *"Oh I'm just I'm open minded...I'm very pleased with myself that you know I, I take people as [I] find them, all groups you know and um it doesn't matter what background so I don't think I've got a problem with that... I think I've definitely got the right attitude to develop the understanding and work on the skills"*, GP 102101. Although the GP volunteered at a rural AMS, her involvement was at the individual level only and the practice did not have any engagement with the local Aboriginal Community, AMS or ACCHS.

Prior to taking on the volunteer position at the AMS, the GP had very little knowledge on the provision of culturally appropriate care to Aboriginal and Torres Strait Islander patients, stating that fairness was treating all patients the same: *"Well it's not like we're going to roll out the red carpet for them is it? I mean I treat them the same as I treat every other patient"*, GP 102101. She felt the main barriers to the provision of culturally appropriate care to Aboriginal and Torres Strait Islander patients was a lack of awareness within general practice and felt that the best training was to be directly exposed to Aboriginal and Torres Strait Islander patients.

When initially recruited into the study, the GP was not aware of the Indigenous-specific MBS item numbers available to Aboriginal and Torres Strait Islander patients. After one two-day visit at rural AMS the GP was aware and felt that they were a *"very good idea if it promotes regular health checks"* and *"I just think it's wonderful that you can regularly screen Aboriginals yearly to second yearly"*, GP 102101. Table 15 shows that at no Aboriginal and Torres Strait Islander or other health checks had been performed on any Aboriginal and Torres Strait Islander-identified patients.

Table 15. Consultations and Health Assessments for Aboriginal and Torres Strait Islander patients (past 2 years) (Practice 102)

	Baseline	Follow-up
Aboriginal and Torres Strait Islander Patients	0	4
No of consultations past 2 years	0	38
Aboriginal and Torres Strait Islander Health Check Assessments: (MBS Item 715)	0	0
Other Health Check Assessments: (MBS item numbers 703, 705, 707, 10986, 10987, 81300)	0	0

In regards to the Indigenous PBS Co-payment Measure, the GP stated, *"I think there's still going to be um barriers to taking regular medication for a lot of patients and you, you don't want money to be one of them."* She felt that the Measure was, *"Excellent if it encourages compliance. I feel that CtG should be available to all practitioners not just those registered by Indigenous PIP!"*, GP 102101.

The practice was an accredited practice and was eligible to register for the IHIP, however, the Practice Principal apparently would not register. As a result, no patients were registered to the Indigenous PBS Co-payment Measure or the IHIP.

6.2.6 Assessment by the USP

The USP reported that the level of service provided by the reception staff was variable. When telephoning to make an appointment at baseline, the USP reported that the first time she called the receptionist *"...barked 'Surgery' to answer the phone. It was like, 'What was that!?' I had to call back. A few minutes later she answered again, 'Surgery, can I help you?' It was better, but not much. But she was okay when trying to fit me in for an appointment."*

During her visit at baseline, the USP found the receptionist on duty to be very pleasant. She reported that the receptionist made eye contact with her when talking to her and that *"...the receptionist was talking and laughing with the other patients, so it made me feel at ease."* Although the USP felt a little uncomfortable when first entering the surgery because it was as she described, *"crampy,"* she was quickly put at ease by the pleasant environment created by the receptionist.

The USP spent six minutes waiting for the GP and 40 minutes in the consultation. Smoking, blood pressure and physical activity were assessed, but nutrition, alcohol intake, weight and waist circumference were not and no referrals to dieticians or lifestyle change services were made. The USP stated that she was moderately comfortable with the GP and felt that the GP was concerned for her. She reported that the GP explained things to her so that she could understand them and wrote down the instructions for her so that she would not forget them (although the GP did assume that she was literate). The USP stated she would return to the practice again if the same GP was present. The GP stated that she suspected that the USP was the study patient, not because of what the USP did, but because she had been identified as an Aboriginal patient and it was very rare for the GP to get new Aboriginal patients.

At follow-up, the USP reported that when she rang to make her appointment she was put on to a recorded voice telling her that she was on hold. The USP reported that after about six minutes the receptionist answered and rushed, "*Can I put you on hold?*" and put her back on hold again without waiting for an answer. The USP reported that she was then on hold again for about another six minutes and that when she was taken off hold, the receptionist was still speaking to someone else. The USP said, "*It made me feel like I was not the priority.*"

When she arrived for her appointment, the USP reported that the receptionist acknowledged her when she walked in and that she saw the 'Are you Aboriginal' sign on the wall behind the receptionist which made her feel like she was welcome. The USP reported that the receptionist was helpful and very nice in general and that she was very comfortable in the waiting room as a result.

The USP waited 30 minutes for her appointment and spent 25 minutes in the consultation. A medical student was with the GP for this consultation. Smoking, nutrition, alcohol intake, physical activity and weight were assessed and a referral to a dietician was made. The USP reported that she felt that the GP explained things well, that the GP was not judgemental, and made her feel welcome and comfortable and feel important as a patient because she seemed to have time for her. The GP stated that she did not suspect that the USP was the study patient and claimed that she was unaware that she would be receiving a second visit from a patient.

The USPs were correctly identified as Aboriginal at both time-points and although a private billing practice, the GP elected to bulk-bill the patient (the bulk-billing was cancelled once the researcher informed the practice that the USP was the study patient and the University was billed for the consultation).

6.2.7 Evaluation of the implementation of the intervention

None of the staff except one part-time GP would enrol in the study. The practice had some well-established Indigenous status identification systems in place, and because she believed that the receptionists were effectively checking patients' Indigenous status, the participating GP would not check this information herself. The GP developed the impression throughout the study that the main aim of the study was to enhance her cultural awareness knowledge, yet she would not take part in the Aboriginal and Torres Strait Islander Cultural Awareness Training offered in the study. The GP was impatient for most visits and usually enquired how long each session would take and tried to cut the sessions short. Although the USP was initially bulk-billed for a health assessment at follow-up, it is the opinion of the researcher that this was performed because the GP had a medical student with her at the time and the opportunity presented for the GP to demonstrate one. In addition, the consultation lasted 25 minutes and Aboriginal and Torres Strait Islander Health Assessments take much longer.

The GP did not transfer the information from the intervention to the other staff in the practice. As a result the NPT domains of Coherence, Cognitive Participation, Collective Action and Reflexive Monitoring were not met and the implementation of the intervention was not effective at the practice level. The full analysis of the implementation of the intervention using the NTP framework is provided in Appendix 10.

6.3 Practice 103

6.3.1 Context

Practice 103 was situated across the road from a major suburban shopping complex in Sydney. The practice was comprised of four consulting rooms, a back-office area and a staff area. There was an additional area for basic pathology collection that was accessed externally from the practice and was manned by an external pathology company.

Organisation of the practice: Practice 103 was a practitioner-owned medical practice. The practice was an accredited practice and a private billing practice and no patients were bulk-billed. There were three full-time and two part-time GPs employed, with two full-time and two part-time reception staff. There was no Practice Manager or nurse employed. Demographics of participating staff members have been provided in Table 3 (p70).

The practice priorities were set by the Practice Principals. They viewed quality improvement as a priority area and were open and adaptable to change, as were the GPs and staff. There were no regular staff or clinical meetings, however, if something important needed to be discussed or there was going to be a large change, a combined meeting was scheduled and all staff including clinical staff, were asked to attend. Information at other times was communicated verbally amongst the team. Both reception staff and GPs were comfortable raising any matter with the Practice Principals and to have input into decisions regarding the practice. As a result, they appeared content and relaxed in their workplace and there appeared to be good team collaboration. The participating GP and reception staff were all keen to sign up for the study, but all stated that they felt they didn't have any Aboriginal patients. The Practice Principals also felt that they did not have any Aboriginal or Torres Strait Islander patients but were supportive of the staff signing up for the study even though they themselves did not wish to.

6.3.2 Identification of patient's Indigenous status

Although a New Patient Registration Form existed, only some reception staff asked new patients to fill out the form, whilst other reception staff entered patient information immediately into the practice software. At baseline, the New Patient

Registration Form asked patients their name, date of birth, contact details, Medicare details, and Indigenous status; the latter question asked, "Aboriginal or Torres Strait Islander? Y or N." The question was not asked according to Best Practice Guidelines. When this was highlighted to the Practice Principals, they said that the form would no longer be used and the reception staff were trained to ask the question verbally according to Best Practice Guidelines. The Indigenous status of all patients in the practice from the clinical records audit is shown in Table 16.

Table 16. Indigenous status of patients ≥ 18 years (Practice 103)

Indigenous status	Baseline (%)	Follow-up (%)
Aboriginal	0	0.1
Torres Strait Islander	0	0
Both Aboriginal and Torres Strait Islander	0	0
Neither	0	3.2
Refused / Inadequately stated	-	-
Unidentified	100	96.8

At baseline, reception staff did not verbally ask patients their Indigenous status and relied solely on the registration form; reception staff who did not give patients a registration form, did not ask patients their Indigenous status. This improved at follow-up, with reception staff working towards routinely asking new patients their Indigenous status. At baseline there was no consensus amongst staff in regards to how new and existing patients were identified: the GP was not aware how new or existing patients were identified; some reception staff members assumed that the GPs also checked, and some reception staff members were not aware how existing patients were identified. At follow-up all staff agreed that GPs asked all new patients their Indigenous status; some receptionists also checked at registration whilst others relied on patients to self-identify their Indigenous status because they felt that the new 'Are you Aboriginal' sign which had been placed up at reception was sufficient. There was much less agreement about how the Indigenous status of existing patients was identified, with the GP and staff each assuming that the other was attending to the task, demonstrating that they all relied on existing patients to self-identify.

The USP was not asked to fill in a patient registration form when she presented, and was asked her details by the receptionist who then entered the details

directly into the practice software. The USP was not asked her Indigenous status at registration, by reception or by the GP at either baseline or follow-up (Table 17), and the Indigenous status was not recorded on the medical record.

Table 17. How the USPs Indigenous status was identified and recorded (Practice 103)

	Baseline	Follow-up
USP asked Indigenous status	No	No
Yes - asked on registration form	-	-
Yes - asked by reception	-	-
Yes - asked by GP	-	-
Indigenous status question asked according to Best Practice Guidelines	No	No
USP Indigenous status correctly recorded in medical record	No	No

At baseline, the GP and reception staff were not aware of any barriers or enablers to Indigenous status identification. The GP was unsure as to whether or not Indigenous status was required and felt that patient safety may be an issue for some patients. At follow-up the GP and the staff were much more aware of the barriers and enablers to Indigenous status identification, mentioning a number of issues ranging from patients' knowledge on why they are being asked the question, staff being comfortable asking the question, incorporating asking the question into normal practice routines and providing welcoming practice environments.

At baseline the GP was not aware if the patient's Indigenous status was recorded in the patient medical record, and there was a mixed level of knowledge amongst the reception staff. At follow-up they were all aware that the patients' Indigenous status was recorded on the medical record.

6.3.3 Assumption of literacy

The GP and practice staff informed the researcher that they assumed all patients were literate and did ask patients if they needed help with any forms or paperwork.

6.3.4 Practice environment

Practice 103 was modern and fashionably decorated. The waiting room area was very large, with room for 24 patients to be seated. Chairs were lined around two walls and shop-front style window and there was a 'personal space' gap between each chair. There was an additional separate area that had a couch for patients to sit on and this area also had a play area for children. There was ample room (several meters) between the patient seating area and the reception desk. The reception desk was placed roughly half way along the waiting room. The front of the reception counter was high and the reception staff could not be seen unless one was standing in front of them at the desk.

The walls were bare except for three small paintings and a poster for after-hours care. Behind reception there were a number of signs displayed regarding the billing rates, practice hours and other particulars of the practice and a small sign asking patients to inform reception immediately if they were experiencing chest pain. There was a large sign displayed under the reception counter stating that longer appointments were available and to let reception know at the time of booking if one was required. There was a television in the area where the couch was that appeared to be turned on whenever the practice was open. It was loud enough to be heard by all patients in the waiting room but the volume was not designed to give patients privacy when speaking to reception staff as this was not necessary due to the large size of the waiting room and the distance between the reception desk and the seating area. Some gossip/entertainment magazines were available for patients to read and there was a large pamphlet rack which contained health information pamphlets in the area where the couch was. The consultation rooms were neat and tidy and comprised a GP desk, two chairs for patients to sit on, an examination table and cupboards, and some paintings on the walls.

At baseline the practice did not display any visual symbol of welcome such as the Aboriginal or Torres Strait Islander flag, and there were no posters or brochures encouraging self-identification of Indigenous status. The reception staff felt that the physical environment of the practice looked comfortable and was welcoming to all patients. The GP said, "*I wouldn't know what I need to do any differently*", GP 103101. The practice was quite willing to improve its physical environment to Aboriginal and Torres Strait Islander patients, and at follow-up displayed the

'Welcome' poster in the waiting room, an 'Acknowledgement to Country' behind the reception desk, and placed 'Are you Aboriginal' signs at the reception desk and prominently in each consulting room so that they were in the patient's direct line of site.

6.3.5 Culturally appropriate and targeted care

At baseline, no GPs or staff had undertaken any cultural awareness training within in the past 12 months or anytime previously; all participants chose to receive cultural awareness training as part of the intervention. The GP's motivation for taking part in the study was because Aboriginal and Torres Strait Islander health was an interest of hers as she had done some work overseas in a third world country during her medical training. Although she felt she had no specific training on the provision of culturally appropriate care, the GP felt she had the right attitude and was willing to learn: *"We don't have any Aboriginal patients here...I mean it's a family practice and so they don't really come here for their sort of problems....so I don't know if this study is relevant to me...but I think it would be good to know if I am being culturally appropriate to all my patients"*, GP 103101. The GP seemed unaware that she stereotyped the health issues experienced by Aboriginal and Torres Strait Islander peoples, and although she was confident that there were no Aboriginal and Torres Strait Islander patients at the practice, she wanted to ensure that she was prepared in case she did get any in the future: *"I don't think we have any Aboriginal patients, but it is good to know what to do just in case I get some"*, GP 103101.

The reception staff elected to enrol in the study because they wanted to learn about providing the best possible care to Aboriginal and Torres Strait Islander patients. The practice did not have any engagement with the local Aboriginal Community, AMS or ACCHS. The lack of cultural awareness training and engagement with Aboriginal organisations was reflected in the low level of awareness amongst staff at baseline regarding the provision of culturally appropriate care to Aboriginal and Torres Strait Islander patients. The GP and reception staff believed culturally appropriate care meant treating everyone equally: *"I mean I still just see them as any other human being and trying to be sensitive to their needs, but I would probably still treat them the same"*, GP 103101. At follow-up, there was a greater understanding that the provision of

appropriate care was not treating all patients the same, but treating them according to their needs.

At baseline, one receptionist was aware that there were Indigenous-specific MBS services available to Aboriginal and Torres Strait Islander patients; the GP and other receptionists had no knowledge of these or of the Indigenous PBS Co-payment Measure. At follow-up all staff were aware that the Indigenous-specific MBS item numbers existed and they all felt that the Indigenous PBS Co-payment Measure helped reduce the cost barrier for medicines. The GP expressed frustration that the Indigenous PBS Co-payment measure was tied to the Indigenous health PIP: *"I don't really know where the governments coming from with that really, I think if they're entitled, I think if, if they're considered a group of people that are entitled to cheaper scripts, I just think they should get it"*, GP 103301.

Table 18 shows that at no Aboriginal and Torres Strait Islander or other health assessments had been performed on any Aboriginal and Torres Strait Islander-identified patients.

Table 18. Consultations and Health Assessments for Aboriginal and Torres Strait Islander patients (past 2 years) (Practice 103)

	Baseline	Follow-up
Aboriginal and Torres Strait Islander Patients	0	3
No of consultations past 2 years	0	12
Aboriginal and Torres Strait Islander Health Check Assessments: (MBS Item 715)	0	0
Other Health Check Assessments: (MBS item numbers 703, 705, 707, 10986, 10987, 81300)	0	0

The practice was an accredited practice and was eligible to register for the IHIPIP, however, according to the participating GP, the Practice Principals would not register for the program. This resulted in no patients being enrolled to the IHIPIP or the Indigenous PBS Co-payment Measure.

6.3.6 Assessment by the USP

At both time points the USPs reported that the level of service provided by the reception staff was invariably polite and friendly. At baseline when the USP turned up for her appointment, she was initially a little disconcerted when she first walked in because the reception desk was so far from the door and she could not see the receptionists behind the high counter. The USP reported the receptionists appeared very shy and quiet but were very nice. The USP stated she would have been more comfortable as a new patient in the waiting room if she would have seen a visual symbol of welcome or any health-related pamphlets or other information for Aboriginal patients.

At baseline, the USP stated that she was very comfortable with the doctor and that the doctor was thorough and asked her if she had had any previous tests. She stated that the doctor was very nice to talk to and explained things to her so that she could understand them and explained what was causing her symptoms and why a request was being made for an x-ray. The USP stated that she would return to that practice again if given the choice because she felt the doctor and reception staff were nice and the doctor was good.

At follow-up, the USP reported that seeing the 'Welcome' poster and 'Acknowledge to Country' as she walked into the practice made her feel at ease and welcome as a patient at the practice. Although she felt that the reception staff were nice, the USP said that she was not comfortable with the GP because she felt that the GP was not listening to her and did not have time for her as a patient.

At baseline the USP spent 11 minutes waiting for her appointment and 13 minutes with the GP; at follow-up she spent 30 minutes waiting and 20 minutes with the GP. There was little change in the content of the consultation and no referrals to dieticians or lifestyle change services were made at either time point.

At baseline, the GP stated that she did not suspect that the USP was the study patient during the consultation, but after the consultation she wondered if the USP was the study patient because the USP presented with only one issue and the GP was used to patients presenting with multiple issues. At follow-up the GP

did not suspect that the USP was the study patient. The receptionists stated that they did not suspect that the USPs were the study patients at either time point.

6.3.7 Evaluation of the implementation of the intervention

The GP and staff demonstrated positive responses across all four domains of NPT. In terms of coherence, they understood that they needed to change their Indigenous status identification systems and the physical environment of the practice, as well as gain knowledge and understanding in order to provide appropriately targeted care. In terms of cognitive participation, the staff were committed to quality improvement and willingly undertook all training, including the Aboriginal and Torres Strait Islander Cultural Awareness Training, and felt that it helped make them aware of why they were identifying patients' Indigenous status. Collective action was high: at baseline, this practice was not recording the Indigenous status of their patients at all; at follow-up, they were working towards making this part of their usual routines, and although the GP often forgot to ask patients their Indigenous status, reception staff were making a conscious effort to ask all patients, and the GP placed the 'Are you Aboriginal' sign prominently in every consulting room as a prompt to patients. The 'Welcome' poster was prominently placed near the entrance of the practice, the 'Acknowledgement to Country' was displayed at reception and Indigenous status identification pamphlets were also added to the patient information rack. In terms of reflexive monitoring, the GPs and reception staff saw that more patients were having their Indigenous status recorded, and that this in turn could lead to more targeted care. The staff and GP transferred the knowledge they had gained to the other GPs in the practice and saw that the study was having a flow-on effect to other GPs in the practice and that the Practice Principals were identifying the Indigenous status of patients as well. The full analysis of the implementation of the intervention using the NTP framework is provided in Appendix 11.

6.4 Practice 104

6.4.1 Context

Practice 104 was situated within a small suburban shopping complex in Sydney. The practice was comprised of four consulting rooms, a treatment room, a back office area and a staff area.

Organisation of the practice: Practice 104 was one of several medical practices owned by a large corporation. The practice was an accredited practice and all patients were bulk-billed. There were four full-time and two part-time GPs employed; a full time practice nurse and five part-time reception staff. There was one senior receptionist who was considered the Practice Manager, although this was not her official title. All the practices reported to the full-time Operations Manager who worked across all the practices. Demographics of participating staff members have been provided in Table 3 (p70).

The overall practice priorities were set by the Operations Manager who attended the practice about once per fortnight. The general day-to-day priority areas were overseen by the Senior Receptionist. Quality improvement was a priority area for both the Operations Manager and the Senior Receptionist and they were open and adaptable to change. The participating GP was also open and adaptable to change, but it was not known to what degree the other GPs and staff within the practice were. The surgery was closed every day at lunch time and the GPs used this time to discuss clinical issues in an informal manner. Formalised clinical meetings with the Operations Manager present occurred as needed. Formal staff meetings with the Operations Manager also occurred as needed, usually about once a quarter. Information at other times was communicated to the staff verbally by the Senior Receptionist. The staff and GPs were encouraged to have input into decisions regarding the practice and this high decision latitude resulted in the staff and GPs appearing content and relaxed in their workplace.

The participating GP originally enrolled in the study at another practice (Practice 101) due to her interest in the health of indigenous populations both nationally and internationally, and was keen to continue in the study. When she moved, she asked the Operations Manager if she could continue in the study and the Operations Manager also signed up. He did not ask the other staff if they wished

to sign up and mentioned that one GP and one other staff member were the minimum amount of staff required to undertake Aboriginal and Torres Strait Islander Cultural Awareness Training in order to qualify for the Australian Government's \$1000 sign on fee for the IHIPIIP.

6.4.2 Identification of patient's Indigenous status

All new patients were asked to fill out a New Patient Registration Form at reception. At baseline the form asked the patient's name, date of birth, contact details, Medicare details, and Indigenous status; the latter question asked, "Are you Aboriginal or Torres Strait Islander?," with answer options of "Yes Aboriginal, Yes Torres Strait Islander, No." When the Operations Manager was informed that Best Practice Guidelines recommended a "Both Aboriginal and Torres Strait Islander" option, he updated the form. The Indigenous status of all patients in the practice from the clinical records audit is shown in Table 19.

Table 19. Indigenous status of patients ≥18 years (Practice 104)

Indigenous status	Baseline (%)	Follow-up (%)
Aboriginal	0.05	0.15
Torres Strait Islander	0	0.02
Both Aboriginal and Torres Strait Islander	0.05	0.09
Neither	4	18
Refused / Inadequately stated	-	-
Unidentified	96	81.8

At baseline, patients were not verbally asked their Indigenous status. The practice relied solely on new patients self-identifying on the New Patient Registration Form and the Indigenous status of existing patients was not identified. At follow-up, although the GP was making a concerted effort to ask all her patients their Indigenous status, it was not done routinely for all patients.

The USP was not asked her Indigenous status and her Indigenous status was not recorded on the medical record at either baseline or follow-up (Table 20).

Table 20. How the USPs Indigenous status was identified and recorded (Practice 104)

	Baseline	Follow-up
USP asked Indigenous status	Yes	Yes
Yes - asked on registration form	Yes	Yes
Yes - asked by reception	No	No
Yes - asked by GP	No	No
Indigenous status question asked according to Best Practice Guidelines	No	No
USP Indigenous status correctly recorded in medical record	No	No

The GP trained and practiced in Canada where indigenous cultural awareness was a prominent issue in society. However, she was unaware of the need to identify patients' Indigenous status in Australia. At baseline, the GP felt that patients should be asked the Indigenous status question in a standardised way. She felt that patient safety played an important role in self-identification and believed that some people may not want to identify their Indigenous status at reception but would be more willing to do so in a private consultation with a GP, however, realised that some patients may never feel safe identifying as Aboriginal and Torres Strait Islander because of past experiences, (both personal experiences and experiences of Aboriginal and Torres Strait Islanders as a whole). The Operations Manager felt that the practice processes in place were important factors for Indigenous status identification. At follow-up, both the GP and the Operations Manager felt that Indigenous status identification relied on welcoming environments (both physical and the atmosphere created by the staff) and good identification systems at both the reception and GP level.

At baseline, the GP was aware that the patient's Indigenous status was recorded in the patient medical record but the Operations Manager was not. At follow-up, both were aware that the Indigenous status was recorded on the medical record.

6.4.3 Assumption of literacy

The practice staff assumed all patients were literate and did not ask patients if they needed help with any forms or paperwork.

6.4.4 Practice environment

The waiting room for Practice 104 was set up so that chairs were lined around two walls of the waiting room and there was a 'personal space' gap between each chair. There was ample room between the patient seating area and the reception desk. There was also a small play area for children. One wall was dedicated to displaying health posters. On the opposite wall there was a large pamphlet rack which contained health information pamphlets. Some gossip/entertainment magazines were available for patients to read. The consultation rooms were neat and tidy and comprised a GP desk, two chairs for patients to sit on, an examination table and cupboards. At baseline there was an immunisation poster on the wall in one consultation room highlighting the different immunisation needs for Aboriginal and Torres Strait Islander patients compared to other Australians. Apart from this poster, there were no other posters, signs, pamphlets or other information that either mentioned or depicted Aboriginal and Torres Strait Islander peoples or encouraged self-identification of Indigenous status. Both the GP and the Operations Manager said that although they felt that the physical environment was inviting to all patients, they did not know if it was welcoming to the Aboriginal and Torres Strait Islander community: "*I think it is inviting but I'm not sure if there is a specific, you know, aspect of it that would be inviting to Aboriginal or Torres Strait Islander[s]*", Practice Manager 104301.

The practice was quite willing to improve its physical environment to Aboriginal and Torres Strait Islander patients, and at follow-up a large 'One simple question could help you close the gap' poster was displayed along with the other posters, 'One simple question could help you close the gap' and 'Are you Aboriginal' brochures were in the patient pamphlet rack, the 'Welcome' poster was displayed in the waiting room and the 'Are you Aboriginal' sign was displayed prominently in each consulting room. The 'Welcome' poster was also displayed in the participating GPs consulting room, as was a piece of Aboriginal artwork that had been sourced from the local Aboriginal and Torres Strait Islander community.

6.4.5 Culturally appropriate and targeted care

At baseline the GP had previously completed the RACGP online Aboriginal and Torres Strait Islander Cultural Awareness Training, however, no other GP or staff member within the practice had undertaken any training. The GP said that she

voluntarily undertook the training because Aboriginal and Torres Strait Islander health was an interest of hers and because in Canada, indigenous cultural awareness training was a part of the standard medical training and she therefore felt that she should be aware of the needs of Aboriginal and Torres Strait Islander peoples: *"I just wanted to learn a little bit more um about what would be culturally appropriate...I don't think I have a practice population that has a lot of Aboriginal and Torres Strait Islander persons but I thought at least if I did some training I'd have some knowledge of what would be appropriate, what would be inappropriate...I didn't want to offend anybody without knowing"*, GP 104101. She also wanted to know what services were available to Aboriginal and Torres Strait Islander patients: *"I'm new to this country so am not familiar with all the benefits available. In Canada, our First Nations people have special services...I don't know if you have that here"*, GP 104101.

The Operations Manager was, *"...open to doing you know whatever is necessary really to ensure that you know any patient [at] one of our practices has the right access to health care and um has the tailored health care that they need"*, Practice Manager 104301. However, he was sceptical about the Australian Government's minimum requirement of only two staff members within a practice to having to undertake Aboriginal and Torres Strait Islander Cultural Awareness Training to qualify for the IHIP and felt that a teamwork environment was required for knowledge translation: *"Um I think in the right organisation, it, it, it could be enough. You don't want sort of any criteria to be too cumbersome, but um again and from past experience it was, you know, whoever was most um open to the idea and had the time to do it and it wouldn't necessarily result in a you know um, it doesn't necessarily result in a train-the-trainer mentality. The one off course for that individual doesn't mean that the other ten people in the practice would have the same level of understanding; you know I doubt that very much...in the right organisation I think that train-the-trainer mentality works because you don't want to have to have every say ten employees go through it, that's a little bit cumbersome, but um in the right organisation you know there are adequate training processes in the practice or the organisation so that a skill, so that that training can be spread amongst the rest of the employees or GPs alike"*, Practice Manager 104301.

At baseline, the GP felt that there was a general lack of Aboriginal and Torres Strait Islander cultural awareness training for medical practitioners in Australia

compared to the training she had received overseas. She had completed the RACGP online Cultural Awareness Training purely out of self-interest, not as a requirement for any incentive payment or Continuing Professional Development (CPD) points. She felt this online training lacked a local element, and mentioned that in Canada all medical students received indigenous cultural awareness training that was specific to the local indigenous community and that this was lacking in Australian general practice. In contrast, the Operations Manager who had not completed any cultural awareness training felt that culturally appropriate care for Aboriginal and Torres Strait Islander patients was treating them the same as any other patient. At follow-up, there was a greater understanding that the provision of appropriate care was not treating all patients the same, but treating them according to their needs. The Operations Manager also felt that time constraints were an import factor in being able to provide culturally appropriate care.

The GP felt that if cultural barriers existed for providing health care to Aboriginal and Torres Strait Islander patients then they should be removed: *"I think that um I think that's it's important I think that given that the health outcomes I've seen so far for people who are Aboriginal and Torres Strait Islanders are so poor in terms of life expectancy and um disease prevalence, and um gosh I mean the diseases that affect people that are Aboriginal and Torres Strait Islanders are diseases that have been eradicated in most of medicine and yeah we're still fighting the same sort of battles...so I think it's really, really important um that if there are cultural barriers in providing health care that we need to identify what those are and figure out what we can do to um to remove them"*, GP 104101.

The practice did not have any engagement with the local Aboriginal Community, AMS or ACCHS. At baseline, the GP was not aware of the Indigenous MBS item numbers and the Indigenous PBS Co-payment Measure; the Operations Manager was aware of them and felt that they were a good idea so long as they were utilised because they addressed a specific need: *"I think it's good from a, from a um, uh, a healthcare stand point, standpoint, to um provide I guess specific benefits to um addressing an area of need, such as you know, you know like there are for diabetes um team care arrangements and what not, but um uh I don't know how often it's used. Again, again it comes into that awareness of knowing that the patient is an Aboriginal and Torres Strait Islander to begin with*

and whether then um there's a conscious choice from the GP to, to utilise um those item numbers", Practice Manager 104301.

Table 21 shows that the number of Aboriginal and Torres Strait Islander-identified patients had increased substantially between baseline and follow-up, however, no Aboriginal and Torres Strait Islander or other health assessments were performed on any Aboriginal and Torres Strait Islander-identified patients.

Table 21. Consultations and Health Assessments for Aboriginal and Torres Strait Islander patients (past 2 years) (Practice 104)

	Baseline	Follow-up
Aboriginal and Torres Strait Islander Patients	4	12
No of consultations past 2 years	20	66
Aboriginal and Torres Strait Islander Health Check Assessments: (MBS Item 715)	0	0
Other Health Check Assessments: (MBS item numbers 703, 705, 707, 10986, 10987, 81300)	0	0

The practice was an accredited practice and was eligible to register for the IHIPIP, although it was not registered at baseline. The Operations Manager was sceptical about the lasting impact of the IHIPIP: "...in terms of whether it has any lasting impact on the practice uh I'm not sold on that. You know I've seen it at other organisations that it's actually a, a tick-box type process and they're, they're simply aiming for the initial payment but don't really care about the future um identification of the patients and um enrolment in the process each year, they're, they're mostly chasing that initial one-off payment", Practice Manager 104301.

As a result of enrolling in the study, Aboriginal and Torres Strait Islander health was highlighted as a priority area to the Operations Manager and the practice subsequently enrolled into the IHIPIP. Although he felt the Indigenous PBS Co-payment Measure was of benefit to Aboriginal and Torres Strait Islander patients, he felt that having it tied to a PIP payment was creating extra barriers for them: "I think it somewhat becomes a barrier...for the Aboriginal and Torres Strait Islander patients because they're um it means that they can't see any GP at any time and still receive the, the financial benefits on the PBS items. Um, um and so I think because it's just like any, any patient really if you make an extra hurdle you're going to cull the crowd at some point and I feel that um, you know the PBS benefits are great but...having it linked to the PIP and the sign up, and the sign up I think in a specific practice, I think potentially poses as a barrier because it's

an extra step that some people may not realise they need to do or may not be told they need to do um or may just not want to do because that it is an extra step", Practice Manager 104301. Table 22 shows the number of patients enrolled to the IHIPIP or the Indigenous PBS Co-payment Measure from the patient medical record audit.

Table 22. Patients enrolled in the IHIPIP and/or Indigenous PBS Co-payment Measure (Practice 104)

	Baseline	Follow-up
Indigenous Health Incentive only	N/A	0
PBS Co-payment Measure only	N/A	0
Both	N/A	1

N/A = Not applicable

The GP also felt that the Indigenous PBS Co-payment Measure should be made available to all eligible patients, not just those who attended IHIPIP-registered practices: "I think that having worked in an accredited and unaccredited practice it would be nice if the unaccredited practices could offer the CtG scripts um...Because there may be um patients who attend that practice as their primary practice and primary place of health care and um if you say that they then can't get CtG scripts because it's an unaccredited practice you're sort of punishing the patient...Uh practice accreditation is not just up to the GP, it depends on the practice environment the, whoever is actually running the practice themselves. And um from experience you can sometimes have very little control over what happens in a particular practice environment um and you know some practice management people just flat out refuse to become accredited, it's too much work, so then the patients suffer um from something that has absolutely nothing to do with them. I mean it may not have anything to do with the GP themselves either, so um I think the, the, certainly the practice incentive payment should be for accredited practices because then you're saying that you're going to adhere to a certain standard. But I don't think the CtG scripts should necessarily have to come from an accredited practice", GP 104101.

6.4.6 Assessment by the USP

The USPs reported variable levels of service provision from the reception staff. At baseline, the USP found the staff to be polite and friendly. When telephoning to

make an appointment, the USP reported the receptionist was polite and helpful and she was informed that she could get an appointment the same day if she wanted. During her visit the USP also found the receptionist to be polite and friendly. The USP stated she would have been more comfortable as a new patient in the waiting room if she would have seen a visual symbol of welcome, or any health-related pamphlet or other information for Aboriginal patients.

The USP spent nine minutes waiting for her appointment and seven minutes with the GP. The USP reported that she was very comfortable with the GP and said that the doctor was easy to talk to and explained things to her so that she could understand them. The USP stated that she would return to that practice again if given the choice because she felt the doctor and reception staff were nice.

At follow-up, the USP reported that when making the appointment, the receptionist was very nice on the telephone, spoke very well, was welcoming and very well-mannered and made her feel like she was just as important as any other patient. When the USP arrived for her appointment, she reported that the receptionist on duty was extremely rude. The USP reported that the receptionist acted like she didn't want to be there and made the patient feel like she was also not wanted at the practice. The USP reported that when she first presented at reception, the receptionist did not even acknowledge that someone was standing in front of her and was shuffling paperwork around the desk. The USP reported that she would feel more comfortable if the receptionist had at least indicated that a patient was standing in front of her, but reported that the receptionist made her feel like she was "*invisible*." The USP reported that the receptionist did not look at her again during the rest of the encounter and put the New Patient Registration Form down on the desk and told the USP to fill in it in a gruff manner.

The USP spent 45 minutes waiting for her appointment and 15 minutes with the GP. She reported that the GP was nice and friendly but was rushed, and although she would see the doctor again in another venue, she would not return to the practice because of the receptionist's rudeness and the way the receptionist made her feel like she was not wanted at the practice. There was little change in the content of the consultation between baseline and follow-up and no referrals to dietitians or lifestyle change programs were made at either time point. The GP and staff stated that they did not suspect that the USPs were the study patients at either time point.

6.4.7 Evaluation of the implementation of the intervention

Positive responses were obtained across all four domains of NPT. In terms of coherence, the GP and Operations Manager understood that they needed to change their Indigenous status identification systems and the practice physical environment, as well as gain knowledge and understanding in order to provide appropriately targeted care. In terms of cognitive participation, both the GP and the Operations Manager were committed to quality improvement and they were keen to implement any change that would ensure patients received appropriately targeted health care, however, the Operations Manager would not invite the other GPs and staff to participate in the study. They willingly undertook all training, including the Aboriginal and Torres Strait Islander Cultural Awareness Training, and felt that it helped increase their awareness about effective Indigenous status identification systems and providing appropriate care to Aboriginal and Torres Strait Islander patients. At baseline, the practice was relying on patients to self-identify their Indigenous status on a New Patient Registration Form, and there was no system in place to identify the Indigenous status of existing patients; at follow-up, the GP was consciously making an effort to incorporate this into her usual routines, however, did forget at times when time and other constraints placed pressure on her as was the case with the USP at the follow-up visit. Although the Operations Manager did not change the Indigenous status identification systems for existing patients at reception, he did place the 'Are you Aboriginal' sign in all consulting rooms as a prompt to patients and the other GPs. In terms of reflexive monitoring, the GP and Operations Manager saw that more patients were having their Indigenous status recorded, and that more patients were being identified as having Aboriginal and/or Torres Strait Islander backgrounds, which in turn could lead to them receiving more targeted care.

The GP and Operations Manager saw the impact the training offered in the intervention had had on an individual level and felt that the practice's physical environment was more welcoming to Aboriginal and Torres Strait Islander patients as more patients were self-identifying their Indigenous-status. However, because the Operations Manager did not invite the other GPs and staff to participate in the study, and the knowledge was not translated effectively to the rest of the staff, the impact of the intervention was limited. The full analysis of the implementation of the intervention using the NTP framework is provided in Appendix 12.

6.5 Practice 201

6.5.1 Context

Practice 201 was situated along a suburban shopping strip on a main thoroughfare in Sydney. It contained two consultations rooms, only one which was used regularly. There was an additional area upstairs which had a consultation room dedicated to beauty and laser treatments, a back-office and a staff area.

Organisation of the practice: Practice 201 was a practitioner-owned, solo-GP medical practice. It was an accredited practice and a private billing practice, but some patients were bulk-billed at the discretion of the GP. The GP worked full time, his wife was the Practice Manager and worked part-time and was involved in the day-to-day running of the practice, and one part-time receptionist was also employed. There was no nurse employed. Demographics of participating staff members have been provided in Table 3 (p70).

The practice priorities were set by the GP and the Practice Manager. Quality improvement was a priority area for both and they were open to change. However, the Practice Manager at times saw the need to change as a failure on her part and was less open to change than the GP. Being such a small team, they did not schedule regular meetings, preferring to discuss matters verbally as they arose. The practice was closed during lunch offering the opportunity to discuss things daily. The receptionist was encouraged to have input into decisions regarding the practice and this high decision latitude resulted in her appearing content and relaxed in the workplace and there appeared to be good team collaboration.

The participating GP had a keen interest in Aboriginal and Torres Strait Islander health and had previously worked with the local Aboriginal community and undertaken a volunteer placement in a remote area. His keenness to sign up for the study spilt over to the rest of the staff.

6.5.2 Identification of patient's Indigenous status

All new patients were asked to fill out a New Patient Registration Form which asked their name, date of birth, contact details, Medicare details and Indigenous status. At baseline the question read, "Are you an Aboriginal Australian or Torres Strait Islander? Yes/No." When the Practice Manager was informed this was not according to Best Practice Guidelines, she added, "if yes please circle either or both which ever applies to you". The Indigenous status of all patients in the practice from the clinical records audit is shown in Table 23.

Table 23. Indigenous status of patients ≥18 years (Practice 201)

Indigenous status	Baseline (%)	Follow-up (%)
Aboriginal	0.6	0.8
Torres Strait Islander	0	0
Both Aboriginal and Torres Strait Islander	0.5	0.7
Neither	73.2	96.4
Refused / Inadequately stated	-	-
Unidentified	25.7	2.1

According to the Practice Manager, the practice was also effectively working at identifying the Indigenous status of existing patients. At baseline, the Practice Manager stated that they were half way through the alphabet. There did not appear to be a system in place for how the Indigenous status of existing patients was identified and the researcher could not get a firm response on how this was achieved alphabetically. From the response received it appeared to the researcher that the patient records were being worked through alphabetically and many patients were recorded as being non-Indigenous according to staff guess. The GP and all staff agreed that the Indigenous status of new patients was identified solely via the New Patient Registration Form, but there was no consensus on how existing patients were identified, with the GP stating that he sometimes asked existing patients their Indigenous status and that they sometimes choose to self-identify, whilst the staff indicated that existing patients were identified by the Patient Registration Form.

At baseline, the receptionist discreetly pointed out to the USP that she had not completed the Indigenous status question. When the USP asked why she needed to fill out the question, the receptionist answered, "It's very important, we

need to know", Receptionist 201501. The USP identified as being Aboriginal and her Indigenous status was correctly recorded on the medical record (Table 24). At follow-up, reception did not prompt the USP to complete the Indigenous status section on the registration form. Once in the consultation, the USP asked for a script and it was at this point that the GP asked her Indigenous status. The USP reported that when she asked the doctor why he needed to know, the GP replied, *"There's something called Closing the Gap and it gives you discounted medication."* The USP reported that when she replied that she was Aboriginal, the doctor ticked the CtG script box in the software and correctly identified her on the medical record (Table 24). The USP reported that she was not asked if she was registered for the Indigenous PBS Co-payment Measure and was not asked to sign any paperwork to register for it.

Table 24. How the USPs Indigenous status was identified and recorded (Practice 201)

	Baseline	Follow-up
USP asked Indigenous status	Yes	Yes
Yes - asked on registration form	Yes	Yes
Yes - asked by reception	Yes	No
Yes - asked by GP	No	Yes
Indigenous status question asked according to Best Practice Guidelines	No	No
USP Indigenous status correctly recorded in medical record	Yes	Yes

The GP trained and practiced overseas in New Zealand where indigenous cultural awareness is a prominent issue in society. The GP felt that time and a fear of discrimination were barriers to Indigenous status identification but he was also sceptical as to whether these really existed, and felt that patient safety was the enabler. The Practice Manager on the other hand felt that Indigenous status identification was the responsibility of the patient and they could identify if they wanted to and felt that there were no barriers to Indigenous status identification. The receptionist, although being of Māori descent and having only been in Australia for a few years, didn't know of any barriers to Indigenous status identification. At follow-up, all three felt that the barriers to Indigenous status identification were that patients may not want to self-identify: the GP and receptionist felt this was due to patient safety; the Practice Manager felt that both patient safety and staff comfort asking the question played a role. All felt that

asking patients to self-identify on a form was an enabler of Indigenous status identification as it was a non-confrontational method.

All staff agreed that patient's Indigenous status was recorded in the patient medical record although at baseline the receptionist was unaware as to the reasons why it was collected: *"I know when, if we do have patients come in that are Aboriginal or Torres Strait Islander we don't discriminate in any way. It's up to them if they want to identify themselves as Aboriginal or Torres Strait Islanders. And then if they mark it then we just then put it on their file and that's as far as it goes as far as I'm aware"*, Receptionist 201501.

6.5.3 Assumption of literacy

The practice staff assumed all patients were literate and did not ask patients if they needed help with any forms or paperwork.

6.5.4 Practice environment

Practice 201 was modern and tastefully decorated with various cultural artworks from the south-pacific region. The waiting room area was small, with room for around four patients to be seated. Two chairs had their backs against a shop-front style window and there was also a small couch against the opposite wall which allowed another two patients to be seated. There were large and impressive batik prints from the Pacific Islands hung in the waiting room and the hallway. Some gossip/entertainment magazines were available for patients to read in the waiting room and there was a sign on the wall stating that the practice was under constant video surveillance. The waiting room was in a separate area to the reception desk, affording patients privacy when at reception. The reception desk was situated so that patients were standing at it immediately when entering the practice. There was a very large and impressive Aboriginal painting behind the reception desk. The receptionist pointed out, *"We do get a lot of comments on our Aboriginal art"*, Receptionist 201501. On the reception desk, there was a three-slot pamphlet display holder. One series of pamphlets contained information on the practice; the other two were patient health pamphlets, neither of which were related to Aboriginal and Torres Strait Islander health or Indigenous status identification. At follow-up the practice displayed the 'Welcome'

poster near the entrance of the surgery and three 'Are you Aboriginal' pamphlets were also placed into the pamphlet rack, but they were placed behind the other pamphlets and were therefore not easily visible to patients.

The consultation room was neat and tidy and comprised a GP desk, two chairs for patients to sit on, an examination table and cupboards, and a Pacific Islander batik print hanging on the wall. At follow-up, the batik had been changed to Aboriginal artwork. Although the GP and the staff said that they did not engage in any activities to be more welcoming to the Aboriginal or Torres Strait Islander community, when asked directly the GP stated that there was artwork in the practice to make Aboriginal and Torres Strait Islander patients feel more welcome, and the GP and staff all felt that the physical environment of the practice was inviting to all patients because of the various indigenous artwork displayed from around the South-pacific region.

6.5.5 Culturally appropriate and targeted care

At baseline, the GP had previously completed Aboriginal and Torres Strait Islander Cultural Awareness Training but the Practice Manager and receptionist had not. Both the receptionist and Practice Manager undertook Aboriginal and Torres Strait Islander Cultural Awareness Training as part of the study.

The GP's motivation for taking part in this research was because he had an interest in Aboriginal and Torres Strait Islander health. He had previously worked with the local Aboriginal community as well as having undertaken a remote volunteer placement. In reply to the Expression of Interest advertisement, the Practice Manager stated, *"I know [GP name suppressed] will be interested. He did a youth health clinic in [location suppressed]...He's done the Cultural Awareness Training and also the Cultural thing at the TAFE...It's a thing he's really interested in"*, Practice Manager 201301. The GP incorrectly believed that engaging with the Closing the Gap Officer at the Medicare Local was engaging with the AMS/ACCHS (Medicare Local Closing the Gap Officers are not Indigenous-identified positions and are not employees of AMS/ACCHS). The GP felt that culturally appropriate service delivery stemmed from one's personal background: *"Um well look it all comes back to cultural background...you know my first language wasn't English...and you know I'm used to being a bit of a*

minority and um as are Aboriginal people in our dominant culture so um that uh kind of gives me a bit of insult, insight into, into where they're coming from....And then an educational background that helps...I'm from New Zealand and you know it's a big Māori population, Pacific Islander population, so my education in the um 1970's um had a big cultural component...the whole cultural thing is something I've been brought up with", GP 201101.

At baseline, the GP and staff felt that culturally appropriate care for Aboriginal and Torres Strait Islander patients was treating them the same as any other patient. The GP felt, *"Aboriginal people are just another cultural group and everybody regardless, every cultural group um deserves a fair go", GP 201101,* and felt that a major barrier in general practice was time. The Practice Manager believed that general practice offered confidentiality to Aboriginal and Torres Strait Islander patients, which she believed they could not get at the AMS/ACCHS. At follow-up, there was a broader awareness that welcoming practice environments and targeted care were important factors for culturally appropriate care.

Both the GP and Practice Manager were aware of the Indigenous-specific MBS item numbers available to Aboriginal and Torres Strait Islander patients. The GP and Practice Manager felt that these enabled better care to Aboriginal and Torres Strait Islander patients because GPs received an incentive to spend time with Aboriginal and Torres Strait Islander patients: *"Um well uh it basically means because you're being paid a bit more for looking after Aboriginal folk it still is economical to look after them, so I get to do something I'm interested in and get paid for it so it's a win-win situation", GP 201101.* He felt that the item numbers were currently underutilised at the practice, but explained a strategy that the practice had put in place in order to better utilise the MBS Item numbers: *"Well I think they're a good idea and they are currently underutilised around here but we've got a strategy in place where they get be more utilised in the future... We are um getting rid of um uh patients who abuse us or um don't um value our practice and uh um by putting up the price, uh but at the same time we cut quite a few people a bit of slack. Um so you know um I'm quite happy to, to look after Aboriginal and TSI folk, um bulk billing uh some of them because I kind of enjoy the work but um, um we've gotten rid of all the, I'm not interested in all the um, um doctor shoppers, um, um whingers and so forth and if people aren't prepared to look after their own lives and take responsibility for their own health um I don't*

particularly want to look after them. So we've upped, upped the price and this is a simple system that um is known to reduce your number of patients. So we're actually um working to make the practice work better for us and for the people that we want to look after", GP 201101.

The Practice Manager felt that the item number system was laborious and believed that this was a contributing factor to item numbers being underutilised: "It's time. Most GPs don't have time to return phone calls within 48 hours...and that's why things like the item numbers...if it takes another two minutes to look up an item number you know, it's a real pain and I think that's probably why a lot of the item numbers don't get used by a lot of doctors because it's just easier to put in 23, 36", Practice Manager 201301.

Table 25 shows that the percentage of health assessments performed on Aboriginal and Torres Strait Islander-identified patients had increased at follow-up:

Table 25. Consultations and Health Assessments for Aboriginal and Torres Strait Islander patients (past 2 years) (Practice 201)

	Baseline	Follow-up
Aboriginal and Torres Strait Islander Patients	13	15
No of consultations past 2 years	153	175
Aboriginal and Torres Strait Islander Health Check Assessments: (MBS Item 715)	2	7
Other Health Check Assessments: (MBS item numbers 703, 705, 707, 10986, 10987, 81300)	0	0

Both the GP and Practice Manager were aware of the Indigenous PBS Co-payment Measure. The GP felt that this aided medication compliance by reducing the barrier of the cost of medication: "...that's a positive move because the price of medicines is a big issue for quite a few people and uh when you've got a working employed Aboriginal person whose got diabetes and heart, uh diabetes and high blood pressure and they're on four medications it's suddenly stacking up to you know 120 bucks a month. It's a, it's a hell of a big difference between that and nothing", GP 201101.

The practice was an accredited practice and was IHIPIP registered. The Practice Manager seemed confused about patient eligibility and reported that she just,

"enrol[s] them in both" (enrols Aboriginal and Torres Strait Islander patients in both the IHIPIP and the PBS Co-payment Measure) and *"send[s] it to Medicare and let them sort it out"*, Practice Manager 201301. This was reflected in Table 26.

Table 26. Patients enrolled in the IHIPIP and/or Indigenous PBS Co-payment Measure (Practice 201)

	Baseline (Indigenous-identified patients n=13)	Follow-up (Indigenous-identified patients n=15)
Indigenous Health Incentive only	0	0
PBS Co-payment Measure only	0	0
Both	6	5

6.5.6 Assessment by the USP

At both time points the USPs reported that when they telephoned to make an appointment, they found the receptionists polite and friendly, and were informed upfront that they would not be bulk-billed for the consultation. At both time points the USPs found the receptionist to be very pleasant and approachable and reported that the receptionist made eye contact when speaking with them.

At baseline, the USP reported that the large Aboriginal painting at reception put her at ease when she entered the practice, making her feel welcome and giving her a sense of belonging. She said that the sign stating that she was being recorded on video made her uncomfortable.

The USP reported that she was not comfortable during the consultation and said that although she had agreed for a medical student to be present during the consultation, she felt that the doctor should have been addressing her during the consultation and not the student. The USP reported that the doctor had told her that, *"...when it comes to health he puts it back on the patient and if I need to go further with it go back and see him."* The USP reported that the doctor advised her to buy a blood pressure machine and was given a printout of one he recommended for \$89.00. The USP had attended the practice with a Health Care Concession Card and felt that this was not an expense that a patient on a limited income could afford. She reported that the GP instructed her to check and record her blood pressure for a couple of weeks and come back to see him if she felt

she needed to be treated. She reported that the GP had informed her of what her blood pressure reading should be but she could not remember what the numbers should look like.

When the USP was asked if she would return to the practice again given the choice she replied that she wouldn't. She was offended that, "*The doctor...[said]...that he had more Aboriginal knowledge than me...Because Aborigines in remote areas live differently to Aborigines in urban areas. Not all of them are the same. Just because he has worked with remote Aborigines doesn't mean he understands me as a rural one. I'm not like that. We live differently; different upbringings, different environments. He thinks we are all the same, that we all live like that. We are very different.*" The USP was initially charged \$136.00 for the consultation (the Medicare rebate for Item 36 = \$70.30)¹⁵⁹ before the researcher identified her as the study patient and the University was billed for the consultation.

At follow-up, the USP reported that the doctor explained things to her in a way that she could understand and that she felt like the doctor was listening to her and that she would return to practice again if given the choice because she felt it was a nice environment.

At baseline the USP spent 47 minutes waiting for her appointment and 14 minutes with the GP; at follow-up waited 36 minutes and spent 24 minutes in the consultation. There was little change in the content of the consultation and no referrals to dieticians or lifestyle change programs were made at either time point.

The GP and staff stated that they did not suspect that the USP was the study patient at either time point.

6.5.7 Evaluation of the implementation of the intervention

In terms of coherence, the participants felt that they did not need to change their Indigenous status identification systems and that they were already providing appropriately targeted care. The GP had previously completed Aboriginal and Torres Strait Islander Cultural Awareness Training prior to the intervention and had experience in Aboriginal and Torres Strait Islander health, and because he

was aware of the disparities in health between Aboriginal and Torres Strait Islander patients and other Australians, he understood the purpose of identifying patients' Indigenous status. His own interests in Aboriginal and Torres Strait Islander health helped demonstrate his shared sense of purpose. The receptionist and Practice Manager joined the study because the GP was interested. However, the Practice Manager felt that Indigenous status identification was the responsibility of the patient and the GP and therefore did not have a full sense of the purpose of the intervention. There was little cognitive participation: only the Practice Manager and receptionist readily attended all training sessions, but although the Practice Manager attended the training, she believed it was up to patients to self-identify their Indigenous status and she did not actively engage or commit to the intervention. The GP did not engage in any training offered in the intervention but he did read and discuss the results of the Practice Feedback Report with the Practice Manager.

There was little collective action demonstrated. The receptionist was already doing all that was required in the intervention as part of her usual duties so it is not known whether she would have done what was required in the intervention if she needed to change her usual routine. The Practice Manager felt that Indigenous status identification was the responsibility of the patient and the GP, and did not ask patients their Indigenous status. She was not comfortable asking patients their ethnicity even after receiving training, and would not display any signage such as the 'Are you Aboriginal' sign to help patients and staff alike understand why they were being asked their Indigenous status. As the receptionist did not need to change any of her usual routines, she was unaware of any changes that had taken place as part of the intervention and hence there was little reflexive monitoring on her part. The Practice Manager did not make any changes to her work, and therefore was similarly unaware that the intervention had had any impact. The GP, although having limited collective action, did see that the practice had to make changes to its Indigenous status identification systems so that he could provide appropriately target care. As all four domains of the NPT were not met at a practice level, the impact of the intervention was limited. The full analysis of the implementation of the intervention using the NTP framework is provided in Appendix 13.

6.6 Practice 202

6.6.1 Context

Practice 202 was situated within a large corporate setting in suburban Sydney. The practice was comprised of eight consulting rooms, a large three-bed treatment room, a back-office area, Practice Manager's Office and a staff area.

Organisation of the practice: Practice 202 was a large corporate owned medical practice. It was an accredited practice and a private billing practice but some patients were bulk-billed. Three full-time and three part-time GPs were employed, along with one full-time Practice Manager, one full-time and two part-time nurses, and three full-time and three part-time receptionists. Demographics of participating staff members have been provided in Table 3 (p70).

The Director of the practice and the Practice Manager saw quality improvement as a priority area and were open and adaptable to change, as were the staff, although it is not known how adaptable and open to change the non-participating GPs were. Clinical meetings were held regularly once a fortnight and minutes were distributed to all staff. Staff meetings were adhoc and occurred about once a month and these were also minuted and distributed to all staff. Information at other times was communicated to the staff verbally by the Practice Manager and then followed up in writing in the form of a memo to staff. The staff and GPs were encouraged to have input into decisions regarding the practice and this high decision latitude resulted in the staff and GPs appearing content in their workplace. The practice was very busy at times and the staff were placed under great demand, however, this did not seem to affect the staff morale or team functioning.

Two GPs in this practice signed on to the study. The main motivation for one GP was gaining Continuing Professional Development (CPD) points. The main motivation for the other GP and staff was an interest in learning more about Aboriginal and Torres Strait Islander health issues and to improve service delivery to these patients.

6.6.2 Identification of patient's Indigenous status

All new patients were asked to fill out a patient registration form at reception, which asked their name, date of birth, contact details, Medicare details and Indigenous status; the latter question asked, "Do you identify as an Aboriginal or Torres Strait Islander? Yes/No." Although the Practice Manager was informed this was not according to Best Practice Guidelines, the form was not updated by the time follow-up data was collected. The Indigenous status of all patients in the practice from the clinical records audit is shown in Table 27.

Table 27. Indigenous status of patients ≥18 years (Practice 202)

Indigenous status	Baseline (%)	Follow-up (%)
Aboriginal	0.1	0.3
Torres Strait Islander	0	0
Both Aboriginal and Torres Strait Islander	0.1	0.2
Neither	54.3	60.6
Refused / Inadequately stated	-	-
Unidentified	45.5	38.9

At both time points there was little consensus amongst the staff in regards to how new and existing patients had their Indigenous status identified, and some receptionists believed that both they and the GPs asked patients their Indigenous status, however most agreed that the nurses did not check Indigenous status.

At the baseline visit to GP 202101, the receptionist incorrectly recorded the USP's Indigenous status on the medical record as non-Indigenous based on the USP's physical appearance (Table 28). On the USP's visit to GP 202102, the receptionist pointed out that the Indigenous status question had been left blank and asked the USP to complete the section. The USP identified herself as being Aboriginal and was correctly recorded in the medical record (Table 28). On this occasion, the GP also asked the USP her Indigenous status. At follow-up, the USP was not asked her Indigenous status verbally on either visit; her Indigenous status was not recorded in the medical record for the visit to GP 202101, and her Indigenous status was incorrectly recorded in the medical record as non-Indigenous based on her physical appearance for the visit to GP 202102 (Table 28).

Table 28. How the USPs Indigenous status was identified and recorded (Practice 202)

	Baseline		Follow-up	
	GP 202101	GP 202102	GP 202101	GP 202102
USP asked Indigenous status	Yes	Yes	No	No
Yes - asked on registration form	Yes	Yes	No	No
Yes - asked by reception	No	Yes	No	No
Yes - asked by GP	No	Yes	No	No
Indigenous status question asked according to Best Practice Guidelines	No	No	No	No
USP Indigenous status correctly recorded in medical record	No	Yes	No	No

At baseline, the staff and GP views regarding the enablers and barriers to Indigenous status identification were quite divergent. The enablers included staff education, cultural awareness training, patient safety and having adequate time, and one receptionist felt that physical appearance was an enabler; barriers included patients not self-identifying, staff not prompting patients to complete the section on the registration form if it had not been answered, lack of staff awareness and lack of time. Two receptionists were not aware of any barriers or enablers to Indigenous status identification. One GP pointed out that the medical record software program did not display Indigenous status in a prominent position on the computer screen and suggested it should be highlighted in a different colour or placed more prominently rather than being off to the right hand side of the screen. At follow-up, the responses were much more focused towards having effective practice systems in place, having staff awareness of why the Indigenous status question was being asked and staff being comfortable asking the question, and having practice environments that promoted self-identification of Indigenous status, as well as having sufficient time. One GP mentioned that the patients at the practice were from diverse ethnic backgrounds, making it difficult to focus on one ethnicity.

The staff and GPs were aware that the patient's Indigenous status was recorded in the patient medical record at both time points.

6.6.3 Assumption of literacy

The GP and practice staff assumed all patients were literate and did ask patients if they needed help with any forms or paperwork.

6.6.4 Practice environment

The practice had a modern decor aimed towards a younger patient market. On entering the practice there was sign pointing towards a ticket machine situated on the side wall. However, because people generally seek out a reception desk when entering a medical practice, the sign was easily missed because it was in the opposite direction to the reception desk. The ticket machine asked all patients to take a ticket regardless of whether they had an appointment or enquiry. There was a sign attached to the machine which said to see the nurse immediately in the case of emergency. There was a small couch for patients to sit on next to the ticket machine and another couch on the adjoining wall. A row of 12 seats lined the wall facing reception and there was a 'personal space' gap between each seat.

The reception desk was partially partitioned so that the receptionists sat within individual cubicles, although the patients standing in front of them were not within partitions. There was a screen on the wall behind reception which displayed the ticket number being served and what counter was servicing that ticket. An automated voice called the ticket numbers. There was around one meter between the reception desk and the chairs facing it. Some reception staff lowered the volume of their voice when speaking to patients in what appeared to be an attempt to afford patients some privacy when at reception, particularly when personal matters were being discussed. However, other staff did not make any attempt to lower their voices and patients in the waiting room could hear everything that was being discussed at these times. There were a number of health posters on the walls and a large pamphlet rack which contained health information pamphlets.

For the first USP visit at baseline, none of the posters or pamphlets had anything that either mentioned or depicted Aboriginal and Torres Strait Islander peoples, nor was there any information encouraging self-identification of Indigenous status, or any other visual symbol of welcome. The Practice Manager was aware

that the study had a focus on Indigenous status identification, and prior to the second USP visit she placed a poster and some pamphlets in the waiting room that encouraged self-identification of Indigenous status. At follow-up, the practice had made a conscious effort to make their practice more inviting to Aboriginal and Torres Strait Islander patients and to promote self-identification: the 'Welcome' poster was placed on the front entrance door, an 'Acknowledgement to Country' and 'Are you Aboriginal' sign was displayed on the wall behind the reception desk along with a poster promoting self-identification of Indigenous status, and an 'Are you Aboriginal' sign was also displayed in the waiting room and prominently in every consulting room as a prompt to patients and GPs.

The consultation rooms were a good size and comprised a GP desk, two chairs for patients to sit on, an examination table and some shelves or cupboards. The rooms generally appeared to be tidy. The practice had an ongoing relationship with a local Aboriginal educational organisation and several staff felt that this engagement made the practice more welcoming to the Aboriginal or Torres Strait Islander community.

At baseline most staff felt that the physical environment of the practice was inviting to all patients and one receptionist thought this was in part due to the ticketing machine method employed by the practice: *"Yes I think it's good...Um it's clear, it's clean, it's direct, everyone goes through the same channel of taking a ticket before they approach the front line staff"*, Receptionist 202505. One GP, however, felt that this system of patients taking tickets made the practice uninviting to all patients: *"I think the environment of the practice is um a bit weird frankly to everybody...it's got this uh, I think fairly appalling system of people coming in and taking a number and then waiting to be called like you're in the RTA, um uh and then a security door which is completely pointless um between the reception area and the um consulting areas...so I think that that's sort of a bit unfriendly to everybody really...But no more so to Aboriginal people than to anyone else"*, GP 202102. This GP was aware that Aboriginal and Torres Strait Islander visual symbols of welcome were important factors for improving the physical environment for a practice for Aboriginal and Torres Strait Islander patients and that the practice did not have these: *"I don't know that we've got say, posters in the waiting room saying you know, 'Aboriginal people welcome here' kind of thing because I know those kinds of things are available and I've heard from Aboriginal people that they say that's good to see"*, GP 202102.

Another receptionist felt that the physical environment of the practice could be made more inviting to Aboriginal and Torres Strait Islander patients if it had more signage, but felt that this was not possible because it excluded other ethnicities: *"It's inviting to everyone but maybe they'd feel more comfortable if we had more signage...Maybe if we had something Aboriginal about you know, 'We see,' but we everyone you know that's the thing, we can't write 'We see Aboriginal and Torres Strait Islander people' because we see everyone"*. Receptionist 202501.

6.6.5 Culturally appropriate and targeted care

The Practice Manager had previously done some consultative work at an AMS and she was the only participant that had undertaken any Aboriginal and Torres Strait Islander Cultural Awareness Training at baseline (Table 29). One GP had previously worked in a practice that had substantial numbers of Aboriginal and Torres Strait Islander patients, as well as having worked on Aboriginal and Torres Strait Islander health focused research projects, and he had a good level of knowledge regarding the provision of culturally appropriate care to Aboriginal and Torres Strait Islander patients.

Table 29. Number of staff having undertaken cultural awareness training (Practice 202)

Cultural Awareness Training	Baseline		Follow-up	
	GP (n=2)	Staff (n=8)	GP (n=2)	Staff (n=5)
Last 12 months	0	0	2	5
> 12 months	0	1	0	0

The Practice Manager felt that all staff should undertake Aboriginal and Torres Strait Islander Cultural Awareness Training to ensure that all staff received the same level of training and felt that it should be undertaken annually to ensure that awareness levels did not wane: *"I actually believe it should be annually to ensure that everyone's maintaining best practice and it's ongoing"*, Practice Manager 202301. A nurse who had recently moved from New Zealand was surprised at the lack of Indigenous cultural awareness in Australia: *"...I'm very aware of the Māori cultural requirements, and it's so much more, uh everyone's aware at home, you have to be, and I've been quite amazed since I've lived here that there isn't the awareness...I think New Zealand are well ahead with their, their cultural*

awareness...[It's] such a driven thing in New Zealand. So we're well ahead certainly compared to Australia with it", Practice Nurse 202401.

One GP felt that Aboriginal and Torres Strait Islander Cultural Awareness Training was important for understanding the current health status of Aboriginal and Torres Strait Islanders today. However, he believed that Aboriginal and Torres Strait Islander peoples were disadvantaged in today's society because education was not highly valued in their cultures and this played a part in their health status: "Um, not, without absolving the responsibility that each individual has for their own health and their own wellbeing, but understanding the culture they belong to makes a big difference to what, uh to what they're experiencing now...I mean because east Asian cultures like what I come from have a big advantage, everything from the importance that education plays and that families are willing to sacrifice any amount to ensure that their kids get a good education...[and] that there was always a way out of poverty and uh, well basically the way out of poverty was to get a good job...Whereas I think Aboriginal and Torres Strait Islanders suffer big disadvantage when getting, when making use of the education system to, to I guess improve themselves or achieve a better lifestyle because they don't have that cultural imperative behind them. And I've talked to a few and they've said, "Look I'm at university, but every time I go back they all say 'Why do the white man's job?', "...and in a way trying to pull them down, back to, 'You're forgetting your own background, where you come from'...Some are very driven but others eventually succumb, saying look I'll just go with the flow", GP 202101.

Several staff felt that felt that culturally appropriate care for Aboriginal and Torres Strait Islander patients was treating them the same as any other patient, whilst two receptionists believed that culturally appropriate care meant bulk-billing patients; and one receptionist believed that all Aboriginal and Torres Strait Islander peoples had Health Care Concession Cards which stated their Indigenous status and that Aboriginal and Torres Strait Islander peoples were therefore bulk-billed no matter what practice they attended. This receptionist, however, recognised that culturally appropriate care included treating patients according to need.

One GP felt that many people stereotyped Aboriginal and Torres Strait Islander peoples as having an alcohol problem and therefore felt that to provide cultural

appropriate care he could not address the issue of alcohol until he had had several consultations with the patient and a trusting patient-doctor relationship had been formed: *"I think alcohol's too sensitive uh every time I've brought it up I have to bring it up so gently.... I don't think they need to be smirred, smeared any further than they already are... I find it a very touchy problem with the Aboriginals... Aboriginals in general...because of the general perception that the population perceives that the doctors perceive that they're more likely to have an alcohol problem and it becomes a vicious cycle"*, GP 202101.

Several staff felt that an important factor to providing culturally appropriate care to Aboriginal and Torres Strait Islander patients was the adequate training of staff. One GP felt that the best training for GPs was to provide one-on-one sessions and that the best incentive to get GPs to do that training was to offer CPD points, whilst the other GP mentioned that training should include information specific to the local Aboriginal and Torres Strait Islander populations.

At follow-up, there was a greater awareness that in order to provide targeted care to Aboriginal and Torres Strait Islander patients, patients' Indigenous status needed to be known and visual symbols of welcome and staff attitudes played important roles in creating welcoming practice environments.

At baseline the GPs, nurses and Practice Manager were aware of the Indigenous-specific MBS item numbers. Although they felt this enabled better care to Aboriginal and Torres Strait Islander patients and remunerated doctors for spending extra time with patients, some felt that the item numbers were underutilised due to the laborious nature of the MBS item number system: *"...the item numbers are clunky for everybody you know. Clunky and slow and tedious and require you to be thinking about Medicare item numbers rather than the patient in front of you. Uh so sometimes they seem more a distraction than a help,"* GP 202102. This GP pointed out that the underutilisation of the item numbers in the practice could be as a result of the practice nurses' priorities being focused on acute presentations and not health checks: *"...Yeah we don't make very good use of the um item numbers generally in the practice...because I think we haven't um yet made use of our practice nurses very well in terms of um uh the um various item numbers ... Practice Nurses who might in other practices be helping with Care Plans and uh Health Assessments [here they] don't do that much at all because they're busy doing things like you know acute care stuff and*

uh vac-, immunisations and all those things and they're pretty flat [out] doing that....Yeah we, we haven't got ourselves probably sufficiently organised to really uh look at the, the MBS items and how the nurses could be more involved", GP 202102.

At follow-up the staff were much more aware of the Indigenous-specific MBS item numbers and felt that they aided targeted care. The views of the MBS Item Number system being too time consuming and complex had not changed for the GPs and Practice Manager. One GP felt that having to do a second Care Plan in the year and the additional paperwork required in order for Aboriginal and Torres Strait Islander patients to get an additional five allied health visits was a deterrent: *"No it's, uh I think that we all hate paper work and I think anything that means more paper work which means that the person may not get the extra five because the other doctors not aware of it or it means another lot of forms to be filled out and I think it's a definite deterrent...Very cumbersome. That means you have to do two Care Plans every year", GP 202101.* The other GP still felt that the practice did not have a system in place to properly utilise the item numbers: *"...they're useful that they're there but um the applicability of them you know is dependent on you having ah a system in the practice for making use of those items...and I think as we haven't really got a system for, for making use of the items and we haven't got the practices nurses um involved in an organised way", GP 202102.*

The views of the GPs were reflected by the Practice Manager who noted that the item numbers were rarely billed: *"They don't get used very often", Practice Manager 202301.* This is clearly demonstrated in Table 30 which shows that the number of health assessments being performed had changed very little, although many more Aboriginal or Torres Strait Islander patients had been identified. The Practice Manager suggested that one issue with Care Plans and health assessments was that sometimes patients didn't realise that they had been performed and GPs were disincentivised to do them because they would not be reimbursed for their work if these had already been performed by another GP: *"...because patients don't realise they can present to a practice for a referral or a script and they're not even aware that a Care Plan has been done so it's actually generally at the rejection stage that you find out that [you are] not eligible to actually claim that so then another item number applies which is probably financially [a] huge decrease as well...Well from a GP's perspective, well from my*

perspective is there an incentive? Well it's actually, administratively there's more actually involved in trying to recoup that money", Practice Manager 202301.

Table 30. Consultations and Health Assessments for Aboriginal and Torres Strait Islander patients (past 2 years) (Practice 202)

	Baseline	Follow-up
Aboriginal and Torres Strait Islander Patients	34	79
No of consultations past 2 years	154	378
Aboriginal and Torres Strait Islander Health Check Assessments: (MBS Item 715)	1	3
Other Health Check Assessments: (MBS item numbers 703, 705, 707, 10986, 10987, 81300)	0	0

At baseline, few staff were aware of the Indigenous PBS Co-payment Measure; those that were felt that it aided medication compliance by reducing the barrier of the cost of medication: *"...it's an excellent idea...the idea of providing um uh PBS relief for Aboriginal people in terms of cost because PBS costs are a significant barrier for, for um people to access medicines", GP 202102.* However, the GP felt that the registration system and eligibility criteria was overly complex and felt that this would dissuade both practices and patients alike: *"Well I think it's overly complex. I really do. I think it's very hard to understand how it works and um and all the steps you've got to go through to you know register practice and etcetera, etcetera...I don't know what the figures are like on [the] uptake but it would surprise me if it's, if it's working very well because I think it must be difficult for Aboriginal people to understand, difficult for health providers to understand. I mean I imagine probably Aboriginal Medical Services have got it worked out because they would do it all the time but for, for uh mainstream general practice...I would imagine that many have not really engaged with it. And just trying to understand how it works in terms of the person getting um the um say the free nicotine patches uh the, the language is so complex and um difficult to follow and the different, you know just the number of steps involved is to my mind excessive uh for it to actually work....so I think it's a bit of a dog", GP 202102.* The Practice Manager felt that additional paperwork would dissuade GPs also: *"If the doctors have to fax it though...more paperwork, busy, busy, move on to the next patient and not come back to that", Practice Manager 202301.*

At follow-up most staff were aware of the Indigenous PBS Co-payment Measure and felt that it helped reduce barriers to accessing medication. The Practice

Manager felt that patients were happy to comply with the registration process if it resulted in cheaper medications: "...the patients are actually more than happy to fill out the forms to ensure that that's supplied. No problems whatsoever", Practice Manger 202301. Others felt that the paperwork was still a deterrent but felt that the advantage outweighed this: "I don't know too much about it but I think there's a lot of paper work involved. Um and I think that might slow down um getting more patients involved in that. And I think that um it might discourage the patients to you know actually do all the paper work and as well it might be taking up too much time for the doctors...Um but I know that once they do do it, they've got a good advantage", Practice Nurse 202402.

Although one GP had become more familiar with the system, his views were similar to those he had at baseline in that he still felt it was overly complex, and that Aboriginal and Torres Strait Islander patients might also find it difficult to navigate their way through the process: "Well I think they've changed a bit in that as you get more familiar with it and work through the complex bureaucracy of how it works or the complex administrative aspects of how it works um and you sort of think, yeah I think I sort of understand it, um yeah you can make it work...You know the pharmacist now seems to understand it so it seems to be working better but it took a while...but I still think it must be very difficult for Aboriginal people and Torres Strait Islander people to negotiate their way through because it's so complicated. It's so hard to understand um because there's so many steps you know, the, the practice has got to be registered, the patients got to register with the practices too, there's a form, but in fact the form there's two different sort of aspects to the form, the pharmacist has got to you know, you got to know you got to know the things to write on the scripts. It's just sort of, seems to be designed to be difficult um and ah it is...there must be a lot of Aboriginal people missing out because of the, the difficulty of working out how you can actually get access to that", GP 202102.

The practice was an accredited practice and had been registered for the IHIPIP for about one year at baseline, however, due to the perceived complicated process of registering patients to the IHIPIP and PBS Co-payment Measure, had not yet begun to utilise the program (Table 31). At follow-up, 13 patients (around 16% of the Aboriginal and Torres Strait Islander-identified patients) were enrolled into the PBS Co-payment Measure, and two were enrolled into the Indigenous IHIPIP.

Table 31. Patients enrolled in the IHIPIP and/or Indigenous PBS Co-payment Measure (Practice 202)

	Baseline (Indigenous identified patients n=34)	Follow-up (Indigenous identified patients n=79)
Indigenous Health Incentive only	0	0
PBS Co-payment Measure only	0	13
Both	0	2

One GP felt that the tying the Indigenous PBS Co-Payment Measure to the IHIPIP dissuaded practices to take up the program due to the administrative burden of the PIP: *“Well I think similarly, I think it's just uh going to be too, yet another task and um and I think that many practices won't do it because they just won't think it's, it's just too many, you know another task. You've got to do accreditation stuff and you know ... yet another uh form and process. Again I don't know, I mean maybe the uptake has been better then I think it has been. But um you know the whole PIP thing is a problem because there's multiple PIPs for multiple things and it's a, uh it's a complex process and if practices you know trade off the amount of effort versus the income...So you know again, not a bad idea, but whether from an administrative point of view it's, it's going to reach out as much, broadly as one would hope it would, I doubt [it]”, GP 202102.*

6.6.6 Assessment by the USP

The USP reported that when she rang to make the appointment for the baseline visit with GP 202101 she was put on hold for eight minutes. She reported that the receptionist had difficulty understanding her and that she had to spell her name for the receptionist four times. When she telephoned to make the appointment with GP 202102, the USP reported that the receptionist was polite and informed her that there would be a fee for the consultation.

When the USP presented at the practice for her visit with GP 202101, she reported that the receptionists ignored everyone walking in and out. The USP explained that patients were required to take a ticket. The USP reported that the ticket machine was not immediately visible when entering the practice and it was only when she was standing at the reception desk and being ignored by the receptionists that she glanced at a monitor on the wall and saw a ticket number

being displayed so realised she was supposed to get a ticket and went searching for the machine. She reported that she felt this process was cold and impersonal for a medical practice.

The USP waited 47 minutes to see GP 202101 and spent 18 minutes in the consultation. The USP reported that she felt very comfortable with GP 202101 and felt that he was nice and down to earth. The GP provided her with a printout of the consultation notes so that if she went to another GP she could receive continuing care. To ensure that the USP did not forget the instructions he gave her regarding the change in medications, the GP wrote them down for her and he also provided the USP with his mobile number and offered to make a follow up house call. No referrals to a dietician or lifestyle modification program were made. The GP and staff stated that they did not suspect the USP was the study patient for the visit to GP 202101.

On her visit to see GP 202102, the USP reported seeing a self-identification of Indigenous status poster immediately upon walking into the practice and stated that this put her more at ease, and because she was feeling more comfortable on this occasion, she noticed the design in the carpet and commented it looked similar to Aboriginal dot-work. However, she reported that she was very embarrassed by the receptionist who saw her on this occasion because the receptionist discussed her billing arrangements from where she was seated in the waiting room and other patients were listening to the conversation. The USP felt that the receptionist should have asked her to come over to the desk so that the conversation could be carried out in a more discreet manner.

The USP waited 17 minutes to see GP 201102 and spent 13 minutes in the consultation. The USP reported that GP 201102 was softly spoken and had a nice manner. She reported that he clearly explained what was causing her symptoms and what action she needed to take and informed her to make follow up appointments with the both the nurse and himself. The USP reported that the doctor explained that she had a higher risk of diabetes and other diseases because she was Aboriginal and that she should think about her smoking and the risk of heart attack and stroke. The USP said that she was comfortable with the conversation because the GP brought her lifestyle factors and her risk factors together with her Aboriginality and she felt that this was important health information that she need to know. No referrals to a dietician or lifestyle

modification program were made. Although the staff did not suspect that the USP was the study patient, GP 201102 stated that he did suspect that the USP was the study patient, not because of what she did, but because she was an Aboriginal patient that was older than the usual younger patients which attended the practice, and she had listed her address as being some 30 kilometres away.

For both visits, the USP reported that if given a choice, she would see the doctors again in another venue but would not return to that practice again because patients were treated as numbers at reception and because of how the receptionist embarrassed her.

At follow-up, the USP reported that when she telephoned to make appointment with GP 202101, the receptionist did not state her name and was rushed. The USP reported that the receptionist did not explain things properly to her and she did not understand why she was being asked if she needed a 15 minute or half an hour appointment. The receptionist then asked the USP if she was a new patient and when the USP indicated that she was the receptionist informed her that she needed a half an hour appointment. The USP felt that the receptionist should just have asked upfront if she was a new patient. The USP reported that the receptionist then rushed that she would not be bulk-billed and to, "*Bring your Medicare Card and Eftpos Card*" before hanging up. The USP reported that she was left wondering if she was able to pay cash for the consultation.

The USP reported that when she telephoned to make the appointment with GP202102 the receptionist was rude and impatient and asked her questions about why she wanted to see the doctor which the USP felt was not the receptionists business. When the USP replied that she was seeing the doctor for "*normal medical stuff*", the receptionist sighed and replied, "*I don't know if you need 15 minutes or half an hour*". The receptionist then abruptly provided an appointment time and hung up. The USP reported that she was very uncomfortable after the encounter. The USP then called back to change her appointment time with the same GP and a different receptionist answered the telephone. The USP reported that this receptionist sounded unhappy and like she didn't want to be there and the USP reported that the receptionist made her feel unimportant.

When she arrived for her appointment with GP 202101, the USP reported that she was not aware that there was a ticket machine and was not expecting one in a medical practice, so just walked straight up to reception. She stated that the receptionist ignored her until she said, "*Excuse me*". The USP reported that the receptionist was then helpful and explained that she had to fill in some paperwork. The USP reported that she was moderately comfortable entering the practice except, "*The ticket machine makes me feel like I'm in an RTA*". The USP reported that the 'Welcome' poster, 'Acknowledgement to Country' and other material around the practice asking Aboriginal and Torres Strait Islander patients to self-identify made her feel welcome as a patient and put her at ease. However, she said that she was minimally comfortable in the waiting room because a receptionist was yelling at a patient who had left the practice to come back to sign some paperwork.

The USP waited 33 minutes for her appointment and the consultation lasted 13 minutes. The USP reported that she felt that GP 202101 was nice and seemed liked he wanted to help her, and that he listened to her and explained things simply and clearly and gave her advice. No referrals to a dietician or lifestyle modification program were made. The USP reported that she would return to the practice again because the GP made her feel comfortable.

When the USP arrived for her appointment with GP 202102, she found she had been booked in with a different doctor to and was told by the receptionist that she would need to come back another day because the doctor she wanted to see was booked out and patients with appointments had priority. The USP reported that this made her feel like she was not as important as other patients because she did have an appointment and that reception shouldn't have made her feel that way because it was not her fault that reception had made a mistake with her appointment. The USP reported that if she didn't have to make a new appointment because she was the study patient, then she would not have returned. The USP left and called back later that day to make a new appointment with GP 202102. The USP reported that the receptionist who answered the telephone was very rude and sarcastic with her and that the receptionist "*didn't care that [she] had been booked in with the wrong doctor*" and said that the receptionist "*spoke to [her] like [she] was stupid.*" The USP reported that the receptionist was so rude that she wanted to hang up the telephone and not make the appointment. The USP said, "*This is the third receptionist I've spoken to. I've*

called on two separate days and spoken to three different receptionists, and they have all been really rude. What's wrong with the receptionists at this practice?"

The USP reported that she was not at all comfortable making the appointment on all three occasions. The researcher can confirm that the USP checked with the receptionist on every occasion that she was booked in with the correct GP.

When she arrived for her visit with GP202102, the USP reported that the receptionist she saw was nice and explained what she needed fill out in the new patient paperwork but appeared rushed. The USP waited 27 minutes for her appointment and spent 20 minutes in the consultation. The USP reported that she was very comfortable with the doctor and that he was nice and that he spoke clearly and used plain language so she understood him well. No referrals to a dietician or lifestyle modification program were made. Although the USP said that she would be happy to see the GP again, she reported that if given a choice she would not return to the practice again because the practice was too busy and she felt that the reception staff were rude and impatient and they seemed to have no time for patients. The GP and staff stated that they did not suspect that the USP was the study patient.

6.6.7 Evaluation of the implementation of the intervention

The GP and staff demonstrated positive responses across all four domains of NPT. In terms of coherence, they understood that they needed to change their Indigenous status identification systems and the practice physical environment, as well as gain knowledge and understanding in order to provide appropriately targeted care to Aboriginal and Torres Strait Islander patients.

In terms of cognitive participation, the staff were committed to quality improvement and willingly undertook all training, including the Aboriginal and Torres Strait Islander Cultural Awareness Training and felt that it helped make them aware of why Indigenous status identification was important. In addition, the results of the Practice Feedback Reports and the recommendations provided as part of the intervention were discussed at both the clinical staff and non-clinical staff meetings so that the knowledge gained as part of the intervention was transferred to non-participating staff members.

There was a high level of collective action. At baseline, the practice was relying on patients to self-identify their Indigenous status on a New Patient Registration Form, and there was no system in place to identify the Indigenous status of existing patients; at follow-up, the reception staff were conscious of ensuring that the Indigenous status question was answered and the GPs were making some efforts to ask patients their Indigenous status, although this was not yet usual routine. The practice made considerable changes to their physical environment to help facilitate Indigenous status identification, and displayed Aboriginal artwork, an 'Acknowledgment to Country', and patient information leaflets on Indigenous status identification in the reception and waiting room area, and displayed the 'Are you Aboriginal?' sign at reception and in every consulting room.

In terms of reflexive monitoring, the GPs and some staff saw that more patients were being identified as having Aboriginal and/or Torres Strait Islander backgrounds, which in turn could lead to them receiving more targeted care. The GPs and staff felt that they had gained awareness and felt that the practice's physical environment was more welcoming to Aboriginal and Torres Strait Islander patients as more patients were self-identifying their Indigenous-status.

Although positive responses were obtained across all four domains of the NPT, the impact of intervention was limited by the high number of GPs employed in the practice and the high turnover of reception staff. The full analysis of the implementation of the intervention using the NTP framework is provided in Appendix 14.

6.7 Practice 203

6.7.1 Context

The practice was situated along a shopping strip on a main road through suburban Sydney. The practice comprised two consulting rooms, only one of which was used, the other was used as a back-office.

Organisation of the practice: Practice 203 was a practitioner-owned solo-GP medical practice. At baseline the practice was accredited, but the GP decided that accreditation was too expensive an exercise to continue compared to what it yielded in Practice Incentive and Service Incentive Payments, so the GP did not reaccredit his practice. The practice was a private billing practice but many patients were bulk-billed at the discretion of the GP. The GP worked full time. His wife was the Practice Manager and worked part-time, and two part-time receptionists were also employed. There was no nurse employed. Demographics of participating staff members have been provided in Table 3 (p70).

The practice priorities were set by the GP and quality improvement was a high priority area. Both he and the staff were open and adaptable to change. There were no regular staff meetings, however, if something important needed to be discussed or if there was going to be a large change, a meeting was scheduled and all staff were asked to attend. Being such a small team, information at other times was communicated verbally. The staff were encouraged to have input into decisions regarding the practice and this high decision latitude resulted in the staff appearing content and relaxed in their workplace. The staff appeared comfortable raising any matters with the GP and there appeared to be good team collaboration. The participating GP had an interest in Aboriginal and Torres Strait Islander health, quality improvement, and for knowledge and skill development in general. His keenness to sign up for the study spilt over to the rest of the staff.

6.7.2 Identification of patient's Indigenous status

Patients were not asked to fill out a patient registration form at reception. Instead reception directly asked patients their name, date of birth, contact details and Medicare details and input these directly in the patient medical record. At baseline, only the GP asked patients their Indigenous status. This was not done

systematically and was often done so primarily on appearance. At follow-up, both the reception staff and GPs asked all patients their Indigenous status. The Indigenous status of all patients in the practice from the clinical records audit is shown in Table 32.

Table 32. Indigenous status of patients ≥18 years (Practice 203)

Indigenous status	Baseline (%)	Follow-up (%)
Aboriginal	1.3	0.9
Torres Strait Islander	0	0
Both Aboriginal and Torres Strait Islander	0	0
Neither	0	5.9
Refused / Inadequately stated	-	-
Unidentified	98.7*	93.2*

* Some patients have ethnicity other than Aboriginal and/or Torres Strait Islander recorded but the practice software does not record these patients as being non-Indigenous.

At baseline, there was some consensus between the GP and the practice staff in regards to how Indigenous status was identified for new and existing patients, although one receptionist didn't know how new patients were identified and the GP thought that the reception staff also asked new patients their Indigenous status. At follow-up there was full consensus that both reception and the GP asked all new and existing patients their Indigenous status. At baseline, the GP asked the USP her Indigenous status; at follow-up both reception and the GP asked the USP her Indigenous status. At both time points the USP's Indigenous status was correctly recorded as Aboriginal on the medical record (Table 33).

Table 33. How the USPs Indigenous status was identified and recorded (Practice 203)

	Baseline	Follow-up
USP asked Indigenous status	Yes	Yes
Yes - asked on registration form	N/A	N/A
Yes - asked by reception	No	Yes
Yes - asked by GP	Yes	Yes
Indigenous status question asked according to Best Practice Guidelines	No	No
USP Indigenous status correctly recorded in medical record	Yes	Yes

The staff and GP views regarding the enablers and barriers to Indigenous status identification were varied. At baseline, the Practice Manager felt that a lack of staff awareness and knowledge was important for Indigenous status identification and that a main barrier was that Aboriginal and Torres Strait Islander patients did not self-identify because they feared that they would be discriminated against. One receptionist did not know what factors inhibited Indigenous status identification; the other felt that it was difficult to identify some Aboriginal and Torres Strait Islanders because their skin colour was variable. At follow-up, one receptionist was still unaware of any barriers to Indigenous status identification whilst the other felt patients might not self-identify. However, they and the Practice Manager felt that staff having the confidence to ask the Indigenous status question and having practice environments that promoted self-identification of Indigenous status were enablers. At both baseline and follow-up, the GP felt that practitioners were not comfortable asking patients their Indigenous status because they were concerned that non-Indigenous patients would be offended. The GP felt that patient safety was an enabler and that a visual symbol showing a practice was "*Indigenous-friendly*" might aid self-identification and that reception staff played an important role in the process.

At baseline, only the GP and Practice Manager were aware that the patient's Indigenous status was recorded in the patient medical record; at follow-up all staff were aware.

6.7.3 Assumption of literacy

Patients were not asked to fill in any paperwork at reception and hence the reception staff did not ask patients if they needed help with paperwork. The GP stated that he did ask patients if they needed assistance with paperwork.

6.7.4 Practice environment

The practice was modest and unremarkable. The waiting room area was a good size, with room for 11 patients to be seated. Chairs were lined around two walls and shop-front style window and there was a 'personal space' gap between each chair. There was ample room between the patient seating area and the reception desk, affording patients some privacy when at reception. The reception desk was situated so that patients could see the reception staff as soon as they entered.

On the wall behind the reception desk there were a few health posters including ones on e-health and quit smoking. Next to the reception desk there was a large pamphlet rack which contained health information pamphlets. The walls in the waiting room were bare except for a small painting. There was an array of gossip/entertainment magazines available in the waiting room area and a few patient health information pamphlets were also on a coffee table with the magazines. At baseline there were no posters or pamphlets that either mentioned or depicted Aboriginal and Torres Strait Islander peoples, nor was there any information encouraging self-identification of Indigenous status. Outside the consultation room there was an area cordoned off with a curtain which was used for storage and it appeared to be quite cluttered. The large consultation room comprised a GP desk (which was cluttered with paperwork), two chairs for patients to sit on, an examination table and cupboards. There were also several piles of paperwork scattered around the room.

At baseline the staff felt that the physical environment of the practice was inviting to all patients and the GP stated that he hadn't been informed otherwise: *"To my knowledge yes [the physical environment is inviting] but maybe it's not because we don't know what their needs are, but none of my Aboriginal patients have told me I must change something in my waiting room"*, GP 203101. The GP felt that an open, inclusive practice was the most important environment to have: *"I don't discriminate against any patients whether they're clean, dirty, badly dressed... we try to be non-discriminative against, against all our patients, I think that [is] the most important environment"*, GP 203101. However, he suggested that perhaps some sort of visual symbol or signage might make the physical environment of the practice more inviting to Aboriginal and Torres Strait Islander patients. He suggested that practices could be deemed 'Indigenous friendly' by either an external organisation that was specifically trained to assess practices, or by the local Aboriginal and Torres Strait Islander community themselves: *"Again something in the practice that identifies this practice as being, I'll use the words, user friendly...So, so they must know that here's a practice with a certain logo, so you must earn the logo...because if I welcome them [it] does not mean I am user friendly, but there has been some organ-, outside organisation that has established this is a user friendly practice. And it may mean that every two or three years this practice must be revisited to find out have you still got the same standards and discrim-, non-discriminative practices against health....And also the actual patient's themselves can come together and say...well let us approach*

organisation X that gives the label out and tell them here's another practice that we think that, that, that ought to be used", GP 203101.

The practice was quite willing to improve its physical environment to Aboriginal and Torres Strait Islander patients, and at follow-up displayed the 'Welcome' poster and an 'Acknowledgement to Country' on the front door, and a 'Welcome' poster on the wall behind the reception desk and another in the hallway. Additional health posters with Aboriginal artwork were also displayed on the wall behind the reception desk and in the waiting room. The 'Are you Aboriginal' sign was prominently displayed on the reception counter and in the consultation room in the direct line of site of the patient. Pamphlets encouraging self-identification of Indigenous status were also added to the pamphlet rack.

6.7.5 Culturally appropriate and targeted care

At baseline, only the GP had previously completed any Aboriginal and Torres Strait Islander Cultural Awareness Training; at follow-up all staff had completed training.

The GP's motivation for taking part in this research was because he was trained and worked in an African country where indigenous cultural awareness was a prominent issue in society and Aboriginal and Torres Strait Islander health was also an interest of his. The GP also had an interest in quality improvement and for knowledge and skill development in general. He felt that everyone needed to have Aboriginal and Torres Strait Islander Cultural Awareness Training and that this needed to be on a local level: *"I think we, uh we all need education in that field because as a non-Indigenous person we don't always understand the culture...so there are education that has to take place because we've all got to learn. I think even a person who is an Indigenous born doctor, does he know all the, I don't know, maybe he don't because I think it depends on where they're brought up, on where they lived. They may also have lost some of the cultural aspects of, of their own, uh, uh, group", GP 203101.*

At baseline, one receptionist felt that culturally appropriate care for Aboriginal and Torres Strait Islander patients was treating them the same as any other patient, whereas the other staff and the GP recognised that culturally appropriate care

included treating patients according to need: *"I treat all my patients equal. But I am aware some people are more at risk. I know diabetics are more at risk of getting other diseases, I know depending where the Indigenous person lives, uh, they're different here in Sydney than for example out in the outback, who are in the health industry, even poorer"*, GP 203101. At baseline, the GP and Practice Manager felt that one of the biggest issues regarding the provision of culturally appropriate care to Aboriginal and Torres Strait Islander patients was not knowing the Indigenous status of the patient. At follow-up, most staff felt that staff awareness of culture and what services were available were important in providing appropriately targeted care. The GP also felt that continuity of care was important.

The practice staff were not involved with billing patients and were therefore not well versed on the MBS Item Number system. The GP felt that although many non-Indigenous patients could also benefit from the additional items numbers offered to Aboriginal and Torres Strait Islander patients, the Aboriginal and Torres Strait Islander morbidity and mortality rates were due to colonisation and hence the additional item numbers were warranted for this patient group: *"It's a very good idea but other people that don't belong to those groups sometimes also qualify because there's a lot of other people with other illnesses that may, can benefit from this similar items, but I like the idea that we look after our Indigenous people...Because um unfortunately one of the reasons why their health is so bad is because of western man. It's as simple as that...We are the cause for their ill health"*, GP 203101.

He also felt that the MBS Item Number system was exploited by some practices in order to generate additional income: *"Well if you look at the so called health assessments we do on paper...ah Care Plans, Team Care Plan Arrangements, most doctors do them solely just to, to actually generate money and the Federal Government has actually said we are not getting any increase in the medical rebate according to the CPI because there's other ways to make money for the practice. And ah, so there are some practices that will do these check-ups to actually, because they care about their patients, but I think a large number of them just do it for the sake of the money"*, GP 203101.

Table 34 shows that no Aboriginal and Torres Strait Islander or other health assessments were performed although there were up to 21 patients identified as

Aboriginal and Torres Strait Islander with a total of up to 250 consultations between them.

Table 34. Consultations and Health Assessments for Aboriginal and Torres Strait Islander patients (past 2 years) (Practice 203)

	Baseline	Follow-up
Aboriginal and Torres Strait Islander Patients	21	15
No of consultations past 2 years	250	235
Aboriginal and Torres Strait Islander Health Check Assessments: (MBS Item 715)	0	0
Other Health Check Assessments: (MBS item numbers 703, 705, 707, 10986, 10987, 81300)	0	0

Only the GP was aware of the Indigenous PBS Co-payment Measure available to Aboriginal and Torres Strait Islander patients. At baseline, the GP felt that some patients were confused about eligibility and that the government hadn't informed the population of the scheme or the eligibility requirements, which resulted in GPs bearing the brunt of misinformed patients who were disgruntled about not being eligible. The GP did not realise that he himself did not correctly understand the eligibility requirements, thinking that patients needed to be over 16 years of age and have an established chronic disease for more than six months in order to be eligible for the program.

The GP felt that the Indigenous Health Practice Incentive Payment offered to practices was, *"much too little"* but that the requirement to undertake Aboriginal and Torres Strait Islander Cultural Awareness Training was a good one: *"I can understand that they will force you to update your skills and your knowledge about the difference Indigenous people expect from their GP, specialist or practice staff, fantastic idea"*, GP 203101.

The GP felt that tying the Indigenous PBS Co-Payment Measure to the IHIPIIP disadvantaged Aboriginal and Torres Strait Islander patients and created more barriers to accessing care instead of reducing them: *"I first of all believe that to link, um to force a practice to be accredited to get co-, co-payments for seeing any patient and especially Indigenous patients is wrong. Because for example there is often very good doctors that decide they don't want to accredit anymore because the red tape to accredit is getting more and the money we're getting*

back from the government is getting less and less. It's actually a waste of time to accredit...so they're actually going to punish Indigenous patients who say I like Dr X, he's a marvellous man or woman, he doesn't discriminate against anybody but now he's not accredited...It's nonsense to tell the practice look you've got to accredit to see Indigenous people. If you're not accredited then your Indigenous people can't get Co-payments, they can't get this, they can't get that, you're forcing your patients to go and see an inferior doctor...So, so now you're punishing your patient", GP 203101.

He felt that tying the Indigenous PBS Co-Payment Measure to the IHIPIIP forced doctor-shopping and increased health care cost because services were being duplicated: *"... if you are not an accredited practice you can't receive a CtG prescription at all, it's not allowed and which forces the patient to see me for good medicine and then actually they ask another GP to get their prescriptions. Doctor shopping, and ah it's so I get paid for the service and the patients goes elsewhere to get their prescriptions; two payments for the same thing so it's a big fiasco. So I think the Government has to relook at the whole issue of the PBS prescription for the Indigenous populations", GP 203301.*

The GP believed that all medical practitioners, including specialists should be able to offer the Indigenous PBS Co-payment Measure to Aboriginal and Torres Strait Islander patients, and that patients should receive a unique CtG number so that they could access the Measure anywhere, just like patients with a Health Care Concession Card could receive a reduced-cost prescription at any medical practitioner: *"And why doesn't the same apply to specialists? Why if a patient goes from my practice with a referral letter and goes to the heart specialist and he writes a prescription, must the patient then come back to me and I've got to rewrite the prescription and put the patients CtG number on? What happens if the patient goes to casualty, they get a prescription, must the patient wait until Monday for me to rewrite the prescription? Double cost, waste of money, waste of resources...They [the Australian Government] didn't think if the patient's got a CtG number it should be valid right throughout Australia", GP 203101.*

The GP also felt that the paperwork for the CtG was complicated and cumbersome: *"I think it's too complicated. I believe things, things should be straight forward. A patient walks in, this is my first name, surname, my date of birth, I'm an Indigenous person, tick the box, done... But first I've got to ask them,*

first they've got to sign this form, to me it's, it's nonsense. So indirectly the government doesn't trust me, or do they [not] trust the patient? That's the uh message I, I think most people get, why must you sign all this documentation?", GP 203101.

At baseline, the practice was an accredited practice and was registered for the IHIPIP, however due to the confusion about patient eligibility, Aboriginal and Torres Strait Islander patients were enrolled in both the IHIPIP and the PBS Co-payment Measure (Table 35). The GP decided that reaccreditation was far too costly and decided not to reaccredit his practice. When the GP discovered that his Aboriginal and Torres Strait Islander patients were no longer able to access the Indigenous PBS Co-payment scheme through him and had to see another GP for their prescriptions, he wrote a detailed letter to the researcher dismayed because he felt his Aboriginal and Torres Strait Islander patients were being discriminated against.

Table 35. Patients enrolled in the IHIPIP and/or Indigenous PBS Co-payment Measure (Practice 203)

	Baseline (Indigenous identified patients n=21)	Follow-up
Indigenous Health Incentive only	0	Not applicable
PBS Co-payment Measure only	0	Not applicable
Both	5	Not applicable

6.7.6 Assessment by the USP

The USP reported that when she rang to make the appointment at baseline, the receptionist answered the telephone very politely and gave her name. When the USP arrived for her appointment, she reported that the receptionist made eye contact with her when she walked in but not when she was speaking to her. The USP reported that the receptionist asked for her contact details and Medicare Card details quickly and discreetly and then "*dismissed [her] to sit down.*" The USP felt that the interaction was cold and impersonal. The USP reported that although there were plenty of health information pamphlets, they were not in the immediate waiting room area and patients needed to make a point to go and walk over to them which she felt would not be comfortable if other patients were

watching. The USP stated she would have been more comfortable as a new patient entering the practice, at reception and in the waiting room if she would have seen a visual symbol of welcome or any health-related pamphlets or other information for Aboriginal patients.

The USP waited three minutes for her appointment and the consultation lasted 10 minutes. The USP reported that she was very comfortable with the doctor and felt that he was listening to her and that he spoke to her in a way that she could understand. The USP reported that when she enquired as to why the GP was asking about her Indigenous status he replied, "*Because Aboriginal's get cheaper medication*". When the USP asked the GP about enrolling into the Indigenous PBS Co-payment Measure, she reported that the GP went to the Medicare website and misinformed her that she was not eligible because she had not had an established chronic disease for over six months. Although the USP was very comfortable with the GP, she reported that she would not return to the practice again if given the choice due to the "*cold*" interaction with reception.

At follow-up the USP reported that when she rang to make her appointment she was cut off by the receptionist who said they were not taking any new patients. The USP felt that receptionist didn't even bother trying to help. When the USP called back later a different receptionist answered. This receptionist put the USP on hold whilst she asked the GP if he would see a new patient. The USP felt that this receptionist was trying to help her as a patient. When she arrived for her visit, the USP reported that the receptionist was very nice and helpful and that the 'Welcome' poster, 'Acknowledgement to Country' and signs asking patients to identify their Indigenous status made her feel welcome and put her at ease.

The USP waited 23 minutes for her appointment and the consultation lasted 14 minutes. The USP reported that the GP was nice and she felt that he was listening to her, but that he spoke too fast and she felt rushed and could not understand the GP. Although the USP was happy with the technical quality of care she received, because she felt that there were communication problems with the GP she reported that she would not return to the practice again.

There was little change in the content of the consultation between baseline and follow-up and no referrals to dieticians or lifestyle modifications programs were made. Although a private billing practice, the participating GP happily bulk-billed

some patients, and because the USP was identified as Aboriginal and presented with a Health Care Concession Card, he elected to put her through as a bulk-bill patient at both time points. The billing was subsequently cancelled and the University was charged for the consultations. The GP and staff stated that they did not suspect that the USP was the study patient at either time point.

6.7.7 Evaluation of the implementation of the intervention

The GP and staff demonstrated positive responses across all four domains of NPT. In terms of coherence, they understood that they needed to change their Indigenous status identification systems and the practice physical environment, as well as gain knowledge and understanding in order to provide appropriately targeted care. In terms of cognitive participation, the staff were committed to quality improvement and willingly undertook all training, including the Aboriginal and Torres Strait Islander Cultural Awareness Training and felt that it helped make them aware of why they were identifying patients' Indigenous status and stated that they intended to ask all patients in the future. Collective action was high: at baseline, the practice relied on the GP to identify the Indigenous status of patients; at follow-up, both reception and the GP were working towards making Indigenous status identification part of their usual routines. To facilitate this, the 'Are you Aboriginal' sign was displayed prominently at reception, in the waiting room and in the consultation room; the 'Welcome' poster and 'Acknowledgement to Country' were displayed on the front door and the 'Welcome' poster was also displayed at reception, in the hallway and in the consultation room; a poster promoting Indigenous status identification was displayed at reception and pamphlets were also added to the patient information rack. In terms of reflexive monitoring, the GP saw that more patients were having their Indigenous status recorded, and that this was leading to more targeted care, and the staff felt that they had gained awareness and knowledge. The full analysis of the implementation of the intervention using the NTP framework is provided in Appendix 15.

6.8 Between Cases and Across Cases

6.8.1 Identification of patient's Indigenous status

There was an increase in the number of patients with their Indigenous status identified from baseline to follow-up (Table 36). In addition, each practice also increased the number of Indigenous-identified patients, with the exception of Practice 203 which was no longer seeing some nursing home patients so the overall number of Indigenous-identified patients in that practice dropped.

Table 36. Change between baseline and follow-up: Indigenous status of patients ≥18 years (practices n=7)

Pract ID	Time-point	Indigenous (%)	Non- Indig. (%)	Refused/ Inad. (%)	Unidentified (%)
101	Baseline	0	41	59	0
	Follow-up	0.12	38.9	60.9	0.08
102	Baseline	0	14	0	86
	Follow-up	0.1	56.3	0.1	43.5
103	Baseline	0	0	-	100
	Follow-up	0.1	3.2	-	96.8
104	Baseline	0.10	4	-	96
	Follow-up	0.26	18	-	81.8
201	Baseline	0.11	73.2	-	25.7
	Follow-up	0.15	96.4	-	2.1
202	Baseline	0.2	54.3	-	45.5
	Follow-up	0.5	60.6	-	38.9
203	Baseline	1.3	0	-	98.7*
	Follow-up	0.9#	5.9	-	93.2*

- Practice software does not have refused/Inadequately stated option

* Some patients had an ethnicity other than Aboriginal and/or Torres Strait Islander recorded but the practice software did not record these patients as being non-Indigenous.

Practice was no longer seeing some nursing home patients resulting in the overall number of Indigenous-identified patients in that practice dropping between baseline and follow-up.

There are a number of contributing factors for the increase in the number of patients with their Indigenous status identified. At baseline, most practices were relying solely on patients to self-identify on the New Patient Registration Form (Table 37). At follow-up, although the USP was still not asked her Indigenous status 50% of the time, practices were verbally asking more existing patients their Indigenous status. This is shown in Table 36 as the number of both new and existing patients with their Indigenous status recorded had increased across all practices. At baseline, although nearly all practices had some system in place to

identify the Indigenous status of new patients via their New Patient Registration Form, only two practices (Practice 102 and 201) stated that they were working on updating the Indigenous status of existing patients, and only Practice 102 could demonstrate a definitive system of identifying existing patients to the researcher. Both of these practices were practitioner-owned accredited practices; Practice 102 was a multi-doctor practice (this practice could demonstrate a system for identifying existing patients); Practice 201 was a solo GP practice. The reception staff and practice managers in both practices had not undertaken any Aboriginal and Torres Strait Islander Cultural Awareness Training at baseline, however, the practice managers at both practices were actively engaged in the day-to-day running of the practice and this suggests that Indigenous status identification was as a result of the practice having established systems in place. At follow-up, five of the seven practices were working on updating the Indigenous status of existing patients, further supporting that the Indigenous status identification systems in a practice played an important role in Indigenous status identification.

Table 37. How the USPs Indigenous status was identified and recorded (8 USP visits to 7 practices)

	Baseline	Follow-up
USP asked Indigenous status	7	7
Yes - asked on registration form	6	6
Yes - asked by reception	3	3
Yes - asked by GP	2	2
Indigenous status asked according to Best Practice Guidelines	0*	3
USP Indigenous status correctly recorded in medical record	4	4

* Existing patients only

At baseline, Practice 102 was the only practice that asked their patients the Indigenous status question either verbally or via the patient registration form, according to Best Practice Guidelines (Table 37). This again suggests that following Best Practice Guidelines for the identification of Indigenous status was as a result of the Practice Manager being actively engaged in the day-to-day running of the practice and the practice having established practice systems in place. This is supported by having an additional two practices having asked the Indigenous status question according to Best Practice Guidelines (Table 37) at follow-up.

At baseline, even though she did not answer the Indigenous status question on the registration form and was not verbally asked by reception or the GP, the USP was recorded as non-Indigenous at both Practice 101 and Practice 202 based on physical appearance alone (Table 37). Both of these practices were corporation-owned practices; one was an accredited practice, the other was not. However, Practice 202 had a second GP enrolled in the study and the USP was correctly identified as Indigenous on the medical record. At baseline the staff in both practices had not undertaken any Aboriginal and Torres Strait Islander Cultural Awareness Training and were therefore not aware of why Indigenous status was recorded nor of the need to do this. This suggests that it is individual staff practices and the practice systems in place within a practice that affect Indigenous status identification, not practice accreditation status or practice ownership. The USP was again marked as non-Indigenous in the medical record at one USP follow-up visit at Practice 202. According to the Practice Manager, the receptionist on duty was a new staff member and the Practice Manager had not yet trained her on this aspect of her work.

At baseline, there was some consensus as to whether or not the patient's Indigenous status was recorded in the patient medical record (Table 38), but two GPs from separate practices (GP 101101 and GP 103101) did not know if this information was recorded. Both GPs were from multi-doctor practices. GP 101101 was from a non-accredited corporation-owned practice; GP 103101 was from an accredited, practitioner-owned practice. Neither GP had undertaken any Aboriginal and Torres Strait Islander Cultural Awareness Training. This suggests that it is the individual's level of knowledge and awareness and not the number of GPs, practice ownership or accreditation status that affects whether staff are aware that Indigenous status is recorded in the patient medical record. This is further supported by the observation that at follow-up all participants were aware that Indigenous status was recorded on the medical record.

Table 38. Staff responses as to whether patients' Indigenous status is recorded on the patient medical record

	Baseline		Follow-up	
	GP n=8 (% within GPs)	Staff n=21 (% within staff)	GP n=8 (% within GPs)	Staff n=13 (% within GPs)
Yes	6 (75%)	17 (81%)	8 (100%)	13 (100%)
No	0 (0%)	1 (5%)	0 (0%)	0 (0%)
Don't know	2 (25%)	3 (14%)	0 (0%)	0 (0%)

Most participants demonstrated more knowledge and awareness regarding the barriers and enablers to Indigenous status identification at follow-up compared to baseline (Table 39). At baseline, many practices externalised the problem of Indigenous status identification to the patient stating that they didn't have Aboriginal and Torres Strait Islander patients in their practice, patients were reluctant to identify their Indigenous status, patients did not complete forms correctly, or patients would be offended if asked their Indigenous status, and several participants believed patients Indigenous status could be identified by physical appearance. Very few internalised the issue being due to their own practice routines and systems. At follow-up the focus shifted from being an external one to an internal one, with participants stating that the barriers to Indigenous status identification were due to a lack of staff knowledge and awareness, staff not feeling comfortable asking patients their Indigenous status, staff not asking Indigenous status as part of their normal routines, and practice environments which did not promote self-identification of Indigenous status. The most marked changes were seen in the participants who fully engaged in the intervention and undertook Aboriginal and Torres Strait Islander Cultural Awareness Training.

6.8.2 Assumption of literacy

All practices in this study assumed their patients were literate because their practices were located in urban Sydney. Five of the seven practices used paper-based New Patient Registration Forms. The GPs and staff in the two other practices verified to the researcher that they too assumed all their patients were literate. This did not change after the intervention.

Table 39. Change in staff knowledge regarding the barriers and enablers to Indigenous status identification between baseline and follow-up (practices n=7)

Staff knowledge regarding the barriers and enablers to Indigenous status identification		
Practice	Baseline	Follow-up
101	Participants felt that they did not have any or very few Aboriginal or Torres Strait Islander patients. The GP did not have any knowledge in regards to the barriers and enablers of Indigenous status identification and believed patients could have their Indigenous status identified by physical appearance. Participants that did have knowledge felt that patients were reluctant to identify or that they would be offended if asked their Indigenous status.	At follow-up, the GPs focus on Indigenous status identification was from a practice perspective – he felt that staff confidence in asking the question and knowing the why the question was being asked were important, as were having effective practice systems in place, incorporating Indigenous status identification into normal practice routines and practice environments which promoted Indigenous status identification.
102	The GP felt that the practice did not have any Aboriginal or Torres Strait Islander patients. The GP felt that a barrier to Indigenous status identification was that Aboriginal and Torres Strait Islanders could not be identified by physical appearance and that identification was not at the forefront of her mind in a consultation.	Although the GP felt that awareness was an enabler, she felt that the main barrier to identification was reception staff not asking patients their Indigenous status. She did not see that the clinical staff had a role to play in Indigenous status identification.
103	The GPs and staff felt that they did not have any Aboriginal or Torres Strait Islander patients. They had very little knowledge and awareness regarding the barriers and enablers to Indigenous status identification, and the GP felt that Aboriginal and Torres Strait Islander patients could be reluctant to disclose their Indigenous status.	At follow-up the GP and the staff were much more aware of the barriers and enablers to Indigenous status identification, mentioning a number of issues ranging from patients knowledge on why they are being asked the question, staff being comfortable asking the question, incorporating asking the question into normal practice routines and providing welcoming practice environments that promoted self-identification of Indigenous status.

Staff knowledge regarding the barriers and enablers to Indigenous status identification		
Practice	Baseline	Follow-up
104	<p>The GP felt that patient safety played a role in Indigenous status identification and believed that some people may not want to identify their Indigenous status at reception but would be more willing to do so in a private consultation with a GP, and recognised that practice environments played a role in providing culturally safe environments. She also felt that the Indigenous status identification question should be asked in a standardised way. She was not aware why Indigenous status was recorded. The Operations Manager felt that Practice Accreditation played a role in Indigenous status identification, in that accredited practices were more than likely to identify Indigenous status because of accreditation requirements.</p>	<p>At follow-up, the GP had a much rounder view regarding the barriers and enablers to Indigenous status identification, stating that there were barriers that existed with the GP, the practice environment and as well as with the patient themselves. The Operations Manager felt that the processes at reception were major factors which influenced Indigenous status identification (firstly asking the question, secondly ensuring that patients had completed the Indigenous status question), as well as a need for GPs to also check. He also recognised that welcoming practice environments promoting Indigenous status identification played an important role.</p>
201	<p>There was a general consensus that it was the patient's responsibility to self-identify. The Practice Manager felt that patients were reluctant to do so; the GP recognised that patient safety played an important role, and felt that time was also an issue.</p>	<p>At follow-up, all felt that the barriers to Indigenous-status identification were that patients may not want to self-identify: the GP and receptionist felt this was due to patient safety; the Practice Manager felt that both patient safety and staff comfort asking the question played a role. They all felt that asking patients to self-identify on a form was a non-confrontational method.</p>

Staff knowledge regarding the barriers and enablers to Indigenous status identification		
Practice	Baseline	Follow-up
202	<p>The views regarding the enablers and barriers to Indigenous status identification were quite divergent. Enablers included staff education, cultural awareness training, having adequate time, patient safety and one receptionist felt that physical appearance was an enabler; barriers included patients not self-identifying, staff not prompting patients to complete the section on the registration form if it had not been answered, lack of staff awareness, lack of time and the medical record software program not displaying Indigenous status in a prominent position on the computer screen.</p>	<p>The responses were much more focused towards having effective practice systems in place, having staff awareness of why the Indigenous status question was being asked and staff being comfortable asking the question, and having practice environments that promoted self-identification of Indigenous status, as well as having sufficient time. One GP mentioned that the practice's patients were from diverse ethnic backgrounds, making it difficult to focus on one ethnicity.</p>
203	<p>The views regarding the enablers and barriers to Indigenous status identification were varied. The Practice Manager felt that a lack of staff awareness and knowledge was important for Indigenous status identification and that a main barrier was that Aboriginal and Torres Strait Islander patients did not self-identify because they feared that they would be discriminated against. One receptionist did not know what factors inhibited Indigenous status identification; the other felt that it was difficult to identify some Aboriginal and Torres Strait Islanders because their skin colour was variable. The GP felt that GPs were not comfortable asking patients their Indigenous status because they were concerned that non-Indigenous patients would be offended, and that a visual symbol showing a practice was "<i>Indigenous-friendly</i>" might aid self-identification and that reception staff played an important role in the process.</p>	<p>At follow-up, one receptionist was still unaware of any barriers to Indigenous status identification whilst the other felt patients might not self-identify, whilst the GP felt that non-Indigenous patients might be offended being asked their Indigenous status. All staff, including the GP, felt that having practice environments that promoted self-identification of Indigenous status were enablers and that the 'Are you Aboriginal' sign helped staff confidence in asking the question.</p>

6.8.3 Practice environment

At baseline, Practice 201 displayed a large piece of Aboriginal artwork at reception and the USP found that this visual symbol immediately made her feel more at ease, and made her feel welcome in the practice by giving her a sense of belonging. No practices had any posters, signs or other information that either mentioned or depicted Aboriginal and Torres Strait Islander peoples and the practice environments were found to be uninviting to Aboriginal and Torres Strait Islander patients (Table 40). At follow-up every practice had made at least some improvements. Staff and GPs in some practices were very limited in their capacity to change the physical environments at their work because they felt they did not have input into the decision making (for example Practice 101), which demonstrates that team work and self-efficacy were also important factors in creating welcoming practice environments.

Table 40. Change between baseline and follow-up for visual symbols to encourage self-identification of Indigenous status (practices n=7)

Item	Baseline	Follow-up
Brochures encouraging self-identification	0	7
Signs/posters encouraging self-identification	0	6
Aboriginal artwork/flag	1	6
<i>Acknowledgement to Country</i>	0	3

6.8.4 Culturally appropriate and targeted care

At baseline, there was an overall general lack of Aboriginal and Torres Strait Islander Cultural Awareness Training undertaken across all practices (Table 41); this had increased by 56% (GPs) and 89% (staff) at follow-up. At baseline, participants who had not undertaken any Aboriginal and Torres Strait Islander Cultural Awareness Training previously stated that they did not know what the barriers and enablers to Indigenous status identification were, or they had assumptions which included there were no barriers to Indigenous status identification in general practice, that Aboriginal and Torres Strait Islander patients did not want to identify and/or it was the responsibility of patients to self-identify. The participants who had undertaken some Aboriginal and Torres Strait Islander Cultural Awareness Training believed that the barriers to Indigenous status identification and the provision of culturally appropriate care included a lack of staff training and knowledge, lack of practice systems, and practice

environments that did not promote a safe environment for patients to self-identify. However, knowledge and awareness from Aboriginal and Torres Strait Islander Cultural Awareness Training alone did not result in patients' Indigenous status being identified, demonstrating that these must be combined with effective practice systems and welcoming practice environments. This is supported by the results at follow-up: more participants were aware of the barriers and enablers to Indigenous status identification and the provision of culturally appropriate care, and practice systems and practice environments were improved, which resulted in many more patients having their Indigenous status recorded.

Table 41. Number of staff having undertaken cultural awareness training

Cultural Awareness Training	Baseline		Follow-up	
	GP n=8 (% within GPs)	Staff n=21 (% within staff)	GP n=8 (% within GPs)	Staff n=17 (% within staff)
Last 12 months	1 (12.5%)	0 (0%)	6 (75%)	16 (94%)
> 12 months	2 (25%)	1 (5%)	1 (12.5%)	0 (0%)

Few practices had any engagement with the local Aboriginal and Torres Strait Islander community, or an AMS/ACCHS. Two respondents (GP 201101 and Practice Manager 202301) assumed engagement with the Medicare Local meant that they had engagement with the AMS/ACCHS. GP 102101 stated that there was nothing like direct exposure to Aboriginal and Torres Strait Islander peoples to develop cultural awareness and believed that she was going to gain valuable knowledge and skills from her engagement with a rural AMS. Indeed, the researcher observed a considerable growth in this GP with respect to her knowledge and attitudes in regards to Aboriginal and Torres Strait Islander health since her volunteer placement began. This demonstrates that a greater engagement between a practice, AMS/ACCHS and their local Aboriginal and Torres Strait Islander communities leads to enhanced awareness, knowledge and attitudes of practice staff and the provision of care to Aboriginal and Torres Strait Islander patients.

Few health assessments were undertaken on Aboriginal and Torres Strait Islander patients (Table 42). There was no difference amongst accredited and non-accredited practices, solo or multi-doctor practices, practitioner or corporation-owned practices, or people having undertaken Aboriginal and Torres

Strait Islander Cultural Awareness Training. However, many aspects within a health assessment may be covered over a number of consultations and therefore not billed and/or recorded in the medical record as a specific health assessment item number; hence these figures may not accurately represent the care given to patients.

Table 42. Consultations and Health Assessments* for Aboriginal and Torres Strait Islander patients (past 2 years)

	Total all practices	
	Baseline	Follow-up
Aboriginal and Torres Strait Islander-identified patients	73	131
No of consultations past 2 years	591	795
Aboriginal and Torres Strait Islander Health Check Assessments: (MBS Item 715)	3	10
Other Health Check Assessments: (MBS item numbers 703, 705, 707, 10986, 10987, 81300)	0	0

* The number of health assessments performed has been calculated from the patient medical and/or billing records. Many areas within a health assessment may be covered over a number of consultations and therefore not billed and/or recorded in the medical record as a specific health assessment item number; hence these figures should be viewed with caution.

Several participants (GP 202101, GP 202102, Practice Manager 201301 and Practice Manager 202301) felt that the MBS Item Number system was cumbersome and time consuming. GP 202101 and Practice Manager 201301 felt that it was easier to claim a standard consultation (Item 23) or a Long Consultation (Item 36) than for GPs to look up items numbers.

GP 202102 and Practice Manager 202301 felt that the complexity in registering patients for the IHIPIP and/or Indigenous PBS Co-payment Measure resulted in many practices not engaging in these programs. This can be clearly seen at baseline, where the confusion regarding eligibility criteria and registration of patients into these programs resulted in IHIPIP-registered practices automatically registering patients for both the IHIPIP and the Indigenous PBS Co-payment Measure. It seems highly likely that many practices were confused about their patient's eligibility into these programs and did not enrol patients into the Indigenous PBS Co-payment Measure because the patients were not eligible for the IHIPIP. The number of patients enrolled into the Indigenous PBS Co-payment Measure and the IHIPIP for each practice are shown in Table 43.

Table 43. Patients enrolled in the IHIPIP and/or Indigenous PBS Co-payment Measure

Pract-ice	Baseline				Follow-up			
	No. Indig. Pat.	IHIPIP only	PBS only	Both	No. Indig. Pat	IHIPIP only	PBS only	Both
101	0	N/A	N/A	N/A	3	N/A	N/A	N/A
102	1	N/A	N/A	N/A	4	N/A	N/A	N/A
103	0	N/A	N/A	N/A	3	N/A	N/A	N/A
104	4	N/A	N/A	N/A	12	1*	0*	0*
201	13	0	0	6	15	0	0	5
202	34	0	0	0	79	0	13	2
203	21	0	0	5	15	N/A	N/A	N/A
Total	73	0	0	11	131	1	13	7
%	100	0	0	15	100	0.8	9.9	5.3

N/A Not applicable: Practice was not registered to the IHIPIP and therefore could not enrol patients in the IHIPIP or PBS Co-payment measure

* Practice had been awaiting a visit from the Medicare Local CtG Officer to have the paperwork for enrolling patients in the CtG and PBS Co-payment Measure explained to them. The visit from the Medicare Local was delayed until shortly before the follow-up visit. The practice was still not fully aware how to enrol patients into the scheme after the visit.

6.8.5 Assessment by the USP

The USPs' perceptions of their interactions with the GPs and staff and their experience as a patient in each practice shows that the experience at reception and in the waiting room for Aboriginal and Torres Strait Islander patients is just as important as in the consultation, and their decision of whether or not to return to a GP relies on their more than just the interaction with the GP. If patients have a negative experience at reception or in the waiting room, they may not return to the practice again to see the GP regardless of how happy they are with the GP. Table 44 summarises the USPs perceptions of their interactions and experience as a patient in each practice.

Table 44. Summary of the USPs perceptions of their interactions and experience as a patient in each practice

Practice ID	Baseline	Follow-up
101	<p>USP found receptionist on one visit to be very rude and dismissive and was embarrassed and humiliated because the receptionist asked her personal and confidential information from where she was seated in the waiting room whilst other patients were present. On another visit, a different receptionist was manning the desk and there was chatting amongst the patients the USP found the waiting room had a more welcoming air. USP would have felt more at ease if there was a visual symbol of welcome in the practice. Although the USP was comfortable with the doctor and felt that he was very nice, the USP reported that on the first visit she would not visit the practice again because of the way she was treated by reception.</p>	<p>When the USP telephoned to make the appointment the receptionist was abrupt, rude and arrogant. On the day of the visit, the USP found the receptionist on duty to be very nice, friendly and helpful. The 'Welcome' poster under the reception desk made USP feel welcome and more at ease. USP was comfortable with the doctor and felt that he was very nice. USP stated that she would return to the practice again if given the choice because she had had a positive encounter with both reception and the GP.</p>
102	<p>The USP was so startled by the gruffness of the receptionist when she initially rang to make her appointment that she had to hang up the telephone and call back. USP felt that the receptionist on duty the day of her appointment created a relaxed atmosphere in the practice by laughing and talking with the patients. The USP was moderately comfortable with the GP, and felt that the GP was concerned for her health and explained things so that she could understand them. USP said she would return to the practice again.</p>	<p>After being on hold for nearly 12 minutes to make her appointment, the receptionist took the USP off hold and then kept talking to someone else which made the USP feel like she was not a priority. USP found the receptionist on duty on the day of her visit to be very nice. USP felt that the GP explained things well, was not judgemental, made her feel welcome and comfortable, and made her feel important as a patient because she wasn't rushed and seemed to have time for her. USP said she would return to the practice again.</p>

Practice ID	Baseline	Follow-up
103	<p>USP found the receptionist polite, helpful, fast and thorough when she rang to make her appointment. At her visit, the USP found the reception staff friendly. Receptionists made eye contact with the USP. USP would have felt more at ease if there was a visual symbol of welcome in the practice. USP felt that the GP was thorough and explained things well. USP said that she would return to the practice again because she felt the doctor and reception staff were nice and the doctor was good.</p>	<p>When the USP called to make her appointment, the receptionist made her feel important because the receptionist was not rushing and had time for the USP. The 'Welcome' poster and 'Acknowledge to Country' made USP feel at ease and welcome as a patient. The USP found the reception staff very nice and friendly and said they made her feel important as a patient. GP spoke too quickly for USP to understand. USP felt that the GP was not listening to her because she asked the USP the same questions several times during the consultation. Although the USP found the receptionists and GP very nice, she felt the GP was rushing and didn't really want her there as a patient and just wanted to get the consultation over with and hence stated she would not return to the practice again.</p>
104	<p>USP found the receptionist polite and friendly when she rang to make her appointment. At her visit, USP would have felt more at ease if there was a visual symbol of welcome in the practice. USP felt very comfortable and at ease with the GP. USP felt that the GP explained things well. USP said that she would return to the practice again.</p>	<p>USP found the receptionist very nice and very well-mannered when she rang to make her appointment and made her feel welcome and like she was just as important as any other patient. At her visit, the USP found the receptionist on duty was extremely rude and acted like she didn't want to be there and made the USP feel like she was also not wanted at the practice. The receptionist initially ignored the USP which made her feel "invisible." Receptionist did not look at USP throughout encounter. USP felt the GP was nice and friendly but was rushed. Although the USP would see the doctor again in another venue, she would not return to the practice again because of the receptionist's rudeness and the way the receptionist made her feel like she was not wanted at the practice.</p>

Practice ID	Baseline	Follow-up
201	<p>USP found the receptionist polite and friendly when she rang to make her appointment. At her visit, the USP found the receptionist was very pleasant and approachable and made eye contact. The large Aboriginal painting at reception put the USP at ease when she entered the practice and she felt welcome and had a sense of belonging, but the sign in the waiting room informing patients they were being videoed made her uncomfortable. USP was not at all comfortable during the consultation: she felt that the GP should have been addressing her and not the medical student during the consultation. USP said the GP did not explain things well, used big words and she felt that he was showing off to the student. GP did all the talking. Told USP to buy blood pressure machine and monitor her own blood pressure and come back if she needed to. USP felt GP stereotyped Aboriginals and she was offended at being cast as a rural/remote Aboriginal when she was an urban Aboriginal. She said she would not attend the practice again.</p>	<p>USP found receptionist to be nice and friendly when she rang for the appointment. When she arrived for her appointment, USP found the receptionist very nice and helpful and explained what she needed to fill in on the form. USP was very comfortable with the GP and felt like he wanted her there. GP explained things to her in a way that she could understand and USP felt like the GP was listening to her. USP said that she would return to the practice again because she felt it was a nice environment.</p>
202	<p>Visit 1: USP was on hold for 8 minutes before she could make her appointment. The receptionist had difficulty understanding her. At her visit, USP felt that reception ignore everyone walking in and out. USP explained patients are required to take a ticket and are treated like a number. USP was very comfortable with the GP and felt that he was nice and down to earth. GP provided written instructions for the USP regarding her medication change so that she wouldn't forget the instructions. The doctor had also provided his mobile number and offered to make a house call for follow up. Although the USP would see the GP again, she would not return to the practice because she felt the process at reception was cold and impersonal.</p>	<p>Visit 1: When making the appointment, USP felt that receptionist was rushed and did not explain things properly. USP was initially ignored by the receptionist when she arrived for her appointment, but the receptionist was helpful after the USP gained her attention. Aboriginal visual of welcome made the USP feel welcome and put her at ease. USP was uncomfortable in the waiting room because a receptionist was yelling at a patient who had left the practice to come back. USP felt that the GP was nice and seemed liked he wanted to help her, that he listened to her and explained things simply and clearly and gave her advice. USP said that she would return to the practice again because the doctor made her feel comfortable.</p>

Practice ID	Baseline	Follow-up
	<p>Visit 2: USP found receptionist polite and informative when making the appointment. At her visit, the USP was very embarrassed by the receptionist discussing her billing from where she was seated in the waiting with other patients listening to the conversation. USP found GP to be nice and explained things well and made her feel comfortable. Although USP would see GP again, she would not return to the practice because of how she was treated by reception staff.</p>	<p>Visit 2: When making the appointment, the USP felt that receptionist was rude and impatient and was asking her questions about why she wanted to see the doctor which the USP felt was not the receptionists business. Receptionist ended the phone call abruptly. The USP called back to change her appointment time and a different receptionist answered the telephone. USP felt this receptionist sounded unhappy and like she didn't want to be at work and this made her feel unimportant as a patient. When the USP arrived for her appointment, she was booked in with the wrong GP and told that patients with appointments had priority and that she would need to come back. Because the USP did have an appointment and the practice had made a mistake with her booking, she felt she was not as important as other patients and said if she didn't have to make a new appointment because she was the study patient, then she would not have. When the USP called back to make a new appointment later that day, she found the receptionist to be very rude and sarcastic and said the receptionist spoke to her like she was stupid. The receptionist was so rude that the USP wanted to hang up the telephone and not make the appointment. When arriving for her visit, the USP found that the ticket machine made her feel like she was in a motor registry office. The artwork and other material made her feel at ease and welcome as a patient. The USP found the receptionist on duty to be nice, but rushed. The USP found the GP to be nice; he spoke clearly and used simple plain language. USP said she would see the GP again but not at that practice because she felt that most of the reception staff were rude and impolite and seemed to have no time for patients.</p>

Practice ID	Baseline	Follow-up
203	<p>USP found receptionist very polite when she called to make her appointment. At her visit, receptionist made eye contact with the USP when she walked in but not when speaking to her. The USP felt like she was dealt with in a dismissive way by the receptionist and that the interaction was cold and impersonal. USP would have felt more at ease if there was a visual symbol of welcome in the practice. USP found GP friendly and he explained things to her in a way that she could understand. USP said that she would not return to the practice again due to the "cold" interaction with reception.</p>	<p>When USP rang to make her appointment she was cut off by the receptionist who said they were not taking any new patients. USP felt that the receptionist didn't even bother trying to help. When she called back later a different receptionist answered, put her on hold whilst she asked the GP if he would see a new patient. The USP felt that this receptionist was trying to help her as a patient. At her visit, USP said that all the artwork and other material made her feel welcome and put her at ease. USP found receptionist to be nice and very helpful. USP found GP nice and felt that he was listening to her, but felt that he spoke too fast and she felt rushed and could not understand the GP. USP was happy with the technical quality of care she received but because she felt that there were communication problems she would not return to the practice again.</p>

6.8.6 Evaluation of the implementation of the intervention

As outlined in Section 5.3 in Chapter 5, the Normalisation Process Theory (NPT) is a theory that focuses on processes becoming embedded and sustained (thereby normalised) within practice, and helps to understand why some processes become normalised while others do not. The four domains of NPT are: Coherence (the meaning and sense-making by the participants); Cognitive Participation (the level of participant engagement and commitment); Collective Action (the work done by the participants to enable the practice to happen); and Reflexive Monitoring (the formal and informal appraisal of the utility and effectiveness of the practice). These domains are in a non-linear dynamic relationship with each other as well as the organisational context. May et al propose that in order for an intervention to be effectively implemented all four domains of NPT need to be met.

Table 45 shows that each practice met the NPT domains at different levels. Table 45 also shows that the organisation of the practice (the individual practices and internal factors which may affect performance, such as the characteristics and training of the team members, staff decision-latitude, culture of the organisation, and team collaboration)¹⁵⁷ affected how well the domains of NPT were met.

Coherence was highest in practices where all staff participated in the intervention and where the participants recognised that they needed to change (Practice 203). Not everyone in the practice needed to take part in the intervention for there to be an acceptable level of coherence; this could be achieved by the practice translating the information and knowledge to all its staff members (Practices 103, 202). Cognitive participation was highest in practices where all the staff openly participated in the intervention and were willing to learn, and where staff and GPs saw that they had the self-efficacy to make a difference (Practice 203). Cognitive participation was limited in practices where staff simply went through the motions of attending meetings but were not focused on engaging in the intervention (Practices 102, 201). Not everyone in the practice needed to take part in the intervention for there to be an acceptable level of cognitive participation; this could be achieved by the practice translating the information and knowledge to all its staff members (Practices 103, 202). As expected, the more coherence and cognitive participation within a practice, the higher the collective action (Practice 203). Not everyone in the practice needed to

take part in the intervention for there to be a high level of collective action; practices that functioned well as a team were able to translate the knowledge and skills onto non-participating staff members which resulted in higher levels of collective action across the practice (Practices 103, 202). Reflexive monitoring was highest in practices that fed back the results to all staff members (Practice 103, 203). The follow-up feedback practices received about how many more patients had their Indigenous status identified and how many more had received targeted care, acted as impetus for staff to continue investing time and energy (cognitive participation), to continue asking patients their Indigenous status and providing targeted care (collective action), and increased coherence (Practices 101, 103, 202, 203).

Table 45. Evaluation of the implementation of the intervention across practices (n=7)

Practice 101

Context: Corporate-owned, not accredited. PM covered several practices, seldom present. 2 F/T GPs, 7 P/T reception staff; some got rotated at other practice.

Team Functioning: Staff had no decision latitude → low staff morale; poor team functioning. General apprehension amongst staff whether or not PM would know their individual responses. Quality improvement not a priority area for the PM. PM resistant to change.

<p>Coherence: After participants received the baseline Practice Feedback Report which showed the results of the clinical audit and the USP visit, they understood that in order to improve Indigenous status identification and provide appropriately targeted care they needed to improve their practice systems and environments.</p> <p>There was limited coherence as only two members of the practice received the intervention, and only one (the GP) was allowed to continue in the study as the PM did not allow the reception staff to participate.</p>	<p>Cognitive Participation: Both the receptionist (before she was excluded) and the GP felt that the intervention was a good way of learning about how to provide the best possible care to Aboriginal and Torres Strait Islander patients.</p> <p>Cognitive participation was limited as only two staff members undertook the intervention and knowledge was not transferred to the other staff.</p>	<p>Collective Action: The GP and receptionist made a conscious effort to remember to ask patients their Indigenous status, despite being the only people in the practice to do so, and even though the PM did not allow her to finish the training, the receptionist prompted the USP to complete the Indigenous status question on the Patient Registration Form at the follow-up visit.</p> <p>There was little collective action because only two staff participated in the intervention and knowledge was not transferred to other staff.</p>	<p>Reflexive Monitoring: The GP saw the positive impact the intervention had had on both himself and the receptionist and how this would, in turn, benefit Aboriginal and Torres Strait Islander patients.</p> <p>Reflexive monitoring was limited due to the number of staff that undertook the intervention.</p>
---	--	--	---

Outcomes: Improvements - Indigenous status recording by one receptionist and GP; physical environment within the GPs consultation room, 'Welcome' poster at reception; knowledge, attitudes and beliefs regarding barriers and enablers to Indigenous status identification and the provision of appropriately targeted care.

The impact of the intervention was limited due to the small proportion of staff that participated and the poor team environment which resulted in staff not working co-operatively and knowledge not being transferred to other staff members.

Practice 102

Context: GP owned 2 practices. Both were Accredited. PM covered both practices, Staff: 5 P/T GPs, 1 F/T nurse, 1 P/T PM, 9 P/T reception staff. All staff except the nurse worked across both practices.

Team Functioning: Staff had no decision latitude → low staff morale; poor team functioning. General apprehension amongst reception staff whether or not the PM and Principal would know their responses. Some reception staff openly expressed their dissatisfaction with their lack of decision latitude, and work-load compared to remuneration. PM and Principal open to change particularly if relevant to Practice Accreditation, but PM and staff regarded change as extra work.

Coherence: Although the GP understood that a USP would present at the practice and feedback would be provided on the visit, she developed the impression throughout the study that the main aim of the intervention was to enhance her cultural awareness knowledge, yet she would not undertake the cultural awareness training offered.

No other member of staff would take part in the intervention and hence there was no coherence on a practice level.

Cognitive Participation: Only the participating GP was initially keen to learn of ways to improve her level of knowledge to improve the quality of care offered to Aboriginal and Torres Strait Islander patients. She felt that the receptionists were already identifying patients' Indigenous status and did not recognise that she had to change anything she did.

There was no cognitive participation.

Collective Action: The GP was impatient for most visits and usually enquired how long each session would take and tried to cut the sessions short. She would not undertake any cultural awareness training. The GP believed that the receptionists were effectively checking patient's Indigenous status and would not check this information herself.

There was no collective action.

Reflexive Monitoring: The GP would not recognise that any change in the practice (even physical changes such as signage) was as a result of the intervention, and believed that all her increased knowledge and awareness was due to her volunteer placement at a rural AMS.

The staff had not taken part in the intervention and there was no reflexive monitoring.

Outcomes: Improvements - 'Are you Aboriginal?' sign and Indigenous status identification pamphlets at reception; increased number of patients with Indigenous status identified.

The practice had some well-established Indigenous status identification systems in place, which were driven by Practice Accreditation. Although reception staff checked patients' Indigenous status, they were not aware why the information was being collected. The GPs (excluding the participating GP) were not interested in Aboriginal health and did not check Indigenous status or provide appropriately targeted care. No domains of NPT were met and there was no effect of the intervention at the practice level.

Practice 103

Context: GP owned practice. Accredited. No PM. Staff: 3 F/T and 2 P/T GPs, 2 F/T and 2 P/T reception staff.

Team Functioning: Although only 1 GP enrolled in the study, the Practice Principals were very supportive of her and the reception staff taking part in the study. Staff had high decision latitude → good staff morale and team functioning. Quality improvement was a priority area and the Practice Principals were open to change.

<p>Coherence: Although all members of the practice did not believe that they had any Aboriginal and Torres Strait Islander patients, they believed that the intervention would help them gain knowledge and awareness regarding their Indigenous status recording systems and the provision of care. After they received the baseline Practice Feedback Report, the participants fully understood that they needed to improve their practice systems and environments.</p> <p>Participating GP and receptionists kept the Practice Principals fully informed and there was coherence on a practice level.</p>	<p>Cognitive Participation: The reception staff and participating GP willingly undertook all training, including the cultural awareness training and felt that it helped make them aware of why they were identifying patients' Indigenous status.</p> <p>The Practice Principals did not engage in the intervention at the beginning of the study. After they started seeing the effects of the intervention on the rest of the staff, the Practice Principals actively engaged in identifying patients' Indigenous status and there was cognitive participation at the practice level.</p>	<p>Collective Action: Reception staff were making a conscious effort to ask all patients their Indigenous status, however, the participating GP often forgot to ask patients. Visual symbols of welcome were displayed in the waiting room and reception. The 'Are you Aboriginal' sign was placed prominently in every consulting room (including that of non-participating GPs) as a prompt to patients, resulting in the non-participating GPs being prompted to ask patients their Indigenous status as well.</p> <p>Collective action was high at the practice level.</p>	<p>Reflexive Monitoring: The GPs and reception staff saw that more patients were having their Indigenous status recorded, and that this in turn could lead to more targeted care. The GP and staff also realised that the study was having a flow-on effect to other GPs in the practice and that the Practice Principals were identifying the Indigenous status of patients as well.</p> <p>Reflexive monitoring was high.</p>
--	---	---	--

Outcomes: Improvements - Patient Indigenous status recording by all staff, including those not participating in the study; the physical environment at reception, the waiting room and every consultation room; knowledge, attitudes and beliefs. There was a good working relationship between the reception staff, GPs and Principals, and the knowledge and awareness of those participating in the intervention was transferred to the rest of the GPs to result in a whole of team approach and therefore the intervention was effectively implemented at the practice level.

Practice 104

Context: Corporation owned practice. Accredited. Operations (Ops) Manager covered several practices. Staff: 4 F/T and 2 P/T GPs, 1 F/T nurse, 5 P/T reception staff.

Team Functioning: Staff had some decision latitude. Clinical and non-clinical staff had separate meetings. Ops Manager decided what changes would occur within the practice. Ops Manager was open to change, particularly if it was relevant to quality improvement and/or Accreditation.

<p>Coherence: Both the participating GP and the Ops Manager were keen to implement any change that would ensure patients received appropriately targeted health care. After receiving the baseline Practice Feedback Report, they fully understood that they needed to improve their practice systems and environments. Ops Manager realised the important role reception had to play in identification and creating welcoming environments, however, he would not invite other GPs or reception staff to participate and hence there was limited coherence on a practice level.</p>	<p>Cognitive Participation: The GP and Ops Manager willingly undertook all training, including the cultural awareness training and felt that it would help increase their awareness about effective Indigenous-status identification systems and providing appropriate care.</p> <p>The knowledge was not transferred onto the other staff and therefore only two members of the practice were actively engaged, and only the GP had contact with patients; hence there was limited cognitive participation at the practice level.</p>	<p>Collective Action: The GP consciously made an effort to incorporate Indigenous-status identification into her usual routines and to provide appropriately targeted care, however, did forget at times when time and other constraints placed pressure on her.</p> <p>Although the Ops Manager placed the 'Are you Aboriginal' sign in all consulting rooms as a prompt to patients and the non-participating GPs, he did not transfer the knowledge onto these GPs or the reception staff and there was no collective action on a practice level.</p>	<p>Reflexive Monitoring: The GP and Ops Manager saw that more patients were having their Indigenous status recorded and that more patients were being identified as having Aboriginal and/or Torres Strait Islander backgrounds, which in turn could lead to them receiving more targeted care.</p> <p>However, as no other member in the practice was aware of this, there was no reflexive monitoring on a practice level.</p>
---	---	---	---

Outcomes: Improvements - Patient Indigenous status recording by the participating GP; the physical environment in the waiting room and every consultation room; knowledge, attitudes and beliefs.

The Ops Manager did not invite the other GPs and staff to participate in the study and the information was not transferred to the other members of the practice, hence there was a limited impact of the intervention at the practice level.

Practice 201

Context: Solo-GP practice. Accredited. Wife was F/T PM. 1 P/T reception staff.

Team Functioning: Small team, staff had decision latitude → good staff morale and team functioning. GP was open to change; PM less so.

Coherence: When the receptionist received the baseline Practice Feedback Report, she saw that she was already prompting patients to complete their Indigenous status and felt that she did not need to change anything else. The PM felt that Indigenous status identification was the responsibility of the patient and the GP and therefore did not have a full sense of the purpose of the intervention. Hence there was very little coherence at the practice level.

Cognitive Participation: The GP had previously undertaken cultural awareness training and although he would not take part in the facilitation visits, he did discuss the results of the Practice Feedback Reports with the PM. Although the PM undertook all the training, she felt that Indigenous status identification was the responsibility of the patient and the GP and therefore did not engage in the intervention.

There was very little cognitive participation at the practice level.

Collective Action: The receptionist was already checking patients' Indigenous status and did not need to change her routine. The GP did not check Indigenous status as a matter of course and the PM would not ask patients their Indigenous status and felt that they would self-identify if they wanted to on a registration form. She would not allow the 'Are you Aboriginal' sign to be displayed anywhere within the practice as a prompt to patients. There was very little collective action at the practice level.

Reflexive Monitoring: The receptionist did not need to change any of her usual routines and was therefore unaware of any changes that had taken place as part of the intervention, and the PM would not make any changes to her work. The GP remarked that as a result of the intervention he saw that the Indigenous-status systems in the practice required improving, however, as none of the staff effectively engaged in the intervention, there was no reflexive monitoring at the practice level.

Outcomes: Improvements – Indigenous status recording was high and only 2% of patients did not have their Indigenous status recorded (researcher sceptical as to whether patients were actually being asked the question or whether existing patients had their Indigenous status coded according to staff guess). Welcome poster displayed near entrance. The four domains of NPT were not met at the practice level and therefore there was limited impact of the intervention at the practice level.

Practice 202

Context: Corporation owned practice. Accredited. Staff: 3 F/T and 9 P/T GPs, 2 P/T nurse, 3 F/T and 3 P/T reception staff. 1 F/T PM.

Team Functioning: Staff had some decision latitude. Very busy practice and at times the staff were placed under a great deal of stress but morale appeared good. Good team functioning and good systems in place to ensure information was transferred to all team members. Director and PM were focused on quality improvement and open to change.

Coherence: Once they received baseline Practice Feedback Report participants fully understood that they needed to improve their practice systems and environments and provide targeted care to their Aboriginal and Torres Strait Islander patients.

There were 20 staff employed at the practice, and the number of GPs doubled between baseline and follow-up, and as only two GPs participated in the intervention, coherence was limited at the practice level.

Cognitive Participation: The participating staff willingly undertook all training, including cultural awareness training and felt that it helped make them aware of why Indigenous status identification was important.

The results of the Practice Feedback Reports and the recommendations provided as part of the intervention were discussed at both reception and clinical meetings in order to transfer knowledge to non-participating staff members. Due to the size of the practice and the GP rosters, it did not reach everyone in the practice and cognitive participation was limited at the practice level.

Collective Action: Reception staff were making a conscious effort to ask all patients their Indigenous status; this was more sporadic with the GPs. Visual symbols of welcome and patient information were displayed reception and in the waiting room. The 'Are you Aboriginal' sign was placed in every consulting room (including that of non-participating GPs) as a prompt to patients and GPs that were not participating in the intervention, resulting in the non-participating GPs being prompted to ask patients their Indigenous status as well.

Collective action was high at the practice level.

Reflexive Monitoring: The participating GPs and staff felt that they had gained awareness and skills and felt that the practice's physical environment was more welcoming to Aboriginal and Torres Strait Islander patients, and more patients were self-identifying their Indigenous-status, which in turn could lead to more targeted care.

As it is not known how the non-participating GPs and reception staff viewed the intervention, it can be assumed that there was limited reflexive monitoring at the practice level due to the number of staff and GPs employed versus that that took part in the intervention.

Outcomes: Improvements - Patient Indigenous status recording by all staff, including those not participating in the study; the physical environment at reception, the waiting room and every consultation room; knowledge, attitudes and beliefs; enrolment of patients into Indigenous PBS co-payment scheme and IHIP.

There were good systems in place to ensure transfer of knowledge within the practice and although all four domains of NPT were only partially met for coherence, cognitive participation and reflexive monitoring, there was a high level of collective action.

Practice 203

Context: Solo-GP practice. Withdrew Practice Accreditation due to cost. Wife was P/T PM. 2 P/T reception staff.

Team Functioning: Staff had decision latitude → good team functioning and staff morale. GP was very directed to quality improvement and open to change.

Coherence: After they received the baseline Practice Feedback Report, all staff fully understood that they needed to improve their practice systems and environments and provide targeted care to their Aboriginal and Torres Strait Islander patients.

All members of the practice took part in the intervention and there was full coherence at the practice level.

Cognitive Participation: The staff willingly undertook all training, including the cultural awareness training and felt that it helped make them aware of why they were identifying patients' Indigenous status. The PM and reception staff said they intended to ask all patients their Indigenous status in the future because they felt that they were equipped with the tools to do so. The GP said he would endeavour to make Indigenous status identification routine.

There was full cognitive participation at the practice level.

Collective Action: The staff and participating GP were working towards making Indigenous-status identification part of their usual routines: both the GP and the staff were making a conscious effort to ask all patients their Indigenous status. Visual symbols of welcome and patient information were displayed in the reception and waiting room areas; 'Are you Aboriginal' sign displayed prominently throughout practice.

There was full collective action at the practice level.

Reflexive Monitoring: The GP saw that more patients were having their Indigenous status recorded, and that this was leading to more targeted care. The staff felt that they had gained awareness and knowledge and noticed that more patients were self-identifying their Indigenous status because of the signage and noticed that they were also asking more patients their Indigenous status.

There was reflexive monitoring at a practice level.

Outcomes: Improvements - Patient Indigenous status recording by all reception staff and GPs, including some that were not participating in the study; the physical environment at reception, the waiting room and every consultation room; knowledge, attitudes and beliefs; enrolment of patients into Indigenous PBS co-payment scheme and IHIP.

All staff within the practice fully engaged in the intervention, the intervention was effectively implemented at the practice level.

6.8.7 Summary

At baseline, the Indigenous status of patients was not being adequately or correctly identified in general practice and there was often little agreement amongst the staff within practices as to what systems were in place to identify the Indigenous status of patients. Most practices were relying solely on patients to self-identify on a New Patient Registration Form, and they did not have established systems in place to identify the Indigenous status of existing patients. Only Practice 102 was asking existing patients their Indigenous status according to Best Practice Guidelines at baseline. Many participants believed that they didn't have Aboriginal and Torres Strait Islander patients at their practice, and/or patients were not self-identifying their Indigenous status. Very few participants had had any Aboriginal and Torres Strait Islander Cultural Awareness Training, and few had any knowledge of the barriers and enablers to Indigenous status identification and the provision of appropriately targeted care. However, Aboriginal and Torres Strait Islander Cultural Awareness Training alone did not necessarily result in participants either asking patients their Indigenous status or providing appropriately targeted care, as can be seen by participants GP 104101 and GP 201101, both of whom had had Aboriginal and Torres Strait Islander Cultural Awareness Training at baseline but were not identifying the Indigenous status of their patients.

The aim of the intervention was to provide Aboriginal and Torres Strait Islander Cultural Awareness Training to help increase coherence of why Indigenous status identification and targeted care was important, to combine this with practice environments that promoted self-identification of Indigenous status, and to incorporate Indigenous status identification into the usual practice routines. In order to demonstrate exactly what practices did in regards to Indigenous status identification (as opposed to what they thought they did) and to dispel any misconceptions that it was patients themselves that were not identifying, a clinical record audit showing the number of patients with their Indigenous status identified, and more importantly, with their Indigenous status unidentified, was combined with the results of a USP visit. For most practices the report, when combined with Aboriginal and Torres Strait Islander Cultural Awareness Training, increased their coherence as they saw that a patient had presented to their practice and had not been asked their Indigenous status as opposed to the patient not wanting to self-identify. In the case of Practices 101 and 202, who

recorded the USP as non-Indigenous based on physical appearance alone, it also highlighted that they may have patients incorrectly recorded in their practice database. For Practices 102 and 201, the baseline feedback report demonstrated that their current identification systems were effective on the day. Unfortunately for these two practices, there was a lack of cognitive participation as the Practice Managers took on the view that they were correctly identifying patients Indigenous status and therefore did not need to engage further, and hence there was no or very limited collective action or reflexive monitoring. For Practices 101, 103, 104, 202 and 203, however, it highlighted the importance of Indigenous status identification and the provision of appropriately targeted care to Aboriginal and Torres Strait Islander patients in their practice and the need for change to address it. Cognitive participation was high for most participants as they saw that very little change was required to their working routine in order to effect change. For most, this resulted in a high level of collective action and reflexive monitoring.

The impact of the intervention was limited in practices where the staff had low decision latitude (Practice 101), or by the number of participants within the practice taking part (Practices 101 and 202). Collective action was highest in practices where the staff had decision latitude and thereby felt valued (Practice 103, 202 and 203). Practice 103 and 202 also showed that not all staff needed to personally take part in the intervention for there to be coherence, cognitive participation and collective action, so long as there were effective systems within the practice to translate the information to all staff.

Although there was an increase in the Indigenous status identification rates and improvements to practice physical environments, the assumption of the literacy of patients did not change from baseline to follow-up. Literacy was only highlighted briefly in the intervention and more focus in this area is required to affect change. A number of factors limit the uptake of Aboriginal and Torres Strait Islander Health Assessments, including a lack of GP awareness of their existence, the perceived laborious and tedious nature of the MBS item number system, and issues with recording health assessments in the medical record. More health assessments on Aboriginal and Torres Strait Islander patients could in fact have been performed than were indicated in the medical records, but they were not being recorded in a way that would enable analysis of their uptake or their effectiveness on the long term health outcomes of Aboriginal and Torres Strait Islander patients. The number of patients enrolled in the IHIP and/or

Indigenous PBS Co-payment Measure increased at follow-up which would suggest more targeted care was in fact being offered to patients.

Chapter 7

Discussion and Conclusion

This chapter presents the findings as they relate to the research aim, the research questions and the literature. The strengths and limitations of the study will then be discussed followed by the implications of this research. The chapter ends with a discussion of the overall conclusions drawn from the study.

7.1 Overview

Prior to discussing the results of the study a brief summary of the study will be given first. The overall aim was to test a tailor-made practice facilitation model to improve the acceptability and appropriateness of health care provided to Aboriginal and Torres Strait Islander patients who attend urban mainstream general practice in Sydney. The uniqueness of this study was that Aboriginal unannounced standardised patients (USP) were used. The USPs were recruited from the local Aboriginal and Torres Strait Islander communities in the study areas and were trained to present a standardised patient scenario in general practice. The USPs anonymously attended seven general practices and reported on various aspects of the visits, including their experience in making the appointment, at reception, in the waiting room and various areas covered by the consultation. These data were combined with data from a practice systems audit, a medical records audit and focus groups with members from the local Aboriginal and Torres Strait Islander communities. The results were then fed back to practices via a Practice Feedback Report and practices received training on how to improve their Indigenous status recording systems, the provision of targeted care to Aboriginal and Torres Strait Islander patients, and creating practice environments that were more welcoming to Aboriginal and Torres Strait Islander patients. They were also offered Aboriginal and Torres Strait Islander Cultural Awareness Training. Outcome indicators were measured at baseline and follow-up (at 6-7 months after the intervention). Outcome indicators included: the number of patients with Indigenous status recorded; whether or not the USPs Indigenous status was asked and recorded according to Best Practice Guidelines; knowledge, attitudes and beliefs of GPs and staff regarding the Indigenous status identification methods used in their practice and the provision of appropriately targeted care; whether the practice environment promoted Indigenous status identification; number of health checks offered to Indigenous-identified patients; and for practices enrolled in the Indigenous Health Incentives Practice Incentives Program, the number of eligible patients enrolled in the Indigenous PBS Co-Payment Measure and/or the Indigenous Health Incentives Practice Incentives Program.

Six research questions were asked and these will now be discussed individually.

7.2 Discussion of results in relation to the research questions

7.2.1 RQ1: Is the Indigenous status of patients being identified in general practice?

When recruited into the current study, it was the view of most participants that their practice routinely identified the Indigenous status of their patients. However closer investigation combining data from a patient record audit, practice systems audit and unannounced standardised patient visits, revealed a much different picture. One practice (Practice 103) did not ask any patients their Indigenous status (although the practice had a paper registration form for new patients, they had moved towards a paperless system and new patient information was directly entered into the medical software by the reception staff, who did not ask patients their Indigenous status). Of the remaining six practices, only Practice 102 had a process in place to routinely record the Indigenous status of both new and existing patients, while the remaining practices relied on new patients to identify their Indigenous status on a New Patient Registration Form. Practice 102 was the only practice that asked patients to identify their Indigenous status according to the National Best Practice Guidelines (although this was only on their form for existing patients and the New Patient Registration Form did not ask Indigenous status according to Best Practice Guidelines). When the Aboriginal unannounced standardised patient (USP) presented at each practice, she was asked to self-identify her Indigenous status on a New Patient Registration Form at five practices, but this was only followed up verbally by either reception or the GP at three practices, and the USP was incorrectly recorded as being non-Indigenous in two practices based on physical appearance.

The few studies that have been conducted in Australia regarding Indigenous status identification in general practice have found that few general practices had established processes in place identify the Indigenous status of patients^{35, 36, 38, 50}. The results of this study are very similar to those found those studies as follows. A study on the immunisation needs of Aboriginal and Torres Strait Islander peoples in Queensland in 2003, found only one third of general practices had a routine process in place to check the Indigenous status of their patients³⁶. Of the 21 general practitioners surveyed in that study, seven responded that they asked all patients their Indigenous status (four asked patients to fill in a form, three

asked patients directly). Of the 14 GPs who did not ask all patients their Indigenous status, four practitioners assumed that some patients were Aboriginal and Torres Strait Islander (three on the basis of local knowledge, one on appearance), and five stated that they recorded Indigenous status if the patient self-identified. In a larger national study³⁸, of the 694 GPs that responded about their Indigenous status identification routines, 42% reported that patients were not routinely asked their Indigenous status. Over half (56%) said that they would only ask patients their Indigenous status if they thought the patient was Aboriginal or Torres Strait Islander, 33% reported that they relied on patients to self-identify, and 7% of GPs routinely asked all their patients (note respondents were able to select more than one option).

The difference in the degree of Indigenous status identification between the current study and the two previous studies can be explained by the different methods used in the studies. Data for the two previous studies were collected using self-report surveys. Considering self-report surveys are prone to social desirability bias⁶⁷, one would have expected that a higher number of participants in those studies would have reported that they recorded the Indigenous status of their patients. Indigenous status identification in general practice was first introduced into the general practice industry standards in 2005⁵⁵, hence in 2003-2004 when the previous studies were conducted, Indigenous status identification in general practice was not a priority health issue and the social desirability to collect Indigenous status may have been much lower for practitioners in those studies. Since the release of the *National Best Practice Guidelines For Collecting Indigenous Status In Health Data Sets*⁵⁷ in 2010, there has been a much greater emphasis placed on the importance of Indigenous status identification in general practice. This could explain why all practices in the current study self-reported that they recorded the Indigenous status of their patients. However, this study also triangulated data using various methods. Self-reported responses were checked against patient records, an audit of each practice's systems to identify Indigenous status identification was also conducted, and then USPs tested the actual Indigenous status recording practices within each practice. The triangulation of methods helped to overcome the inherent biases found when using one data source alone^{161, 162}. Each practice was able to clearly see that although they believed that they asked all patients their Indigenous status, the actual process for most practices was quite different.

The findings of the current and previous research are supported by a study in the Australian Capital Territory, where Aboriginal and Torres Strait Islanders peoples who had attended non Aboriginal-controlled general practice were asked about whether or not they had been identified. Six of the 28 people interviewed reported that they had had their Indigenous status identified in general practice (although it is not clear how many of the six were asked their Indigenous status and how many volunteered the information without being prompted either verbally or via a question on a form)⁵¹.

Summary:

- Few practices have a routine process in place to check the Indigenous status of all their patients; those that do tend to rely on new patients self-identifying on a new patient registration form.
- Many practices only ask patients their Indigenous status if they 'appear' to be of Aboriginal and Torres Strait Islander origin.
- Most practices rely on patients to self-identify their Indigenous status.

What this study adds:

- Previous studies have relied on self-reported data or conclusions drawn from medical records. This study supports the findings of previous studies^{35-38, 202} and adds to the literature by demonstrating that patients are not routinely being asked their Indigenous status in many urban general practices.

7.2.2 RQ2: What processes are in place to identify the Indigenous status of patients in general practice?

The lack of Indigenous status identification processes in general practice can be attributed to a number of factors including the level of staff knowledge and awareness regarding Indigenous status identification, practice environments that encourage Indigenous status identification (both of which are discussed Research Question 3 (Section 7.2.3 of this chapter), and how general practice is governed and practice software which will be discussed now. Unlike public hospitals and other government-run health services, the general practice sector is largely under private individual or corporate ownership, and exercises a high degree of autonomy^{203, 204}. Self-regulation is optional, with practices choosing whether or not to become accredited against the industry standards set by the

Royal Australian College of General Practitioners (RACGP)²⁰³. As mentioned in Chapter 1, although recording of Indigenous status is compulsory in the public sector⁵³, it is not mandatory in general practice and general practice processes are guided largely by the RACGP standards.

Regardless of whether general practices decided to be assessed and accredited against the RACGP standards, or whether they used these as guidelines only, the advice given regarding Indigenous status identification has been problematic. As mentioned in Section 1.2.4 in Chapter 1, recording of Indigenous status was first introduced into the *Standards for general practices* (3rd edition)⁵⁵, in July 2005. The document stated:

"The RACGP recognises that improving the health of Aboriginal and Torres Strait Islander peoples is one of Australia's highest health priorities...It is valuable to encourage patients to self identify as Aboriginal or Torres Strait Islander, if appropriate. Some patients may provide this information without being asked, but others may not. It is important not to assume that a person is or is not an Aboriginal or Torres Strait Islander. The nationally accepted question to ask is: 'Are you of Aboriginal or Torres Strait Islander origin?' This exact form of words may not be appropriate in all clinical settings..."⁵⁵(p37).

This left pause for a number of questions. Firstly, when was it "appropriate" to ask patients to self-identify their Aboriginal and Torres Strait Islander status? Secondly, in what circumstances or clinical settings was it not appropriate to ask the nationally accepted question using the wording specified? In addition, stating that "it is valuable to encourage patients to self identify" did not convey the need to gather this information in order to provide appropriately targeted care and in order to accurately measure the health outcomes of Aboriginal and Torres Strait Islander peoples.

In order for practices to measure their compliance against the Standards, indicators were provided. The indicator for Indigenous status identification was that a practice was only required to verbally ascertain, "Our practice can demonstrate that we are working toward recording...self identified cultural background (e.g. Aboriginal and Torres Strait Islander self identification)"⁵⁵(p38). Apart from this somewhat weak assessment method, the wording, "self identified cultural background (e.g. Aboriginal and Torres Strait Islander self identification)"

further downplayed the importance of Indigenous status identification by combining it with cultural background overall.

In 2006 the RACGP released the document, *Fact Sheet: The identification of Aboriginal and Torres Strait Islander people*⁵⁶, which accompanied the 3rd edition Standards and provided more guidance on establishing Indigenous status. It stated:

"The inquiry may be made verbally and recorded by the GP as part of routine medical history taking at first consultation, or by a receptionist or other staff member....Alternatively, the question may be included on a client self-history or practice record form.

The form should use a standard question such as:

Are you Aboriginal or Torres Strait Islander?

- Yes - Aboriginal*
- Yes - Torres Strait Islander*
- Yes – Aboriginal and Torres Strait Islander*
- No.....*⁵⁶(p2).

However, these instructions were still preceded by, *"The nationally accepted question to ask is: 'Are you of Aboriginal or Torres Strait Islander origin?'* This exact form of words may not be appropriate in all clinical settings...⁵⁶", resulting in the instructions on how to ask Indigenous status still remaining unclear.

After the Australian Institute of Health and Welfare released the *National best practice guidelines for collecting Indigenous status in health data sets*⁵⁷ in 2010, the RACGP released a new edition of the Standards, the 4th edition⁵⁴, which aligned the Standards with the National Best Practice Guidelines. In this edition, the importance of collecting Indigenous status was separated from simply collecting other cultural backgrounds:

"E. Our practice can demonstrate that we routinely record Aboriginal and Torres Strait Islander status in our active patient health records.

*F. Our practice can demonstrate that we are working toward recording the other cultural backgrounds of our patients in our active patient health records"*⁵⁴(p40).

In addition, the RACGP released the comprehensive document, *Identification of Aboriginal and Torres Strait Islander people in Australian general practice*⁵⁸ in 2011.

However, updating the Standards and releasing *Identification of Aboriginal and Torres Strait Islander people in Australian general practice* did not resolve the issue surrounding a lack of Indigenous status identification processes in general practice. One reason for this was because of the transition from the 3rd to the 4th edition of the Standards, practices could elect to be guided and/or assessed against either the 3rd or 4th edition of the Standards up until 30 October 2014. In other words, the recommendations in both the 3rd and 4th edition of the Standards were considered current up until 30 October 2014. This is an important point for the current study as the data was collected between 2012 and 2013, and general practices had different guidelines to follow to identify and record Indigenous status.

Having consistent and adequate guidelines to identify the Indigenous status of patients was only part of a larger problem. The ability to record Indigenous status in electronic patient records in general practice software has, and continues to be, a barrier to identification processes^{35, 50}. There are multiple software packages available to handle patient records and no standards have been mandated²⁰⁵. This has resulted in a great variation, with some software packages allowing Indigenous status to be recorded according to the National Best Practice Guidelines, while others do not have an option to record Indigenous status; some packages have a 'refused' option, so staff can ascertain whether or not the patient has been asked the question if their Indigenous status is not indicated in the medical record, whilst others automatically default to recording the patient as non-Indigenous^{35, 37, 50}.

Considering the variation to identify Indigenous status in the industry standards and the ability to record the information, it is no surprise that few general practices had established Indigenous status recording systems in place and that Indigenous status recording in general practice remains low. Other factors including the level of staff knowledge and awareness regarding Indigenous status identification and practice environments also contribute to the lack of Indigenous status identification processes in general practice, and are discussed in the following question.

Summary:

- Recording on Indigenous status is not mandatory in general practices.
- General practice industry standards are set by the RACGP.
- The RACGP Standards for General Practice 3rd Edition did not provide clear instructions for collecting Indigenous status in general practice and did not indicate that Indigenous status was a priority.
- The RACGP Standards for General Practice 4th Edition aligned with the National best practice guidelines for collecting Indigenous status in health data sets.
- The recommendations in both the 3rd and 4th editions of the Standards were considered current up until 30 October 2014.
- Many different medical record software packages are available in general practice, with variable ability to record Indigenous status according to Best Practice Guidelines.

7.2.3 RQ3: What are the different perspectives of providers, staff and Aboriginal and Torres Strait Islander patients in regards to Indigenous status identification?

Provider and Staff views:

Prior to the intervention, the majority of participants in the current study externalised the problem of Indigenous status identification to the patient (see Table 39, p213); few participants internalised the issue being due to their own lack of awareness and lack of practice systems and routines. The findings in the current study concur with those found in previous research as follows.

A recent national study of Indigenous status identification methods in general practice found a common barrier to Indigenous status identification was an assumption that there were no Aboriginal or Torres Strait Islander patients within the practice and that Aboriginal and Torres Strait Islander patients used the Aboriginal Community Controlled Health Services³⁵. These misconceptions, which were based on personal assumption, not data, were also common in the current study. Of the four practices recruited in the South Eastern Medicare Local area, not one participant knew of any existing Aboriginal or Torres Strait Islander patients within their practice, and therefore believed that there were none in their practice, with two GPs stating that theirs was a family practice and therefore not

utilised by Aboriginal and Torres Strait Islander patients. GPs in the three practices recruited in the Eastern Medicare Local area were aware of some existing Aboriginal or Torres Strait Islander patients at their practices. However, there were mixed levels of awareness amongst the practice staff as to whether or not the practices had Aboriginal or Torres Strait Islander patients. This lack of awareness resulted in several participants believing it was not necessary to ask patients their Indigenous status because it was unlikely that they would see an Aboriginal or Torres Strait Islander patient (a view echoed by GPs in studies in the ACT³⁷ and Queensland³⁸) or because patients' Indigenous status could be identified by physical appearance. A belief that patients' Indigenous status can be ascertained on physical appearance has been found in at least two previous studies, with participants stating they only needed to ask the question of people who 'appeared Indigenous'^{35, 36}.

The current study found that some participants were not comfortable asking patients their Indigenous status due to concerns about either offending non-Indigenous patients or because they felt that it was somehow discriminatory to ask patients their Indigenous status. This has also been found in previous research^{35, 37, 38}. This discomfort appeared to be based on a lack of understanding of why the Indigenous status question was being asked and also because staff did not have an adequate response for patients when they queried why they were being asked.

A common finding across the current and previous studies was a view that it was the patients' responsibility to identify their Indigenous status^{35, 36}. Several participants in the current study pointed out that their New Patient Registration Form had a question asking Indigenous status. However, similar to what has been reported elsewhere³⁶, several participants were under the assumption that Aboriginal and Torres Strait Islander peoples were reluctant to identify their ethnicity.

Aboriginal and Torres Strait Islander peoples' views:

Focus groups with members of the local Aboriginal and Torres Strait Islander communities in the study areas revealed that some patients did not know why they were being asked their Indigenous status, and believed that it was for census reasons or somehow linked to their Government support benefits. However, participants in both groups said that they would not be offended being

asked their Indigenous status if it were asked in an appropriate manner and an explanation for why the question was being asked was also provided. Similar views have been presented in the Australian Capital Territory⁵¹ and Queensland³⁶. Although it does not specifically pertain to the general practice setting, a recent national study conducted by the Australian Bureau of Statistics on the perspectives of Aboriginal and Torres Strait Islander peoples regarding Indigenous status identification in data collection contexts²⁰⁶ also supports the findings of the current and previous research.

Summary:

- A range of attitudinal barriers exist in general practice. In order to improve Indigenous status identification in general practice, these must first be addressed. Common misconceptions include:
 - There are no Aboriginal and Torres Strait Islander patients at their practice;
 - Aboriginal and Torres Strait Islander patients are reluctant to self-identify Indigenous status;
 - It is patient's responsibility to identify their Indigenous status;
 - Non-Indigenous patients will be offended if asked their Indigenous status;
 - Ethnicity can be identified by appearance.
- Aboriginal and Torres Strait Islander peoples are happy to be asked their Indigenous status so long as it is done in a discreet and respectful manner, and an adequate explanation is provided for why the question is being asked.

What this study adds:

- This study adds to the current literature to support that misconceptions regarding Indigenous status identification in general practice persist to date. It also provides further evidence that Aboriginal and Torres Strait Islander peoples are happy to be asked their Indigenous status if it is done in an appropriate manner.

7.2.4 RQ4: How feasible and effective is a tailored practice facilitation model in improving *Indigenous status identification* in general practice?

The feasibility of the intervention in general practice:

The current study was feasible in general practice for the following reasons. The use of unannounced standardised patients was acceptable to providers and staff, and increased the face validity of the methods used. The method was acceptable to the local Aboriginal and Torres Strait Islander communities and was affordable.

The majority of the visual resources provided to practices to encourage Indigenous status identification were pre-existing materials that had been freely available for some time; the exceptions to this were the 'Welcome' poster (which was available for purchase for \$25.00 but was provided free-of-charge in the current study), and the notice that all patients are asked their Indigenous status (which was printed by the researcher on an ordinary word processor).

This study also provided in-house Aboriginal and Torres Strait Islander Cultural Awareness Training which was linked in with the practice's current processes and patient records. The Aboriginal and Torres Strait Islander Cultural Awareness Training was based on the material currently offered in the RACGPs online Aboriginal and Torres Strait Islander Cultural Awareness Training, but also incorporated local population statistics and resources. As Medicare Locals receive substantial funding to support general practice, this is a service that the Medicare Locals could offer. When the Medicare Locals are disbanded later in 2014, it is a role that could be taken up by the Primary Health Care Networks which are taking their place.

Pivotal to this study was the use of Aboriginal and Torres Strait Islander unannounced standardised patients. Partnerships between local Aboriginal and Torres Strait Islander community organisations and universities could ensure that Medicare Locals/Primary Health Care Primary Networks could utilise this methodology following the necessary ethical principals underpinning Aboriginal and Torres Strait Islander research.

Effectiveness of the implementation of the intervention:

Described in Chapter 5, the *Normalisation Process Theory* (NPT), "...identifies factors that promote and inhibit the routine incorporation of complex interventions into everyday practice"¹⁹²(p2). According to this theory, the four domains of NPT (coherence, cognitive participation, collective action and reflexive monitoring) must be met in order for an intervention to be effectively implemented. A number of strategies were used in the current study to meet these criteria in order to maximise the implementation of the intervention.

To increase participants coherence, practices received a Practice Feedback Report, which combined the literature, the results of their medical records audit, views of the members of the local Aboriginal and Torres Strait Islander community regarding factors that promoted Indigenous status identification, and the unannounced standardised patient (USP) visit to their practice. The use of multiple sources of information was intentional, as recent reviews have shown that the use of literature²⁰⁷ or audit and feedback²⁰⁸ alone have limited effect, but a positive effect on physician performance has been observed using patient feedback²⁰⁹.

In addition, participants were offered Aboriginal and Torres Strait Islander Cultural Awareness Training. The results of the Practice Feedback Report were linked in with the cultural awareness training wherever possible to help increase meaning to participants. The Practice Feedback Report and cultural awareness training when combined with the tailored practice facilitation, helped increase cognitive participation and collective action by showing practices that they could make a change and equipped them with the necessary tools and knowledge to bring about change. For example, some participants were not comfortable asking patients their Indigenous status because they were concerned about negative reactions from patients or because they would not be able to provide an adequate response if patients queried why they were being asked. To overcome this barrier, practices were provided with a notice to display at reception and in the consultation rooms which stated that they asked all patients their Indigenous status in order to provide the best possible health care. Practices were also offered a range of resources to visually help promote Indigenous status identification in their practices (see Chapter 5 Section 5.2.5).

Although all practices in the current study used a practice software that allowed for Indigenous status to be recorded according to National Best Practice Guidelines, the majority of practices used the *Best Practice* software package which did not have a 'refused' option. To overcome this barrier, practices were trained to elect an ethnicity in the list of 300+ ethnicities available and to use that as the practice's code for refused. This provided practices with a way to work within the restrictions of their practice software.

Seeing positive results in the form of more patients identifying their Indigenous status combined with the follow-up Practice Feedback Report allowed participants to reflect on what they had done (that is, reflexive monitoring), and helped to reinforce their commitment to keep trying to improve Indigenous status recording in their practice.

As discussed in Sections 6.8.6 and 6.8.7 of Chapter 6, the impact of the intervention was limited in some practices and this was primarily due to a lack or low level of coherence and recognition that a problem with Indigenous status identification existed within their practice, lack or low level of engagement of key practice staff in the intervention, and/or poor team functioning within the practice.

Effectiveness of the intervention in improving Indigenous status recording:

The intervention resulted in a noted shift in staff and GP views regarding the barriers to Indigenous status identification. As discussed in Research Question 3 (Section 7.2.3 of this chapter), prior to the intervention the problems associated with Indigenous status identification were externalised to the patient (such as there were no Aboriginal and Torres Strait Islander patients at the practice and patients did not want to self-identify); after the intervention, the problems were associated with internal factors (such as a lack of staff knowledge and awareness, staff not feeling comfortable asking patients their Indigenous status, staff not asking Indigenous status as part of their normal routines, and practice environments which did not promote self-identification of Indigenous status).

Visual resources to encourage Indigenous status identification were incorporated in all practices, albeit at varying levels, and practices all received training on how to embed Indigenous-status recording into their normal routines. As a result, there was an increase in the number of Aboriginal and Torres Strait Islander-identified patients in six of the seven practices, with five practices doubling or

tripling their numbers of Aboriginal and Torres Strait Islander-identified patients. The practice which did not have an increase in the number of Aboriginal and Torres Strait Islander-identified patients (Practice 203) was no longer seeing nursing home patients, and as this represented 28% of their Aboriginal and Torres Strait Islander-identified patients, there was a decrease in the number of Aboriginal and Torres Strait Islander-identified patients at that practice.

As well as an increase in the number of Aboriginal and Torres Strait Islander-identified patients, the intervention resulted in an increase in the overall number of patients with their Indigenous status identified, that is, there was also a noted increase in the number of patients recorded as being non-Indigenous. This resulted in the number of unidentified patients reducing by an average of 16% across all practices (range -0.1 – 42.5%).

Summary:

- The intervention effectively addressed all four domains of the NPT. Variability observed between practices was dependent upon their level of coherence and recognition that a problem with Indigenous status identification existed within their practice, the organisational context of the practice, and their level of engagement in the intervention.
- The use of USPs was acceptable to providers and staff and increased face validity.
- Medicare Locals/Primary Health Care Networks can form partnerships with their local Aboriginal and Torres Strait Islander communities and deliver the intervention as part of their Closing the Gap functions.

What this study adds:

- This study describes
 - A new application in which USPs can be used;
 - An intervention that was found to be effective in increasing Indigenous status identification in general practice, that was acceptable to providers, staff, and the Aboriginal and Torres Strait Islander communities, is affordable and can be feasibly implemented in general practice.
 - This study demonstrates the importance of addressing all domains of NPT and the need to tailor the approach of an intervention to the organisational contexts of the practice as well as their needs.

7.2.5 RQ5: Are Aboriginal and Torres Strait Islander patients being provided with culturally appropriate health care in general practice?

Aboriginal and Torres Strait Islander Health Assessments have progressively been available in the Medicare Schedule Benefits (MBS) for almost 15 years, (for ages 55 years and over since 1999, ages 15-54 years since 2004 and ages 0-14 years since 2006). In 2010, the three separate assessments were merged into the single Aboriginal and Torres Strait Islander Health Assessment (MBS Item number 715)^{25, 26}. Previous research shows that the uptake of these health assessment remains low^{31, 32}, despite research indicating the benefits²⁸⁻³⁰.

The results of the current study also support this. As shown in Table 42 on p218, a review of the patient records showed that at baseline, only three Aboriginal and Torres Strait Islander Health Assessments (MBS Item 715) had been undertaken in the preceding two year period, although there were 73 eligible patients who had attended a total of 591 consultations between them. Aboriginal and Torres Strait Islander Health Assessments should be performed annually and can be undertaken as early as nine months. With 73 eligible patients identified at baseline, a total of 146 Health Assessments could have been performed within the previous two years.

A limitation of previous studies is that their data collection was limited to patient and/or billing records for Aboriginal and Torres Strait Islander Health Assessments. In addition to searching billing data and patient medical records for MBS Item 715, the current study also reviewed the patient records to see if any Aboriginal and Torres Strait Islander-identified patients had any other health assessments recorded, however, none were found.

The results of the current study add to the current literature by demonstrating that the uptake of Aboriginal and Torres Strait Islander Health Assessments remains low to date. This suggests that Aboriginal and Torres Strait Islander patients are not receiving targeted health care according to their needs. However, it is recognised that many aspects within a health assessment may be covered over a number of consultations and are therefore not billed and/or recorded in the medical record as a specific health assessment item number, and conclusions

drawn based solely on health assessment MBS Item Numbers may not accurately represent the care given to patients.

The low uptake of health assessments can be attributed to a number of other factors also. First and foremost, in order to provide targeted care to Aboriginal and Torres Strait Islander patients, their Indigenous status must be known. As demonstrated in Research Questions 1 through 3 (Sections 7.2.1-7.2.3 of this chapter), there were a number of factors that contributed to low Indigenous status identification rates. Included in these are provider and staff attitudes which also play a role in what care is provided to patients. Several participants in the current study believed that the provision of culturally appropriate care was to treat all patients the same. Indeed, some felt that treating patients differently was racist, or that there were many patient groups with high needs and therefore special treatment for Aboriginal and Torres Strait Islander patients was not warranted. These findings have also been reported in other research³⁵. The viewpoint of treating all patients the same was generally expressed by those participants who were not aware of the different health needs of Aboriginal and Torres Strait Islander peoples. Interestingly, several participants who stated that they treated all patients the same said that they treated their patients according to their individual health needs, yet they did not align this concept at a population level to recognise specific health care was required for Aboriginal and Torres Strait Islander peoples based on need.

Practice software was also an issue. Most patient medical records software did not, and to date do not, offer a prompt suggesting that a health assessment be performed. In addition, the health assessment templates offered in some packages are basic templates rather than the comprehensive template available for the Aboriginal and Torres Strait Islander Health Assessment, which pre-populates fields based on data available elsewhere in the patient medical record³⁷.

Another barrier to the uptake of health assessments was that some participants felt that the MBS Item Number system was complicated and laborious. Yet another barrier was a concern about not being remunerated for services rendered because of the current rules regarding health assessment claims. The current MBS Item Number system does not allow for more than one Aboriginal and Torres Strait Islander Health Assessment to be claimed within a nine month

period. Patients may have more than one GP and a GP may perform a health assessment without the patient realising this or remembering it. Hence, if a different GP performs a health assessment, it is not until the claim is rejected that the GP learns that a health assessment has already been claimed within the nine month period. As at June 2014, the MBS fee for an Item 715 was \$208.10²¹⁰, which constitutes a considerable loss of income if rejected.

A GP in this study also highlighted organisational teamwork as a contributing barrier, stating that the nurses in his practice were focussed on acute presentations and were not involved in Health Assessments and Care Plans, which generally targeted older adults as opposed to the younger adults that tended to present at that particular practice. Although all the barriers discussed above are also relevant for non-Indigenous health assessments such as the 45-49 Year-old Health Assessment, the uptake of the Aboriginal and Torres Strait Islander Health Assessment still remains disproportionately low in comparison^{32, 211}. Unless these issues are addressed at the national level, practice-based interventions will have limited effects on the uptake of health assessments.

Another measure of the receipt of appropriately targeted care is the number of patients enrolled into the Governments Closing the Gap Health Initiatives, the IHIPIIP and the Indigenous PBS Co-payment Measure. Currently the only practices that are eligible to enrol patients into these schemes are accredited practices who are also enrolled into the IHIPIIP. Of the 73 Aboriginal and Torres Strait Islander-identified patients at baseline, 68 were patients in practices that were IHIPIIP registered. Of these, 11 (16%) were registered for the Indigenous PBS Co-payment Measure. This further suggests that Aboriginal and Torres Strait Islander patients were not receiving targeted health care according to their needs.

The low numbers of patients enrolled into Closing the Gap Health Initiatives can be attributed to a number of other factors also. Firstly, only accredited practices that are enrolled into the IHIPIIP can enrol patients into the Closing the Gap Health Initiatives, which greatly limits enrolment. As the IHIPIIP is a practice incentive payment, limiting which practices can receive the incentive payment is warranted. However, the Indigenous PBS Co-payment Measure is a financial benefit offered to patients, not practices. Several Aboriginal and Torres Strait Islander focus group participants in the study felt that they were disadvantaged

because their GP was not in an accredited IHIPIP-enrolled practice. They felt that the Government was dictating which GP they could see in order for them to receive the benefit. Patients, GPs and Medicare Local Staff felt that the current restrictions caused doctor-shopping by forcing patients who attended either non-accredited practices or non-IHIPIP enrolled practices, to see a different GP just to prescribe their medications, or forced patients to seek out a new GP for their continued care, even if they had been with the same GP for many years.

Practice 203 clearly demonstrated how the restrictions impacted patients. Like many smaller practices, Practice 203 elected not to become reaccredited due to the increasing cost of accreditation. As a result, they were no longer able to prescribe Indigenous PBS Co-payment Measure scripts to their eligible patients. This forced patients to forfeit the Co-Payment benefit, or to see a second GP for their scripts, or for a small number of patients, to find a new GP.

All stakeholders in the current study agreed that the Indigenous PBS Co-payment Measure was a worthwhile initiative as it reduced the cost barrier of medication for Aboriginal and Torres Strait Islander patients and thereby improved compliance. The current restrictions which only permit accredited IHIPIP-enrolled practices to prescribe Indigenous PBS Co-payment Measure scripts must be addressed in order to allow all eligible patients to benefit from the Co-payment Measure, whilst giving all patients the fundamental right to choose which GP they wish to attend.

Another barrier to patient enrolment into the Closing the Gap Health Initiatives was the paperwork required to enrol patients. GPs are already time poor and any additional paperwork adds to this. In addition, the paperwork is confusing because only one form exists to enrol patients into the PBS Co-payment Measure or the IHIPIP, yet the schemes have different eligibility criteria, and the IHIPIP is a yearly registration whilst the PBS Co-payment Measure is a once-off registration. Therefore, it comes as no surprise that the practices that were IHIPIP registered were confused about patient eligibility and found it difficult to enrol patients into the schemes.

The current study also assessed the number of staff having undertaken Aboriginal and Torres Strait Islander Cultural Awareness Training in the participating practices. Although not a direct indicator of care provided, cultural

awareness training is considered the first step towards cultural sensitivity and cultural safety^{186, 187}. Cultural education has been shown to improve practice, at least in the short term¹⁹⁷. At baseline, only three participants (two GPs and one practice manager) of 31 participants had previously undertaken any Aboriginal and Torres Strait Islander Cultural Awareness Training.

Summary:

- The uptake of the Aboriginal and Torres Strait Islander Health Assessment remains low in general practice.
- Barriers include:
 - Staff/GP misconceptions that all patients must be treated equally;
 - The current MBS billing regulations surrounding health assessments.
- Many general practice medical records software do not provide a prompt to perform a health assessment on Aboriginal and Torres Strait Islander identified patients, and some only have basic templates available for the Aboriginal and Torres Strait Islander Health Assessments.
- Enrolment of patients into the Closing the Gap Health Initiatives is very low.
- Barriers include:
 - GP confusion regarding patient eligibility;
 - Additional paperwork for GPs in an already time poor environment;
 - The restriction that only allows accredited IHPIP-enrolled practices to enrol patients into these schemes.
- Very little Aboriginal and Torres Strait Islander Cultural Awareness Training has been undertaken in general practice.

What this study adds:

- This study adds to the current literature by:
 - Demonstrating that the uptake of Aboriginal and Torres Strait Islander Health Assessments remains low to date;
 - Demonstrating that the uptake of Aboriginal and Torres Strait Islander Cultural Awareness Training is low in general practice, and that a need exists for all staff to undertake the training.
- This study highlights that by only allowing accredited IHPIP-enrolled practices to enrol patients into the Closing the Gap Health Initiatives, particularly the Indigenous PBS Co-payment Measure, the Government has greatly limited the success of the Closing the Gap Health Initiatives. It also demonstrates

how Aboriginal and Torres Strait Islander patients may not necessarily be able to see the GP of their choice if they wish to receive the Indigenous PBS Co-payment Measure.

7.2.6 RQ6: How feasible and effective is a tailored practice facilitation model in improving *the acceptability of health care provided to Aboriginal and Torres Strait Islander patients in general practice?*

The feasibility of the intervention in general practice:

The intervention is feasible in general practice for the reasons discussed in Research Question 4 (Section 7.2.4 of this chapter): because the use of unannounced standardised patients was acceptable to providers, staff and the Aboriginal and the Torres Strait Islander communities, and the method was affordable. In addition, the in-house Aboriginal and Torres Strait Islander Cultural Awareness Training was tied in with the practice's current processes and patient records, a service which could be provided by Medicare Locals/Primary Health Care Networks.

Effectiveness of the implementation of the intervention:

A number of strategies were used to maximise the effectiveness of the implementation of the intervention. The first step required to provide appropriately targeted care to Aboriginal and Torres Strait Islander patients was to know their Indigenous status. As discussed in Research Question 4 (Section 7.2.4 of this chapter), the intervention resulted in an improvement in the Indigenous status identification systems in the participating practices and an increase in the number of Aboriginal and Torres Strait Islander-identified patients. Once patients were identified, they could be offered appropriately targeted care.

To increase participants' coherence, practices received a Practice Feedback Report, which combined the literature, the results of their medical records audit and the unannounced standardised patient (USP) visit to their practice. The results of the Practice Feedback Report were linked in with cultural awareness training wherever possible to help increase meaning to participants.

The Practice Feedback Report and cultural awareness training when combined with the tailored practice facilitation, helped increase cognitive participation and collective action by equipping staff with the necessary tools to bring about change.

All staff received training on the availability of the Aboriginal and Torres Strait Islander Health Assessments and that they were recommended as a yearly check-up. The participating practices all used a practice software that had a pre-loaded template for the Aboriginal and Torres Strait Islander Health Assessment and practices were trained to work within the restrictions of their current practice software. All IHIPIP-registered practices, or practices that had indicated that wanted to become IHIPIP registered, were offered a visit by the Medicare Local to help overcome any confusion associated with the paperwork required to enrol patients into the schemes.

Seeing positive results in the form of the follow-up Practice Feedback Report allowed participants to reflect on what they had done (that is, reflexive monitoring), and helped to reinforce their commitment to keep trying to improve the care they offered to Aboriginal and Torres Strait Islander patients.

As discussed in Sections 6.8.6 and 6.8.7 of Chapter 6, a lack or low level of engagement of key practice staff in the intervention, and/or poor team functioning limited the implementation of the intervention in some practices.

Effectiveness of the intervention in improving the acceptability of health care provided to Aboriginal and Torres Strait Islander patients in general practice:

The intervention increased the acceptability of the care offered to Aboriginal and Torres Strait Islander patients. This is demonstrated at follow-up with the USP finding the practice environments more welcoming which helped her feel at more at ease and welcome as an Aboriginal patient. An important contributor to this was the rate of Aboriginal and Torres Strait Islander Cultural Awareness Training undertaken. After the intervention, nearly all (93%) of participants had undertaken some Aboriginal and Torres Strait Islander Cultural Awareness Training. Previous research has shown that after receiving cultural awareness training, staff were able to provide a more culturally acceptable service³⁵. The USP feedback was tied in with the cultural awareness training in the current study, which helped participants to contextualise the cultural awareness training in real terms.

In addition to providing more culturally appropriate care, the intervention also resulted in an increase in targeted care to Aboriginal and Torres Strait Islander patients. The number of Aboriginal and Torres Strait Islander Health Assessments increased from three (4% of Aboriginal and Torres Strait Islander-identified patients) to 10 (8% of Aboriginal and Torres Strait Islander-identified patients). Although this indicates a two-fold increase at six months from baseline and this number may increase over time, the number of health assessments performed remained significantly low. As discussed in Research Question 5 (Section 7.2.5 of this chapter), a number of barriers with the MBS Item Number system were identified which acted as a deterrent for GPs in performing health assessments and limited the effect of the intervention in increasing the uptake of health assessments.

The number of patients enrolled into the Governments Closing the Gap schemes also increased after the intervention, with the total number of patients enrolled increasing from 11 (15%) to 21 (16%). It should be noted that one practice, Practice 203, was no longer accredited at follow-up and hence could no longer enrol patients into the schemes. If the baseline figures for this practice are excluded from the analysis, the number of patients enrolled into the schemes increased from 12% to 16%. Although these figures indicate only slight increases, the number of patients enrolled in the schemes could increase over time given that these practices have become aware of the patient eligibility criteria and processes for enrolling patients into the schemes. However, as discussed in Research Question 5 (Section 7.2.5 of this chapter), a number of barriers with the Closing the Gap Health Initiatives were identified and limited the effect of the intervention.

As discussed previously, the degree of positive change seen in each practice was dependent upon the level of engagement of key practice staff in the intervention and the level of team functioning (see Sections 6.8.6 and 6.8.7 of Chapter 6). Practices that engaged more and had good team functioning showed more positive results.

Summary:

- As discussed in Research Question 4 (Section 7.2.4 of this chapter), the use of USPs was acceptable to providers and staff and increased face validity. It was also acceptable to the Aboriginal and Torres Strait Islander communities and was affordable. The intervention can be delivered by Medicare Locals/Primary Health Care organisations as part of their Closing the Gap functions.

What this study adds:

- This study described an intervention that was found to be effective in increasing the uptake of Aboriginal and Torres Strait Islander Health Assessments in general practice and increased the number of patients enrolled into the Indigenous PBS Co-payment Measure and the IHIPIP.

7.3 Strengths and limitations

There are a number of strengths and limitations to this research. These can be broadly grouped as research design, sampling, methods and analysis. Each are discussed below.

7.3.1 Research design

As discussed in the Chapter 3, case studies are designed to bring out the details from the participant's viewpoint by using multiple sources of data, allowing the researcher to gain an in-depth understanding of peoples perspectives of issues or processes, and is an ideal methodology when a holistic, in-depth investigation is required¹²⁵. A strength of this study was that a collective case study design was used. This allowed the researcher to understand the different perspectives of general practitioners and their staff, and those of Aboriginal and Torres Strait Islander patients in relation to the appropriateness and acceptability of the care provided to Aboriginal and Torres Strait Islander patients in general practice and to assess the impact of a tailored intervention to improve these. The use of multiple cases allowed the researcher to make comparisons both within practices and across practices. However the qualitative nature of this study limits the validity of the quantitative estimates of implementation and impact.

The theoretical basis for this study drew on accepted models of the determinants of professional behaviour and an accepted theory for assessing the implementation of complex interventions, both which contribute to the overall strength of the research.

7.3.2 Sampling

This study was conducted in seven general practices in two urban Medicare Local areas in Sydney and thus caution is required when transferring results to other areas. The general practice participants were volunteers and are therefore likely to represent general practices with a particular interest in Aboriginal and Torres Strait Islander health. However, the characteristics of providers are broadly similar to those in general practice in Australia²⁰⁵. In addition, the individual practice results at baseline indicated a lack of knowledge, awareness and practice systems, consistent with the findings of previous research^{35-38, 51}, indicating that the sample was not positively biased.

The focus groups with the Aboriginal and Torres Strait Islander communities were conducted with women only. The communities communicated to the researcher that discussions surrounding attending general practice were separate 'women's' and 'men's business'. As a female researcher, it would have been deemed inappropriate to conduct the focus groups with both male and females present, or for the researcher to conduct focus groups with male participants. Having same sex participants may have allowed for more free and open conversation among the participants^{145, 150}, increasing the likelihood that all relevant information was obtained in the focus groups. However, it is possible that men may have identified others factors as being important to them which women did not. Limited funding did not permit the addition of a male researcher to conduct focus groups with men.

7.3.3 Methods

Interviews as a source of data are limited by social desirability bias⁶⁷ and it is possible that the responses obtained in the individual interviews were biased. However, as mentioned above, the baseline findings indicated a lack of knowledge, awareness and practice systems, and these findings have been

found in other research. Similarly, the results obtained in the follow-up interviews were consistent with a previous study in Australia where an increase in staff awareness and motivation to change was observed after receiving some cultural awareness training³⁵. Additionally, the data from the interviews was triangulated with data from multiple sources (audit, observation, surveys and USP visits), which helped overcome any social desirability biases.

Although the USP methodology has not previously been used to assess the acceptability of primary care to indigenous patients, it has been effective to assess the acceptability of care to other patient populations^{212, 213}.

The unannounced standardised patient (USP) visits were carried out by a single USP visit to each practice at either time point. Hence the personal assessments of the level of service provided to the USP are individual views and may reflect the mood of the USP on the day. Similarly, the service provided by the GPs and staff on the day of the USP visit may reflect their actions on a particular day and not in general. The use of USPs can be strengthened by using multiple USPs over a number of visits to each practice to reduce the likelihood of biased assessments¹⁰⁷. Multiple USP assessments were not possible in this study due to limited funding. The USPs used were female and their views on the acceptability of health care could differ from male patients, and the use of both male and female USPs may have strengthened the study.

Another source of potential bias in this study was the effect of the researcher¹⁶¹. The researcher collected the data, delivered the intervention and performed the analysis. The potential for bias was reduced by the various rigour methods employed to increase the trustworthiness of the research (see Section 7.3.5 further below).

7.3.4 Analysis

As mentioned in Chapter 3, epistemology informs the theoretical perspective, which in turn governs the methodology and informs what methods will be used¹¹³. Hence constructionism and interpretivism have implications for what claims can be made regarding the results. Data analysis is a form of interpretive constructionism and the interpretations constructed from the data by the

researcher could differ from that collected by other researchers, but neither reality is more 'true'. The researcher was transparent in her role in reporting both what was done and what interpretations were drawn from this. A number of strategies were employed to increase the rigour of the analysis and these are discussed below in the Rigour section.

7.3.5 Rigour

A strength of this study is the rigour applied to both the research methods and analysis. Lincoln and Guba provide four main assessment criteria (credibility, transferability, dependability and confirmability) to increase trustworthiness in qualitative research¹⁶¹

7.3.5.1 Credibility

Credibility is one of the most important factors of trustworthiness. Member checks, prolonged engagement, persistent observation, triangulation of data and deviant case analysis were used to increase credibility in this research and are outlined below.

Member checks – are considered to be “*the single most critical technique for establishing credibility*”¹⁶¹(p239). The focus group interviews and the Medicare Local interviews were taken back to the participants who were asked to confirm and evaluate the researcher’s interpretations or provide alternative interpretations. Member checks were not performed on the interviews for GPs, nurses and practice staff as the researcher was aware of the amount of time these participants were providing throughout the data collection stages and during the intervention. In addition, the researcher did not want to influence their actions or involvement in the study by providing them with an evaluation of their knowledge, attitudes and beliefs.

Prolonged engagement – The researcher collected data over two time points over a year and remained engaged with the practices between the two time points by providing feedback and training. The researcher was engaged long enough to build rapport and trust which aided understanding and co-construction of meaning between the researcher and the respondents¹⁶¹.

Persistent observation – This study used unannounced standardised patients as an alternative to prolonged observation. Because participants did not know they were being assessed, they were more likely to act in their usual manner⁶⁴.

Triangulation – Source, data collection and researcher triangulation methods were used to increase the credibility of the methods and findings in this research.

Source triangulation: a number of data sources were used in this study (literature, Aboriginal and Torres Strait Islander community members, GPs/staff, Medicare Local staff and USPs). This minimised biases and inadequacies in data, and provided a more comprehensive insight into the phenomena under investigation^{161, 162}.

Data collection triangulation: Multiple data collection methods (literature, focus groups, interviews, surveys, audits and USPs) were employed during this research to overcome the inherent biases from using any one method alone, to develop converging lines of inquiry, and to strengthen the research findings^{161, 162}.

Researcher triangulation: Researcher triangulation was used to review the initial coding frame for the qualitative interview data analysis. The researcher first coded a selection of interviews and created a base code frame. The coding of these interviews was then collaboratively reviewed together with the primary supervisor and a co-supervisor, who cross referenced the coding. This ensured that the data was viewed from different perspectives and reduced the likelihood that the data analysis was biased by individual interpretation^{161, 162}. The evolving conceptual framework was also reviewed with the primary supervisor and a co-supervisor.

Negative or Deviant Case Analysis – Two practices, Practices 201 and 102 were considered deviant cases. The GP in Practice 201 had previously undertaken Aboriginal and Torres Strait Islander Cultural Awareness Training prior to taking part in the study, and was knowledgeable about the health care needs of Aboriginal and Torres Strait Islander patients. The USP found the physical environment of the practice was welcoming. The USP was identified at baseline although the Practice Manager did not believe in the need to identify the Indigenous status of patients and felt that it was up to the patient to self-identify, and the USP felt that the consultation was highly inappropriate. Although Practice

102 had highly effective Indigenous status identification systems in place, the intervention was not effective in increasing staff awareness of why Indigenous status was required, their effect on providing welcoming environments, and the provision of culturally appropriate and targeted care. Exploring these two cases confirmed the patterns that emerged from the data analysis and helped provide a broader explanation for the majority of cases^{161, 162}.

7.3.5.2 Transferability

This can be enhanced by providing sufficient description and context as well as the implicitly stating the assumptions that underpinned the research¹⁶¹. This was achieved in this research through transparent, detailed reporting of the theoretical perspectives, the research design, methodology, methods and results. The epistemological position and theoretical perspective that informed this study were explicitly stated; a detailed description of the data collection and analysis methods was provided; findings were embedded in a rich descriptive context that included participant quotes to enable the reader to see how themes emerged and interpretations were formed; and a rich description of each case embedded within its contextual setting was provided.

7.3.5.3 Dependability

This is analogous to reliability and relates to the extent that the findings can be replicated in similar situations with similar subjects. Because human behaviour is fluid and continually changing, the focus of dependability in qualitative research is determined by whether the results are sensible and consistent with the data collected¹⁶³. To achieve dependability, the researcher kept a journal of all encounters she had with participants, developed a conceptual framework of the evolving thematic analysis, triangulated data, and provided a detailed account of the data collection and analysis methods employed and the theory underlining these.

7.3.5.4 Confirmability

Confirmability refers to the degree to which the results could be confirmed or corroborated by others. Methods to achieve this include external audits, triangulation and reflexivity¹⁶¹, and the latter two were used in this research. Data triangulation has been detailed above. Reflexivity is demonstrated in this research by the use of multiple investigators to develop complementary or

divergent interpretations and by making explicit the researcher's perspectives throughout the research¹⁶¹. The researcher provided a thorough report of her theoretical perspectives and was transparent in how these influenced the research design, methodology, methods and interpretation of findings.

7.4 Implications of this research

There has been debate about the different models of health care available for Aboriginal and Torres Strait Islander patients (see page 28). This thesis does not address this issue.

Effective Indigenous status identification systems are important at both the practice level and at the national level. At the practice level, practitioners must know the Indigenous status of their patients in order to offer targeted services to their Aboriginal and Torres Strait Islander patients and to monitor the quality of care provided to those patients³¹. On a national level, accurate and complete data sets are required to develop and monitor health initiatives and to reduce health inequality. This study has shown that it is possible to improve Indigenous status identification and the provision of care provided to Aboriginal and Torres Strait Islander patients in general practice. A key factor in the uptake of the intervention and a commitment to change by practitioners and staff was that the USPs were from the local Aboriginal and Torres Strait Islander communities, which provided strong face validity. This has important implications for the need to engage the local Aboriginal and Torres Strait Islander communities in continuous quality improvement activities in general practice, as well as implications for policy and research.

A number of factors need to be considered to improve Indigenous status identification in general practice. As discussed earlier in this chapter, although recording of Indigenous status is not mandatory in general practice, it is in public hospitals⁵³. In 2011-12 an estimated 88% of Aboriginal and Torres Strait Islander patients were correctly identified in Australian public hospital admission records²¹⁴, and mandating Indigenous status identification could have played a role in the high rates of Indigenous status identification in public hospitals. However, as general practice is primarily under private and corporate ownership,

mandating Indigenous status recording in general practice is not a simple process and is not necessarily the sole solution. In order to improve Indigenous status identification in general practice a number of factors need to be addressed, including strengthening the requirements to identify Indigenous status and strengthening the systems to record Indigenous status. In addition, this study has shown that strengthening the understanding of why Indigenous status is recorded and seeing that it will make a difference are fundamental to improving Indigenous status identification. These will each be discussed individually before discussing the other implications of this research.

Practice Software: As discussed in the Research Question 2 (Section 7.2.2 of this Chapter), not all practice software allows for the recording of Indigenous status according to Best Practice Guidelines, and many of those that can, do not have a 'refused' option. In order for all general practices to identify and record Indigenous status, this function must be available and this requires active engagement from the software providers. Changes to practice software are often dictated by market pressure. Given that Aboriginal and Torres Strait Islander peoples constitute a small percentage of the patient population in many practices, it is not surprising that there has been insufficient market pressure to change practice software regarding Indigenous status identification. One way market pressure has been applied previously in an area other than Indigenous status identification is by offering practices a Practice Incentive Payment (PIP). The PIP that was provided to support general practice move to computerised prescribing software was associated with a rise in computer use from 15% to 70% between 1997 and 2000^{215, 216}. Offering a PIP for Indigenous status recording could increase Indigenous status recording. However, as PIP enrolment is voluntary, if practices do not understand the importance of identifying Indigenous status, the effect could be greatly limited.

Another way sufficient market pressure has been applied on software providers has been when Government has changed policy, which resulted in software providers having to ensure their software was compliant. For example, the Government (via the National E-health Transition Authority) set a requirement that in order to receive the PIP eHealth Incentive, practices need to ensure that their software systems were compliant with the Governmental eHealth regulations, and that their software vendor was registered as being complaint with those regulations²¹⁷.

Attitudinal Barriers: The research in this thesis showed that attitudinal barriers continue to contribute to low Indigenous status identification rates and the provision of care to Aboriginal and Torres Strait Islander patients in general practice. If practices believe that they don't have any Aboriginal and Torres Strait Islander patients and if they don't understand why Indigenous status is being recorded, it would be counterproductive to mandate Indigenous status recording. A way to help shift these barriers is for all staff to undertake Aboriginal and Torres Strait Islander Cultural Awareness Training³⁵. Although this has been mandated in the public sector²¹⁸, as mentioned earlier, general practice is largely owned by the private sector and mandating that all staff undertake cultural awareness training may not be possible or feasible in this setting. However, the RACGP currently offers a free online Aboriginal and Torres Strait Islander Cultural Awareness Training module to its members and this service could be expanded to cover all staff working within a practice. In order to ensure the training is locally adapted, the RACGP could have different modules for different regions. However, this would be a huge undertaking and it would be more realistic for Medicare Locals/Primary Health Care Networks to engage with their local Aboriginal and Torres Strait Islander communities and deliver localised cultural awareness training. This could be done in collaboration with the RACGP. For example, the Medicare Locals/Primary Health Care Networks could collaborate with their local Aboriginal and Torres Strait Islander communities to add the local content to the RACGP module. In addition to all staff undertaking Aboriginal and Torres Strait Islander Cultural Awareness Training, all undergraduate and graduate medical training should include Aboriginal and Torres Strait Islander Cultural Awareness Training²¹⁹ as part of the curriculum as is commonplace in other countries such as Canada.

Understanding why Indigenous status is recorded and seeing that it makes a difference: Although general practices must demonstrate that they are recording the Indigenous status of patients if they wish to become accredited against the RACGP Standards for General Practice⁵⁴, Indigenous status identification remains low in general practice³⁵. One reason for this is that not all practices are accredited. Hence, one could argue that the Government should mandate Indigenous status recording. But simply mandating Indigenous status recording is not sufficient. Recording data for the sake of data collection will not ensure that the data is collected or collected properly. The USPs in this study were incorrectly recorded in the medical record 25% of the time. As this was based on a very

small number of assessments (n=16), this could be a misrepresentation of the actual level of misreporting of Indigenous status in general practice. Although the overall level of miscoding in general practice is not known, a 2002-2003 study in the ACT public hospital setting found that 191/463 (41%) of patients had been incorrectly coded as being non-Indigenous²²⁰. These data demonstrate that further research is required to determine not only the levels of Indigenous status identification in general practice, but the level of incorrect recording.

The USPs were coded as being non-Indigenous by staff members at baseline who had not yet received training as part of the intervention, or by staff at follow-up who did not take part in the intervention. This further supports the need for practitioners and staff to understand why Indigenous status is being recorded. In addition, at baseline no practices in the current study believed that they were incorrectly recording Indigenous status, and one could safely assume that this belief is shared by the broader general practice population. The use of USPs in the current study was an invaluable tool to show practices that miscoding of Indigenous status did not just occur at "other practices" but in their own practice as well. Quality improvement audits using unannounced standardised patients could be used to monitor the correctness of Indigenous status recording and this is a function that could be performed by the Medicare Locals/Primary Health Care Networks in collaboration with their local Aboriginal and Torres Strait Islander communities. Aboriginal and Torres Strait Islander peoples involvement in quality improvement audits are a vital component of culturally competent health services²²¹.

The use of the Normalisation Process Theory in this research also showed that in addition to understanding why they are collecting the information (coherence), it is important for staff and practitioners to see that what they are doing is leading to change (reflexive monitoring). Apart from seeing more patients with their Indigenous status identified in the medical record, staff and practitioners could see that it was having an effect on the care provided to Aboriginal and Torres Strait Islander-identified patients, as more patients were offered health assessments and more patients were being enrolled into the Closing the Gap Health Initiatives. This helped them to remain engaged and continue to try and improve the Indigenous status recording in their practice (collective action).

Other implications of this research

Another important implication of this study was that the intervention was tailored to each practice. This has implications not only for policy and practice, but research also. Interventions must be flexible so that they can be adapted according to the differing needs of different practices. A one size fits all approach will not work. For example, Practice 102 demonstrated that if a practice has efficient Indigenous status identifications systems in place, training on identifying patients is not useful. This practice would have benefitted from Aboriginal and Torres Strait Islander Cultural Awareness Training and training on why Indigenous status was being recorded. As the staff did not join in the study and the participating GP did not engage in the intervention, this could not be provided. This also demonstrates the need for all staff within a practice to undertake Aboriginal and Torres Strait Islander Cultural Awareness Training.

Another reason to tailor interventions is that people learn in different ways. As discussed earlier in this chapter, the use of literature²⁰⁷ or audit and feedback²⁰⁸ alone have limited effect on physician performance, but a positive effect has been observed using patient feedback²⁰⁹. Data triangulation was not only used as a tool for increasing rigour in this research, it was used a tool for professional training and education to increase coherence: the USP feedback reinforced the literature and audits, and allowed practices to contextualise the issue in real terms. Further research to measure to what degree triangulation of data improves the effect of interventions is warranted.

This study was only conducted in a small number of practices and further research is required to test its effectiveness on a large scale and in different communities across urban, rural and remote areas. The follow-up data collection was collected 6-7 months after baseline and further research is required to measure any long-term change. Ongoing support could be provided by Medicare Locals/Primary Health Care Networks to help improve sustainability.

This study also has implications for how the quality of care to Aboriginal and Torres Strait Islander patients is measured and for the Closing the Gap Health Initiative. Medicare Locals currently report on the number of Aboriginal and Torres Strait Islander Health Assessments undertaken as one of the indicators of the uptake of the Closing the Gap Health Initiative. GPs can cover the various aspects of a health assessment over several consultations and may not

necessarily record or charge for a 715 Health Assessment. This means that the care provided in a 715 Health Assessment may not be recorded in a way that enables analysis of the uptake of the 715 Health Assessment or its effectiveness on the long term health outcomes of Aboriginal and Torres Strait Islander patients. More appropriate methods should be found to accurately monitor health service utilisation. Additionally, the number of Health Assessments undertaken does not measure the appropriateness of care provided to patients and this information is only available via patient feedback. More appropriate methods to measure the quality of care provided to Aboriginal and Torres Strait Islander patients include clinical record audits, USPs, and patient interviews or surveys.

The Indigenous PBS Co-payment Measure as a means to reduce the barrier of the cost of medications and thereby improve medication compliance is a beneficial initiative. However, this research has demonstrated how the Government regulations which only allow PIPHI-registered accredited practices to prescribe Indigenous PBS Co-Payment Scripts is greatly limiting the ability of Aboriginal and Torres Strait Islander patients to see the GP of their choice if they wish to receive this benefit. At the time this research was conducted, although around 70% of practices in the Eastern Sydney Medicare Local area were accredited practices, only 14% were registered to the PIPHI; and in the South Eastern Sydney Medicare Local area, around 50% of practices were accredited but 27% were PIPHI registered. Extending the Indigenous Co-Payment Measure to all medical practitioners should be a priority for the Australian Government.

Finally, the use of unannounced standardised patients is not limited to Indigenous status identification and the quality of care provided to Aboriginal and Torres Strait Islander patients, and could be extended to other quality improvement applications and other populations and warrants further investigation.

Summary:

This study has several implications for practice, policy and research:

- In order to improve Indigenous status identification in general practice, practitioners and staff need to understand why the data is being collected and they need to see that it will make a difference to the care provided to their patients.

- Quality improvement activities regarding Aboriginal and Torres Strait Islander patient care should include engagement with the local Aboriginal Torres Strait Islander Communities.
- Aboriginal and Torres Strait Islander Cultural Awareness Training and quality improvement activities using feedback from the local Aboriginal and Torres Strait Islander Community can help shift attitudinal barriers of GPs and staff.
- Aboriginal and Torres Strait Islander Cultural Awareness Training needs to extend to all staff within a practice.
- Practice software needs to be able to record Indigenous status according to the National Best Practice Guidelines.
- In order to measure the quality of care provided to Aboriginal and Torres Strait Islander patients, quality measures need to be included through audits and patient feedback.
- The Indigenous PBS Co-payment Measure should be extended to all medical practitioners who can provide scripts.
- The use of unannounced standardised patients can be extended to other quality improvement applications and other populations and warrants further investigation.

7.5 Conclusion

This research successfully developed an intervention to increase the rate of Indigenous status identification and the level of care provided to Aboriginal and Torres Strait Islander patients in general practice, that could be effectively implemented in general practice, and was acceptable to providers, staff and the local Aboriginal and Torres Strait Islander communities.

At baseline, this research showed that at the Indigenous status of patients was still not routinely being identified and recorded in the medical record in urban general practice, and that Aboriginal and Torres Strait Islander-identified patients were not necessarily receiving culturally appropriate care or targeted care according to their health needs. It investigated the barriers to Indigenous status identification in general practice, as well as the low uptake of Aboriginal and Torres Strait Islander Health Assessments and the Closing the Gap Health Initiatives. This research then showed that it was possible to improve Indigenous

status identification and the provision of culturally appropriate and targeted care in general practice using a tailored intervention, which could effectively be implemented in general practice and was acceptable to providers, staff and the local Aboriginal and Torres Strait Islander communities.

The methods used in the intervention were novel. This research worked with the local Aboriginal and Torres Strait Islander communities and engaged community members as unannounced standardised patients (USPs), who provided feedback on the level of care they received at each practice as a part of a quality improvement activity. This engagement with the local Aboriginal and Torres Strait Islander communities was a key factor in the success of this research. Each practice also received training on how to embed Indigenous status recording into their normal routines, how to create practice environments that promoted self-identification of Indigenous status, and how to provide more culturally appropriate and targeted care to Aboriginal and Torres Strait Islander patients.

Educational and quality improvement efforts in general practice using the literature or audit and feedback alone, have had limited effect to date. The feedback provided from Aboriginal unannounced standardised patients, reinforced the information provided by the literature and audit and contextualised Indigenous status identification and the provision of appropriate care in each practice in real terms. This promoted active engagement from staff and practitioners and a commitment to change.

This research also identified a number of barriers to enrolment in the Government's Closing the Gap Initiative. This research identified that there was provider confusion about patient eligibility criteria, and that the current regulations in place that only allows accredited practices that are enrolled into the Indigenous Health Initiative Practice Incentive Program, places great limitations on patient enrolment into the Indigenous PBS Co-payment Measure. In addition, the regulation may cause doctor shopping and duplication of services when patients see one doctor for their usual care and other for their scripts.

The poor health of Aboriginal and Torres Strait Islander peoples is a critical concern not only for general practice but also the wider community. The Closing the Gap Health Initiative has tried to address this issue in a number of ways with the introduction of the Chronic Disease Package and the Indigenous PBS Co-

payment Measure. A key requirement to reduce the health disparities experienced by Aboriginal and Torres Strait Islander peoples is the systematic identification of Indigenous status and the provision of culturally appropriate care, culturally acceptable care and targeted care in general practice. This study demonstrates the value of a novel approach to quality improvement in general practice and reiterates the need to engage the local Aboriginal and Torres Strait Islander community in quality improvement activities in general practice that target care provided to them. It warrants further study and possibly wider application.

References

1. Anderson I, Crengle S, Kamaka ML, Chen T-H, Palafox N, Jackson-Pulver L. Indigenous health in Australia, New Zealand, and the Pacific. *Lancet*. 2006;367:1775-85.
2. Australian Bureau of Statistics. Deaths, Australia, 2012. ABS Cat. No. 3302.0 Canberra: ABS; 2013 [updated Released at 11:30 am (Canberra time) Thurs 7 Nov 2013]. Available from: <http://www.abs.gov.au/AUSSTATS/abs@.nsf/Latestproducts/3302.0Main%20Features72012?opendocument&tabname=Summary&prodno=3302.0&issue=2012&num=&view=>.
3. Australian Institute for Health and Welfare. Australia's health 2012. Cat No. AUS 156. Canberra: AIHW; 2012.
4. Australian Bureau of Statistics. The Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples, Oct 2010. Cat No. 4704.0. Canberra: ABS; 2011 [updated Latest ISSUE Released at 11:30 AM (CANBERRA TIME) 19/12/2011 Final]. Available from: <http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/4704.0Chapter830Oct%202010>.
5. United Nations DoEaSA, Population Division, World Population Ageing, 2013. ST/ESA/SER.A/348. New York: United Nations; 2013.
6. Australian Institute for Health and Welfare. The health and welfare of Australia's Aboriginal and Torres Strait Islander peoples, an overview 2011. Cat. no. IHW 42. Canberra: AIHW; 2011.
7. Australian Bureau of Statistics. Estimates of Aboriginal and Torres Strait Islander Australians, June 2011. Cat No. 3238.0.55.001 Canberra: ABS; 2011 [updated Latest ISSUE Released at 11:30 AM (CANBERRA TIME) 30/08/2013]. Available from: <http://www.abs.gov.au/ausstats/abs@.nsf/mf/3238.0.55.001>.
8. Thomson N, MacRae A, Burns J, Catto M, Debuyst O, Krom I, et al. Overview of Australian Indigenous health status, April 2010. Available at <http://www.healthinonet.ecu.edu.au/health-facts/overviews> [Accessed July 8, 2010]. Perth: Australian Indigenous Health/InfoNet 2010.

9. Madden RC, Jackson Pulver LR. Aboriginal and Torres Strait Islander population: More than reported. *Australian Actuarial Journal* 2009;15(2):181-208.
10. Australian Institute for Health and Welfare. Contribution of chronic disease to the gap in adult mortality between Aboriginal and Torres Strait Islander and other Australians. Cat. No. IHW 48. Canberra: AIHW; 2010.
11. Vos T, Barker B, Begg S, Stanley L, Lopez AD. Burden of disease and injury in Aboriginal and Torres Strait Islander peoples: the Indigenous health gap. *International Journal of Epidemiology*. 2009;38:47-7.
12. Scrimgeour M, Scrimgeour D. Health care access for Aboriginal and Torres Strait Islander people living in urban areas, and related research issues: A review of the literature. Darwin: Cooperative Research Centre for Aboriginal Health, 2007.
13. Eades SJ, Taylor B, Bailey S, Williamson AB, Craig JC, Redman S. The health of urban Aboriginal people: insufficient data to close the gap. *Medical Journal of Australia*. 2010;193(9):521-4.
14. Mackerras DEM, Reid A, Sayers SM, Singh GR, Bucens IK, Flynn KA. Growth and Morbidity in Children in the Aboriginal Birth Cohort Study: The urban-remote differential. *Medical Journal of Australia*. 2003;178(2):56-60.
15. Zubrick S, Lawrence D, Silburn SR, Blair E, Milroy H, Wilkes T, et al. The Western Australian Aboriginal Child Health Survey: Volume 1, The Health of Aboriginal Children and Young People. Perth: Telethon Institute for Child Health Research, 2004.
16. Australian Institute for Health and Welfare. Expenditure on health for Aboriginal and Torres Strait Islander people 2006-07. Health and welfare expenditure series no. 39. Cat No. HWE 48. Canberra: AIHW; 2009.
17. Australian Institute for Health and Welfare. Australian hospital statistics 2008-09. Health services series no. 34. Cat. no. HSE 84. Canberra: AIHW; 2010.
18. Starfield B, Shi L, Macinko J. Contribution of primary care to health systems and health. *Milbank Quarterly*. 2005;83(3):457-502.
19. Griew R, Tilton E, Cox N, Thomas D. The link between primary health care and health outcomes for Aboriginal and Torres Strait Islander Australians. Sydney: Robert Griew Consulting; 2008.
20. Australian Institute of Health and Welfare. Access to health services for Aboriginal and Torres Strait Islander people. Cat. No. IHW 46 Canberra: AIHW; 2011.

21. Council of Australian Governments. National Indigenous Reform Agreement (Closing the Gap). Available from http://www.coag.gov.au/intergov_agreements/federal_financial_relations/docs/IGA_FFR_ScheduleF_National_Indigenous_Reform_Agreement.pdf [Accessed 2 August 2010]. 2008.
22. Australian Institute for Health and Welfare. Aboriginal and Torres Strait Islander health services report 2011–12. Online Services Report – key results. Cat. no. IHW 104. Canberra: AIHW; 2013.
23. Couzos S, Thiele DD. Closing the gap depends on ACCHSs [Letter]. *Medical Journal of Australia*. 2009;190(10):541.
24. Commonwealth Department of Health and Aged Care. Closing the Gap Indigenous Chronic Disease Package: Information for General Practice, Aboriginal Community Controlled Health Services and Indigenous Health Services. Canberra: Commonwealth Department of Health and Aged Care; 2010.
25. Commonwealth Department of Health and Aged Care. Medicare Benefits Schedule (MBS) Health Assessments MBS Items 701, 703, 705 and 707 & 10986 Fact Sheet. Canberra: Commonwealth Department of Health and Aged Care; (no date).
26. Commonwealth Department of Health and Aged Care. Medicare Benefits Schedule (MBS) Health Assessment for Aboriginal and Torres Strait Islander People (MBS Item 715) Fact Sheet. Canberra: Commonwealth Department of Health and Aged Care; (no date).
27. Australian Government Department of Health. History of key MBS primary care initiatives 1999-2013. 2014 [updated 03 April 2014]. Available from: <http://www.health.gov.au/internet/main/publishing.nsf/Content/mbsprimarycare-History>.
28. Spurling GKP, Hayman NE, Cooney AL. Adult health checks for Indigenous Australians: the first year's experience from the Inala Indigenous Health Service. *Medical Journal of Australia*. 2009;190:562-4.
29. Hoy WE, Wang Z, Baker PRA, Kelly AM. Reduction in natural death and renal failure from a systematic screening and treatment program in an Australian Aboriginal community. *Kidney International*, Vol (), pp. 2003;63, (Supplement 83):S66-S73.
30. Miller G, McDermott R, McCulloch B, Leonard D, Arabena K, Muller R. The Well Person's Health Check: a population screening program in indigenous

- communities in north Queensland. *Australian Health Review*. 2002;25(6):136-47.
31. Kehoe H, Lovett RW. Aboriginal and Torres Strait Islander health assessments. Barriers to improving uptake. *Australian Family Physician*. 2008;37(12):1033-8.
 32. Kelaher M, Dunt D, Thomas D, Anderson I. Comparison of the uptake of health assessment items for Aboriginal and Torres Strait Islander people and other Australians: Implications for policy. *Australia and New Zealand Health Policy*. 2005;2(21):doi:10.1186/743-8462-2-21.
 33. Australian Government Department of Human Services. Medicare Locals Statistics Reports 2014. Available from: http://www.medicareaustralia.gov.au/statistics/med_locals.shtml.
 34. NSW Government. Aboriginal population by Medicare Local and Year 2011. Available from: http://www.healthstats.nsw.gov.au/Indicator/atsi_popatsi_mimap.
 35. Kelaher M, Parry A, Day S, Anderson I, Paradies Y, Parkhill A, et al. Improving the identification of Aboriginal and Torres Strait Islander people in mainstream general practice. Canberra: The Lowitja Institute; 2010.
 36. Riley I, Williams G, Shannon C. Needs analysis of Indigenous immunisation in Queensland - Final report. University of Queensland: Centre for Indigenous Health, June 2004.
 37. Kehoe H. ACTDGP Aboriginal and Torres Strait Islander Health Awareness Project - Final report. Canberra: ACT Division of General Practice, June 2007.
 38. National Centre for Immunisation Research and Surveillance. Evaluation of National Indigenous Pneumococcal and Influenza Immunisation Program 2003. Unpublished manuscript: NCIRS, 2004.
 39. Norris T, McIntyre R, Menzies R. Role of GPs in Adult Indigenous Immunisation – Results of a National GP Survey. In: 9th National Immunisation/1st PHAA Asia Pacific Vaccine Preventable Diseases Conference: Immunisation at the Crossroads - Challenges and Strategies 19-20 August; Carins. 2004.
 40. Crengle S, Crampton P, Woodward A. Māori in Aotearoa/New Zealand In: Healey J, McKee M, editors. *Accessing Health Care: Responding to Diversity*. Oxford: Oxford University Press; 2004. p. 281-302.

41. Australian Health Ministers' Advisory Council. Aboriginal and Torres Strait Islander Health Performance Framework 2012 Report. Canberra: AHMAC; 2012.
42. House of Representatives Standing Committee on Aboriginal and Torres Strait Islander Affairs. We Can Do It! The Needs of Urban Dwelling Aboriginal and Torres Strait Islander Peoples. Canberra: AGPS, 2001.
43. Penchansky R, Thomas JW. The Concept of Access: Definition and Relationship to Consumer Satisfaction. *Medical Care*. 1981;19(2):127-40.
44. Levesque J-F, Harris MF, Russell G. Patient-centred access to health care: conceptualising access at the interface of health systems and populations. *International Journal for Equity in Health*. 2013;12:18. <http://www.equityhealthj.com/content/2/1/>.
45. Australian Medical Association. AMA Indigenous Health Report Card 2010-11: Aboriginal & Torres Strait Islander Health - Best Practice in Primary Health Care for Aboriginal Peoples and Torres Strait Islanders. Barton: ACT: AMA, 2011.
46. Craig P. Access of Urban Indigenous Populations into Local Primary Health Care Services, report prepared for Macarthur Division of General Practice. Sydney: Centre for Health Equity Training Research and Evaluation, University of New South Wales, 2002.
47. Lau P, Pyett P, Burchill M, Furler J, Tynan M, Kelaher M, et al. Factors influencing access to urban general practices and primary health care by Aboriginal Australians - A qualitative study. *AlterNative: An International Journal of Indigenous Peoples*. 2012;8(1):66-84.
48. Fulton R. Ethnic monitoring: is health equality possible without it? *Better Health Briefing Paper 21*. London: Race Equality Foundation; November 2010.
49. Britt H, Miller GC, Charles J, Henderson J, Bayram C, Pan Y, et al. General practice activity in Australia 2010-11. General practice series No. 29. Sydney: Sydney University Press, 2011.
50. Kehoe H. A call for action: Better Aboriginal and Torres Strait Islander health through better GP identification. Canberra: ACT Division of General Practice, 2007.
51. Scotney A, Guthrie JA, Lokuge K, Kelly PM. "Just ask!" Identifying as Indigenous in mainstream general practice settings: a consumer perspective. *Medical Journal of Australia* 2010;192(10).

52. Australian Institute of Health and Welfare. Taking the next steps: identification of Aboriginal and Torres Strait Islander status in general practice. Cat. no. IHW 100. Canberra: AIHW; 2013.
53. NSW Government. Policy Directive - Aboriginal and Torres Strait Islander Origin - Recording of Information of Patients and Clients. North Sydney: Ministry of Health, NSW; 2012.
54. RACGP. Standards for general practices 4th edition. Melbourne: The Royal Australian College of General Practitioners; 2010.
55. RACGP. Standards for general practices 3rd edition. Melbourne: The Royal Australian College of General Practitioners; Revised edition 2007.
56. RACGP. Fact Sheet: The identification of Aboriginal and Torres Strait Islander people What is required in the RACGP's Standards for general practices (3rd Ed). Melbourne: RACGP, Last reviewed August 2006.
57. Australian Institute for Health and Welfare. National best practice guidelines for collecting Indigenous status in health data sets. Cat. no. IHW 29. Canberra: AIHW; 2010.
58. RACGP. Identification of Aboriginal and Torres Strait Islander people in Australian general practice. Melbourne: The RACGP National Faculty of Aboriginal and Torres Strait Islander Health; 2011.
59. Rethans JJ, Norcini JJ, Baro'n-Maldonado M, Blackmore D, Jolly BC, LaDuca T, et al. The relationship between competence and performance: implications for assessing practice performance. *Medical Education*. 2002;36:901-9.
60. Rethans JJ, Sturmans F, Drop R, van der Vleuten C, Hobus P. Does competence of general practitioners predict their performance? Comparison between examination setting and actual practice. *British Medical Journal*. 1991;303:1377-80.
61. Miller GE. The assessment of clinical skills / competence / performance. *Academic Medicine*. 1990;65(Suppl.):S63-S7.
62. Peabody JW, Luck J, Glassman P, Jain S, Hansen J, Spell M, et al. Measuring the quality of physician practice by using clinical vignettes: a prospective validation study. *Annals of Internal Medicine*. 2004;141:771-80.
63. Halperin M. Do we need USPS? *Australian Family Physician*. 2005;34(10):882-4.
64. Beullens J, Rethans JJ, Goedhuys J, Buntinx F. The use of standardized patients in research in general practice. *Family Practice*. 1997;14(1):58-62.

65. Peabody J, Luck J, Glassman P, Dresselhaus TR, Lee M. Comparison of vignettes, standardized patients, and chart abstraction: A prospective validation study of 3 methods for measuring quality. *Journal of the American Medical Association*. 2000;283(13):1715-22.
66. Stange KC, Zyzanski SJ, Smith TF, Kelly R, Langa DM, Flocke SA, et al. How valid are medical records and patient questionnaires for physician profiling and health services research? A comparison with direct observation of patient's visits. *Medical Care*. 1998;36(6):851-67.
67. Franco LM, Daly CC, Chilongozi D, Dallabetta G. Quality of case management of sexually transmitted diseases: comparison of the methods for assessing the performance of providers. *Bulletin of the World Health Organization*. 1997;75(6):523-32.
68. Montano DE, Phillips WR. Cancer screening by primary care physicians: a comparison of rates obtained from physician self-report, patient survey, and chart audit. *American Journal of Public Health*. 1995;85(6):795-800.
69. Wilson A, McDonald P. Comparison of patient questionnaire, medical record, and audio tape in assessment of health promotion in general practice consultations. *British Medical Journal*. 1994;309(6967):1483-5.
70. Dresselhaus TR, Peabody JW, Lee M, Wang MM, Luck J. Measuring compliance with preventive care guidelines: standardized patients, clinical vignettes, and the medical record. *Journal of General Internal Medicine* 2000;15:782-8.
71. Shah R, Edgar DF, Evans BJW. A comparison of standardised patients, record abstraction and clinical vignettes for the purpose of measuring clinical practice. *Ophthalmic and Physiological Optics* 2010;30:209-24.
72. Leaf DA, Neighbor WE, Schaad D, Scott CS. A comparison of self-report and chart audit in studying resident physician assessment of cardiac risk factors. *Journal of General Internal Medicine*. 1995;10:194-8.
73. Luck J, Peabody JW, Dresselhaus TR, Lee M, Glassman P. How well does chart abstraction measure quality? A prospective comparison of standardized patients with the medical record. *American Journal of Medicine*. 2000;108:642-9.
74. Mant J, Murphy M, Rose P, Vessey M. The accuracy of general practitioner records of smoking and alcohol use: comparison with patient questionnaires. *Journal of Public Health Medicine*. 2000;22(2):198-201.

75. Rethans JJ, Martin E, Metsemakers J. To what extent do clinical notes by general practitioners reflect actual medical performance? A study using simulated patients. *British Journal of General Practice*. 1994;44:153-6.
76. Shah R, Edgar D, Evans BJW. Measuring clinical practice [Review]. *Ophthalmic & Physiological Optics*. 2007;27(2):113-25.
77. Carney PA, Dietrich AJ, Freeman DH, Mott LA. The periodic health examination provided to asymptomatic older women: An assessment using standardized patients. *Annals of Internal Medicine*. 1993;119(2):129-35.
78. Veloski JJ, Rabinowitz HK, Robeson MR, Young PR. Patients don't present with five choices: an alternative to multiple choice tests in assessing physicians' competence. *Academic Medicine*. 1999;74(5):539-46.
79. Dresselhaus TR, Peabody JW, Luck J, Bertenthal D. An evaluation of vignettes for predicting variation in the quality of preventive care. *Journal of General Internal Medicine*. 2004;19:1013-8.
80. Veloski J, Tai S, Evans AS, Nash DB. Clinical vignette-based surveys: A tool for assessing physician practice variation. *American Journal of Medical Quality*. 2005;20:151-7.
81. Chang K, Sauereisen S, Dlutowski M, J. Jon. V, Nash DB. A cost-effective method to characterize variation in clinical practice. *Evaluation & the health professions*. 1999 22 (2):184-96.
82. Rethans JJ, Gorter S, Bokken L, Morrison L. Unannounced standardised patients in real practice: a systematic literature review. *Medical Education*. 2007;41(6):537-49.
83. Beaulieu M, Rivard M, Hudon E, Saucier D, Remondin M, Favreau R. Using standardized patients to measure professional performance of physicians. *International Journal for Quality in Health Care*. 2003;15(3):251-9.
84. Hilarius DL, Kloeg PH, Detmar SB, Muller MJ, Aaronson NK. Level of agreement between patient self-report and observer ratings of health-related quality of life communication in oncology. *Patient Education and Counseling*. 2007 65:95-100.
85. Palonen KP, Allison JJ, Heudebert GR, Willett LL, Kiefe CI, Wall TC, et al. Measuring resident physicians' performance of preventive care. Comparing chart review with patient survey. *Journal of General Internal Medicine*. 2006;21:226-30.

86. Asch DA, Jedrzejewski K, Christakis NA. Response rates to mail surveys published in medical journals. *Journal of Clinical Epidemiology*. 1997;50(10):1129-36.
87. Edwards P, Roberts I, Clarke M, DiGiuseppi C, Pratap S, Wentz R, et al. Increasing response rates to postal questionnaires: systematic review. *British Medical Journal*. 2002;324(7347):1183.
88. Fowles JB, Rosheim K, Fowler EJ, Craft C, Arrichiello L. The validity of self-reported diabetes quality of care measures. *International Journal for Quality in Health Care*. 1999;11(5):407-12.
89. McGinn T, Wyer PC, Newman TB, Keitz S, Leipzig R, Guyatt G. Tips for learners of evidence-based medicine: 3. Measures of observer variability (kappa statistic). *Canadian Medical Association Journal*. 2004;171(11):1369-73.
90. Tsubono Y, Fukao A, Hisamichi S, Hosokawa T, Sugawara N. Accuracy of self-report for stomach cancer screening. *Journal of Clinical Epidemiology* 1994;47(9):977-81.
91. Nicholson JM, Hennrikus DJ, Lando HA, McCarty MC, Vessey J. Patient recall versus physician documentation in report of smoking cessation counselling performed in the inpatient setting. *Tobacco Control*. 2000;9:382-8.
92. Nevitt MC, Cummings SR, Browner WS, Seeley DG, Cauley JA, Vogt TM, et al. The accuracy of self-report of fractures in elderly women: Evidence from a prospective study. *American Journal of Epidemiology*. 1992;135(5):490-9.
93. Flocke SA, Stange KC. Direct observation and patient recall of health behavior advice. *Preventive Medicine*. 2004;38:343-9.
94. Kellerman SE, Herold J. Physician response to surveys: a review of the literature. *American journal of preventive medicine*. 2001;20(1):61-7.
95. Berk ML. Interviewing physicians: the effect of improved response rate. *American Journal of Public Health*. 1985;75:1338-40.
96. Cartwright A. Professionals as responders: variations in and effects of response rates to questionnaires, 1961-77. *British Medical Journal*. 1978;2:1419-21.
97. Shosteck H, Fairweather WR. Physician response rates to mail and personal interview surveys. *Public Opinion Quarterly*. 1979;43(2):206-17.

98. Franco LM, Franco C, Kumwenda N, Nkhoma W. Methods for assessing quality of provider performance in developing countries. *International Journal for Quality in Health Care*. 2002;14(Suppl 1):17-24.
99. Roter DL, Russell NK. Validity of physician self-report in tracking patient education objectives. *Health Education and Behaviour*. 1994;21(1):27-38.
100. Peabody J. Why we love quality but hate to measure it. *Quality Management in Health Care*. 2006;15(2):116-20.
101. Barrows HS. An overview of the uses of standardised patients for teaching and evaluating clinical skills. *Academic Medicine*. 1993;68:443-53.
102. Luck J, Peabody JW. Using standardised patients to measure physicians' practice: validation study using audio recordings. *British Medical Journal*. 2002;325(7366):679.
103. Kinnersley P, Ben-shlomo Y, Hawthorne K, Donovan J, Chaturvedi N. The acceptability of simulated patients for studying and assessing general practice in the United Kingdom. *Education for Primary Care*. 2005;16:540-6.
104. Derkx H, Rethans JJ, Maiburg B, Winkens R, Knottnerus A. New methodology for using incognito standardised patients for telephone consultation in primary care. *Medical Education*. 2009;43:82-8.
105. Glassman PA, Luck J, O'Gara EM, Peabody JW. Using standardized patients to measure quality: Evidence from the literature and a prospective study. *Joint Commission Journal on Quality and Patient Safety*. 2000;26(11):644-53.
106. Gorter S, Rethans JJ, van der Heidje D, Scherpbier A, Houben H, van der Vleuten C, et al. Reproducibility of clinical performance assessment in practice using incognito standardized patients. *Medical Education* ;. 2002;36:827-32.
107. Tamblyn RM, Abrahamowicz M, Berkson L. First-visit bias in the measurement of clinical competence with standarzed patients. *Academic Medicine*. 1992;67(Suppl.):S22-4.
108. Rethans JJ, van Boven CPA. Simulated patients in general practice: a different look at the consultation. *British Medical Journal*. 1987;294 809-12.
109. Halperin M. The unannounced standardised patient methodology. A potential feedback tool for registrar training. *Australian Family Physician*. 2005;34(12):4-6.

110. Elman D, Hooks R, Tabak D, Regehr G, Freeman R. The effectiveness of unannounced standardised patients in the clinical setting as a teaching intervention. *Medical Education*. 2004;38:969-73.
111. Franz CE, Epstein R, Miller KN, Brown A, Song J, Feldman M, et al. Caught in the act? Prevalence, predictors, and consequences of physician detection of unannounced standardized patients. *Health Services Research*. 2006;41(6):2290-302.
112. McLeod PJ, Tamblyn RM, Gayton D, Grad R, Snell L, Berkson L, et al. Use of standardized patients to assess between-physician variations in resource utilization. *JAMA*. 1997;278(14):1164-8.
113. Crotty M. *The foundations of social research: meaning and perspective in the research process*. Thousand Oaks, California: Sage Publishers; 1998.
114. Gray DE. *Doing research in the real world* Second ed. Thousand Oaks, California: Sage Publications; 2009.
115. Berger PL, Luckmann T. *The social construction of reality: a treatise in the sociology of knowledge*. Garden City, New York: Anchor Books; 1966.
116. Crabtree BF, Miller WL, editors. *Doing qualitative research*. Second ed. Thousand Oaks, California: Sage Publications; 1999.
117. Harwell MR. Research design in qualitative/quantitative/mixed methods. In: Conrad CF, Serlin RC, editors. *The SAGE handbook for research in education Pursuing ideas as the keystone of exemplary inquiry*. Second ed. Thousand Oaks, California: Sage Publishers; 2011.
118. Creswell J, Fetters M, Ivankova N. Designing a mixed methods study in primary care. *Archives of Family Medicine*. 2004;2:7-12.
119. Tashakkori A, Teddlie C, editors. *Handbook of mixed methods in social and behavioral research*. Thousand Oaks, California: Sage Publications; 2003.
120. Ajzen I. The theory of planned behaviour. *Organizational Behavior and Human Decision Processes*. 1991;50:179-211.
121. Bronfenbrenner U. Ecological models of human development. In: *International encyclopaedia of education*. 2nd Ed. Vol 3. Oxford: Elsevier; 1994.
122. Creswell JW. *Qualitative inquiry and research design. Choosing among five traditions*. Thousand Oaks, California: Sage Publications; 1998.
123. Yin RK. *Case study research: Design and methods*. Thousand Oaks, California: Sage Publications; 2003.
124. Gerring J. *Case study research: principles and practices* Cambridge: Cambridge University Press; 2007.

125. Tellis W. Application of a case study methodology *The Qualitative Report* [Internet]. 1997; 3(3). (Available from <http://www.nova.edu/ssss/QR/QR3-3/tellis2.html>).
126. Zainal Z. Case study as a research method. *Jurnal Kemanusiaan (The Asian journal of humanities)*. 2007;14(Jun):1-6.
127. Stake RE. *The art of case study research*. Thousand Oaks, California: Sage Publications; 1995.
128. Baxter P, Jack S. Qualitative case study methodology: study design and implementation for novice researchers. *The Qualitative Report*. 2008;13(4):544-59.
129. Commonwealth Department of Health and Aging (2012). Medicare Locals. Available from: <http://www.yourhealth.gov.au/internet/yourhealth/publishing.nsf/Content/medilocal-1p-1>. [Accessed 30 September 2012]. Canberra: Commonwealth Department of Health and Aging.
130. O'Neil J, Elias B, Wastesicoot J. Building a Health Research Relationship Between First Nations and the University in Manitoba. *Canadian Journal of Public Health*. 2005;96(Supp 1):S9-12.
131. Elias B, O'Neil J, Sanderson D. The politics of trust and participation: A case study in developing First Nations and University capacity to build health information systems in a First Nations context. *Journal of Aboriginal Health*. 2004;1(1):68-78.
132. Humphery K. Dirty questions: Indigenous health and 'Western research'. *Australian and New Zealand Journal of Public Health*. 2001;25(3):197-202.
133. Smith LT. *Decolonizing methodologies: research and Indigenous peoples*. Dunedin: Zed Books; 1999.
134. National Health and Medical Research Council. *NHMRC Roadmap: A strategic framework for improving Aboriginal and Torres Strait Islander health through research* Canberra: Commonwealth of Australia; 2002.
135. National Health and Medical Research Council. *Values and ethics: Guidelines for ethical conduct in Aboriginal and Torres Strait Islander health research*. Canberra: Commonwealth of Australia; 2003.
136. Aboriginal Health & Medical Research Council of New South Wales. *Guidelines for research into Aboriginal health. Key principles*. Sydney: AHMRC of New South Wales; 2008.

137. National Health and Medical Research Council. Keeping research on track. A guide for Aboriginal and Torres Strait Islander peoples about health research ethics. Canberra: Commonwealth of Australia; 2005.
138. National Health and Medical Research Council. Australian Research Council, and Australian Vice-Chancellors' Committee. National Statement on Ethical Conduct in Research Involving Humans. Available at: http://www.nhmrc.gov.au/guidelines/ethics/human_research/index.htm 2007.
139. Anderson I. Ethics and health research in Aboriginal communities. In: Daly J, editor. Ethical Intersections: Health Research Methods and Researcher Responsibility. Sydney: Allen & Unwin; 1996. p. 153-65.
140. Miles MB, Huberman M. Qualitative data analysis: an expanded sourcebook. 2nd ed. Thousand Oaks, California: Sage Publications; 1994.
141. Young HN, Bell RA, Epstein RM, Feldman MD, Kravitz RL. Types of information physicians provide when prescribing antidepressants. *Journal of General Internal Medicine*. 2006;21(11):1172-7. PubMed PMID: ISI:000240920800012.
142. Kravitz RL, Franks P, Feldman M, Meredith LS, Hinton L, Franz C, et al. What drives referral from primary care physicians to mental health specialists? A randomized trial using actors portraying depressive symptoms. *Journal of General Internal Medicine*. 2006;21(6):584-9.
143. Gorter S, Rethans JJ, Scherpbier A, van der Heide D, Houben H, van der Vleuten C, et al. Developing case-specific checklists for standardized-patient-based assessments in internal medicine: a review of the literature. *Academic Medicine*. 2000;75(11):1130-7.
144. Kvale S. Doing interviews. Thousand Oaks, California: Sage Publications; 2007.
145. Liamputtong P. Qualitative research methods. Third ed. Melbourne: Oxford University Press; 2009.
146. Kitzinger J. The methodology of focus groups: the importance of interaction between research participants. *Sociology of Health & Illness*. 1994;16(1):103-21.
147. McLafferty I. Focus group interviews as a data collecting strategy. *Journal of Advanced Nursing*. 2004;48(2):187-94.
148. Gibbs A. Focus groups. In: Gilbert N, editor. Social research update. Guildford, United Kingdom: Department of Sociology, University of Surrey; 1997.

149. Morgan DL. Focus groups as qualitative research. Second ed. Thousand Oaks, California: Sage Publications; 1997.
150. Kitzinger J. Introducing focus groups. *British Medical Journal*. 1995;311(7000):299-302.
151. Hayman NE, White NE, Spurling GK. Improving Indigenous patients' access to mainstream health services: the Inala experience. *Medical Journal of Australia* 2009;190:604-6.
152. Braun V, Clarke V. Using thematic analysis in psychology. *Qualitative Research in Psychology*. 2006;3:77-101.
153. Boyatzis RE. Transforming qualitative information. Thousand Oaks, California: Sage Publications; 1998.
154. Bird CM. How I stopped dreading and learned to love transcription. *Qualitative Inquiry*. 2005;11:226-48.
155. QSR International. Nvivo 9.2. Melbourne: QSR International. 2011.
156. Richards L, Morse JM. Read me first for a user's guide to qualitative methods 2nd ed. Thousand Oaks, California: Sage Publications; 2009.
157. Hogg W, Rowan M, Russell G, Geneau R, Muldoon L. Framework for primary care organizations: the importance of a structural domain. *International Journal for Quality in Health Care*. 2008;20(5):308-13.
158. Cabana MD, Rand CS, Powe N, Wu AW, Wilson MH, Abboud PC, et al. Why don't physicians follow clinical practice guidelines? A framework for improvement. *Journal of the American Medical Association*. 1999;282(15):1458-65.
159. IBM. SPSS Version 21. USA. <http://www-01.ibm.com/software/analytics/spss/>. 2012.
160. Fielding J, Gilbert N. Univariate Statistics. Understanding Social Statistics (2nd ed). London: Sage Publications; 2006.
161. Lincoln YS, Guba EG. Naturalistic Inquiry. Beverly Hills, California: Sage Publishers; 1985.
162. Patton MQ. Enhancing the quality and credibility of qualitative analysis. *Health Services Research*. 1999;34(5 Pt 2):1189-208.
163. Merriam SB. Qualitative research and case study applications in education. San Francisco Jossey-Bass Publishers; 1998
164. Cohen D, Crabtree B. Qualitative Research Guidelines Project. July 2006. Available at <http://www.qualres.org/HomeLinc-3684.html> [Accessed october 2012].

165. Malterud K. Qualitative research: Standards, challenges and guidelines. *The Lancet*. 2001;358:483-8.
166. Grol R, Wensing M. What drives change? Barriers to and incentives for achieving evidence-based practice. *Medical Journal of Australia*. 2004;180(Suppl):S57-S60.
167. Schneider M. *An introduction to public health*. 3rd ed. Sudbury, USA: Jones and Bartlett Publishers; 2011. 233-4 p.
168. Bandura A. Self efficacy: Towards a unifying theory of behavioural change. *Psychological review*. 1977;84:191-215.
169. Millstein SG. Utility of the theories of reasoned action and planned behavior for predicting physician behavior: A prospective analysis. *Health psychology*. 1996;15(5):398-402.
170. Walker AE, Grimshaw JM, Armstrong EM. Salient beliefs and intentions to prescribe antibiotics for patients with a sore throat. *British Journal of Health Psychology*. 2001;6:347-60.
171. Legare F, Godin G, Ringa V, Dodin S, Turcot L, Norton J. Variation in the psychosocial determinants of the intention to prescribe hormone therapy prior to the release of the Women's Health Initiative trial: a survey of general practitioners and gynaecologists in France and Quebec. *BMC Medical Informatics and Decision Making*. 2005;5:31.
172. Liabsuetrakul T, Chongsuvivatwongb V, Lumbiganonc P, Lindmark G. Obstetricians' attitudes, subjective norms, perceived controls, and intentions on antibiotic prophylaxis in caesarean section. *Social science & medicine*. 2003;57 (9):1665 -74
173. Nutbeam D, Harris E, Wise M. *Theory in a nutshell: a practical guide to health promotion theories*. 3rd ed. Australia: Mc-Graw Hill; 2010. pp9-21 p.
174. Sheeran P. Intention-behaviour relations: a conceptual and empirical review. *European Journal of Social Psychology*. 2002;12:1-36.
175. Sheeran P, Conner M, Norman P. Can the theory of planned behaviour explain patterns of health behaviour change? *Health psychology*. 2002;20(1):12-9.
176. May C, Finch T. Implementing, Embedding, and Integrating Practices: An Outline of Normalization Process Theory. *Sociology*. 2009;43 (3):535-54.
177. May CR, Mair F, Finch T, MacFarlane A, Dowrick C, Treweek S, et al. Development of a theory of implementation and integration: Normalization Process Theory. *Implementation Science*. 2009;4(29):doi:10.1186/748-5908-4-29.

178. Larson A, Gillies M, Howard PJ, Coffin J. It's enough to make you sick: the impact of racism on the health of Aboriginal Australians. *Aust NZ J Public Health*. 2007;31(4):322-9.
179. Institutionalised racism in health care [editorial]. *Lancet*. 1999;353(9155):765.
180. Karlsen S, Nazroo JY. Relation between racial discrimination, social class, and health among ethnic minority groups. *Am J Public Health*. . American Journal of Public Health. 2002;92(4):624-31.
181. Harris R, Tobias M, Jeffreys M, Waldegraved K, Karlsene S, Nazrooe J. Racism and health: The relationship between experience of racial discrimination and health in New Zealand. *Social Science & Medicine*. 2006;63 1428-41.
182. Parades Y. A systematic review of empirical research on self-reported racism and health. *International Journal of Epidemiology*. 2006;35:888-901.
183. Kandula NR, Hasnain-Wynia R, Thompson JA, Brown ER, Baker DW. Association between prior experiences of discrimination and patients' attitudes towards health care providers collecting information about race and ethnicity. *Journal of General Internal Medicine* 2009;24(7):789-94.
184. Polaschek NR. Cultural safety: a new concept in nursing people of different ethnicities. *Journal of Advanced Nursing*.27:452-7.
185. Williams R. Cultural safety - What does it mean for our work practice? . *Australian and New Zealand Journal of Public Health*. 1999;23(2):213-4.
186. RACGP. Cultural safety training. Identification of cultural safety training needs. Melbourne: The Royal Australian College of General Practitioners; 2010.
187. Nguyen H. Patient centred care: cultural safety in indigenous health. *Australian Family Physician*. 2008;37(12):990-4.
188. Abbott P, Dave D, Gordon E, Reath J. What do GPs need to work more effectively with Aboriginal patients? *Australian Family Physician*. 2014;43(1-2):58-63.
189. RACGP. Cultural awareness and cultural safety training Melbourne: The Royal Australian College of General Practitioners; 2010. Available from: <http://www.racgp.org.au/yourracgp/faculties/aboriginal/education/cultural-awareness/>.
190. South Eastern Sydney Local Health District. Respecting the Difference: Aboriginal Cultural Training. Sydney: NSW Health; nd.

191. RACGP. Checklist of adjudicating cultural awareness education - Working document for the Cultural Respect in General Practice Clinical Audit activity. Canberra: RACGP; 2011.
192. Murray E, Treweek S, Pope C, MacFarlane A, Ballini L, Dowrick C, et al. Normalisation process theory: a framework for developing, evaluating and implementing complex interventions. *BMC Medicine* 2010;8(63):doi:10.1186/741-7015-8-63.
193. Reimann JOF, Talavera GA, Salmon M, Nunˆez JA, Velasquez RJ. Cultural competence among physicians treating Mexican Americans who have diabetes: a structural model. *Social Science & Medicine*. 2004;59:2195-205.
194. Mak DB, Plant AJ, Toussaint S. "I have learnt . . . a different way of looking at people's health": an evaluation of a prevocational medical training program in public health medicine and primary health care in remote Australia. *Medical Teacher*, 2006;28(6):e149-e55.
195. Gibbs KA. Teaching student nurses to be culturally safe: Can it be done? *Journal of Transcultural Nursing*. 2005;16 356.
196. Burgess D, van Ryn M, Dovidio J, Saha S. Reducing Racial Bias Among Health Care Providers: Lessons from Social-Cognitive Psychology. *Society of General Internal Medicine*. 2007;22:882-7.
197. Durey A. Reducing racism in Aboriginal health care in Australia: where does cultural education fit in? *Australian and New Zealand Journal of Public Health*, 2010;34(S1):S87-92.
198. South Eastern Sydney and Illawarra Health Service. Welcome. Sydney: NSW Health; 2008.
199. Australian Bureau of Statistics. Are you Aboriginal? Torres Strait Islander? Canberra: ABS; 2009.
200. Australian Institute of Health and Welfare. One simple question could help you close the gap. Canberra: AIHW; 2012.
201. Cancer Institute NSW. Live strong and healthy. Have a pap test every two years. Sydney: Cancer Institute NSW; (no date).
202. Improving Indigenous Identification in Communicable Disease Reporting Project Steering Committee. Improving Indigenous identification in communicable disease reporting systems. South Australia: University of Adelaide; 2004.
203. Scott A, Coote B. Melbourne Institute Report No. 8. The value of the Divisions network - an evaluation of the effect of Divisions of General

- Practice on primary care performance. Melbourne: University of Melbourne.: Melbourne Institute of Applied Economic and Social Research, 2007.
204. Australian Commission on Safety and Quality in Health Care. Patient safety in primary health care. Consultation report. Sydney: Australian Commission on Safety and Quality in Health Care; 2011.
 205. Britt H, Miller GC, Henderson J, Charles J, Valenti L, Harrison C, et al. General practice activity in Australia 2011-12. General practice series No. 31. Sydney: Sydney University Press, 2012.
 206. Australian Bureau of Statistics. Perspectives on Aboriginal and Torres Strait Islander Identification in Selected Data Collection Contexts. Canberra: ABS; 2012.
 207. Giguère A, Légaré F, Grimshaw J, Turcotte S, Flander M, Grudniewicz A, et al. Printed educational materials: effects on professional practice and healthcare outcomes (Cochrane Review). In: The Cochrane Library, Issue 10. John Wiley & Sons, Ltd. 2012.
 208. Jamtvedt G, Young JM, Kristoffersen DT, O'Brien MA, Oxman AD. Audit and feedback: effects on professional practice and health care outcomes (Cochrane Review). In: The Cochrane Library, Issue 7. John Wiley & Sons, Ltd. 2010.
 209. Reinders ME, Ryan BL, Blankenstein AH, van der Horst HE, Stewart MA, van Marwijk HWJ. The Effect of Patient Feedback on Physicians' Consultation Skills: A Systematic Review. *Academic Medicine*. 2011;86(11):1426-36.
 210. Australian Government Department of Health. MBS Online - Medicare Benefits Schedule 2014 [updated 23 June 2014]. Available from: <http://www9.health.gov.au/mbs/search.cfm?q=715&sopt=S>.
 211. Harris M, Comino E, Islam M. (2014). Predictors of receipt of adult health assessment among New South Wales residents: a linkage study in Australian general practice. In: 2014 Primary Health Care Research Conference: Program & Abstracts. Primary Health Care Research and Information Service, Australia. phcris.org.au/conference/abstract/7998.
 212. Gorter S, Scherpbier A, Brauer J, Rethans JJ, van der Heide D, Houben H, et al. Doctor-patient interaction: standardized patients' reflections from inside the rheumatological office. *Journal of Rheumatology*. 2002;29(7):1496-500.

213. Piribauer F, Thaler K, Harris MF. Covert checks by standardised patients of general practitioners' delivery of new periodic health examinations: clustered cross-sectional study from a consumer organisation. *BMJ Open*. 2012;2:e000744. doi:10.1136/bmjopen-2011-.
214. Australian Institute of Health and Welfare. Indigenous identification in hospital separations data - Quality report. Cat. no. IHW 90. Canberra: AIHW, 2013.
215. McInnes DK, Saltman DC, Kidd MR. General practitioners' use of computers for prescribing and electronic health records - results from a national survey. *Medical Journal of Australia*. 2006;185(2):88-91.
216. Kidd MR, Mazza D. Clinical practice guidelines and the computer on your desk. *Medical Journal of Australia*. 2000;173(7):373-5.
217. National E-health Transition Authority. Practice Incentives Programme (PIP). Available at <http://www.nehta.gov.au/our-work/practice-incentives-programme> . Accessed 16 August 2014].
218. NSW Government. Policy Directive - Respecting the Difference: An Aboriginal Cultural Training Framework for NSW Health. North Sydney: Ministry of Health, NSW; 2011.
219. Abbott P, Reath J, Gordon E, Dave D, Harnden C, Hu W, et al. General Practitioner Supervisor assessment and teaching of Registrars consulting with Aboriginal patients - is cultural competence adequately considered? *BMC Medical Education*. 2014;14:167 <http://www.biomedcentral.com/1472-6920/14/167>.
220. Australian Institute of Health and Welfare. Indigenous identification in hospital separations data - Quality report. Cat. no. HSE 85. Canberra: AIHW, 2010.
221. Tynan M, Smullen F, Atkinson P, Stephens K. Aboriginal cultural competence for health services in regional Victoria: lessons for implementation. *Aust NZ J Public Health*. 2013;37(4):292-3.

Appendices

Appendix 1: Expression of Interest Circular (South-eastern Sydney)

UNSW research centre for primary health care and equity



THE UNIVERSITY OF
NEW SOUTH WALES
SYDNEY 2052 AUSTRALIA

EXPRESSIONS OF INTEREST

Opportunity to participate in Cultural respect in general practice in Sydney RACGP QA&CPD Activity Number: 757942

**This Clinical Audit activity has been approved
by the RACGP QA&CPD Program
TOTAL POINTS: 40 (Category 1)**

**Participants who successfully complete this activity
will also meet the Cultural Awareness component of
the Indigenous Health Practice Incentives program.**

*The University of New South Wales, with Botany Bay/La Perouse
Aboriginal Corporation, is conducting research focusing on
improving health care access to general practice in Sydney
for Aboriginal and Torres Strait Islander peoples.*

*The research will assess the existing cultural appropriateness of
health care offered to Aboriginal and Torres Strait Islander patients
in general practice. Participating practices will be provided with a
patient medical record audit and receive feedback regarding
improving the cultural acceptability of their practice.*

FAX TO: Professor Mark Harris (attn Heike)
Fax 9385 8404, or phone 9385 1103

Yes, I would like more information on this activity

GP Name(s) _____
Practice _____
Phone _____

Appendix 2: Participant Information Sheet - General practice (South- eastern Sydney)



La Perouse/Botany Bay
Aboriginal Corporation

UNSW research centre for primary health care and equity



THE UNIVERSITY OF
NEW SOUTH WALES
SYDNEY 2052 AUSTRALIA

Participant Information Statement – General Practice (south-eastern Sydney)

Cultural respect in general practice in Sydney

Principle Investigator: Professor Mark Harris

What's this study all about and who are we asking to take part?

You are being asked to be part of this study because you are a general practice in an area which has been identified as having a substantial Aboriginal and Torres Strait Islander population. The study will conduct research into the barriers and enablers for Australian Aboriginal and Torres Strait Islander peoples who attend mainstream general practice in urban Sydney. Its focus is on improving access to health care and therefore health outcomes for Australian Aboriginal and Torres Strait Islander peoples. The study will assess the existing cultural appropriateness of health care offered to Australian Aboriginal and Torres Strait Islander patients in mainstream general practice, and offer feedback to practices to facilitate change.

What will happen during the study?

Participation in the Cultural respect in General Practice in Sydney Project will involve:

1. Your agreement to participate
2. Practice audit*
3. Completion of a short questionnaire*
4. An interview*
5. Unannounced simulated patient(s) coming to your practice*
6. Feedback and practice facilitation

(*at Baseline and Post-Intervention)

1. *Your agreement to participate* - The Division of General Practice Close the Gap Officer will first contact you to ask to discuss whether you would be interested in being part of this project. If you agree, you will be asked to provide your written agreement to participate.
2. *Practice audit* - An audit of patient records will be performed to determine the number of Indigenous identified patients, and their current level of usage (number of consults and health checks performed). All patient record data collected will be in deidentified form. The audit will be performed by the Practice, with the UNSW Project Officer present to assist staff with any technical procedures involved in the audit.
3. *Completion of short questionnaire* - Participating staff will receive a brief self-complete questionnaire asking their views on the current Indigenous identification systems used in your practice and the level of culturally appropriate care given.
4. *Interview* - Participating staff may be asked to take part in an interview to determine their views on the barriers or enablers to Indigenous identification and providing culturally appropriate care in general practice.

5. *Unannounced simulated patients* - Unannounced simulated patient(s) will come to your practice to describe their experience of being an Aboriginal and Torres Strait Islander patient in your practice. Medicare will not subsidise any research-related simulated patient consultations and you will be reimbursed the full scheduled fee rebate for the consultation.
6. *Feedback and practice facilitation* - Your practice will be assisted to reflect on the its individual results and how it compares to other practices. The research team will then work with you, the Division and the local community to facilitate process change that is acceptable and feasible both in your practice and to the local Aboriginal community.

What happens with my information?

The information you provide will help us to improve the quality of care provided to Aboriginal and Torres Strait Islander patients in general practice. Any information you provide where any individual or organisation can be identified will remain confidential and will not be disclosed without the written permission of the individual or organisation, except as required by law. The information collected from you will be put together with information from other participants as combined overall results. The findings of this research as well as any tools developed will be shared with the local Aboriginal and Torres Strait Islander communities, general practices, and other health care providers. We plan to present the results as a PhD thesis, conference presentations, journal papers and as recommendations to policy makers. All information will be presented in such a way that no individual or organisation can be identified.

Where can I get more information?

If at any time you would like more information please contact Ms Heike Schütze on 9385 1103.

What if I do not want to participate?

Your decision whether or not to participate will not prejudice your future relations with the University of New South Wales or La Perouse/Botany Bay Aboriginal Corporation. If you decide to participate, you can withdraw your consent and discontinue participation at any time without prejudice.

Is this study approved?

This study has been reviewed and approved by the Human Research Ethics Committee of the University of New South Wales and the Aboriginal Health and Medical Research Council. Any complaints may be directed to any of the following:

Ethics Secretariat, University of New South Wales, Sydney, NSW 2052. Ph 9385 4245. Fax 9385 6648, Email ethics.sec@unsw.edu.au

The Chairperson, Aboriginal Health and medical Research Council Ethics, P.O. Box 1565, Strawberry Hills, NSW 2012. Ph 9698 1099, Fax 9690 1559, Email ahmrc@ahmrc.org.au

Any complaint you make will be investigated promptly and you will be informed out the outcome

Yours sincerely,



Professor Mark Harris

Appendix 3: Participant Consent Form (South-eastern Sydney)



La Perouse/Botany Bay
Aboriginal Corporation

UNSW research centre for primary health care and equity



THE UNIVERSITY OF
NEW SOUTH WALES
SYDNEY • 2052 • AUSTRALIA

PARTICIPANT CONSENT FORM (south-eastern Sydney)

Cultural respect in general practice in Sydney

Principle Investigator: Professor Mark Harris

1. I (name)
of (address)
agree to take part in the study described in the Participant Information Sheet.
2. I acknowledge that I have read and understood the Participant Information Sheet which explains why I have been selected and the aims of this investigation. I confirm that the statement has been explained to me to my satisfaction.
3. Before signing this consent form, I have been given the opportunity to ask any questions relating to the study. I have received satisfactory answers to any questions that I have asked.
4. I understand that my decision to participate is voluntary and that I am free to withdraw at any time without prejudice to my relationships to the University of New South Wales or La Perouse/Botany Bay Aboriginal Corporation.
5. I agree that the research data gathered from the results of the study may be published.
6. I understand that if I have any questions relating to my participation in this research I may contact Heike Schütze, Centre for Primary Health Care and Equity, University of New South Wales, Sydney 2052. Ph 9385 1103, Fax 9385 8404, Email: h.schutze@unsw.edu.au
7. I acknowledge receipt of a copy of this Participant Consent Form and the Participant Information Sheet.
8. Complaints may be directed to any of the following:

Ethics Secretariat, University of New South Wales, Sydney, NSW 2052. Ph 9385 4243, Fax 9385 6648, Email ethics.sec@unsw.edu.au

The Chairperson, Aboriginal Health and medical Research Council Ethics, P.O. Box 1565, Strawberry Hills, NSW 2012. Ph 9698 1099, Fax 9690 1559, Email ahmrc@ahmrc.org.au

Any complaint you make will be investigated promptly and you will be informed of the outcome.

Please PRINT your name _____

Signature _____ Date _____

Researcher's name Heike Schütze

Signature _____ Date _____



La Perouse/Botany Bay
Aboriginal Corporation

UNSW research centre for primary health care and equity



THE UNIVERSITY OF
NEW SOUTH WALES
SYDNEY • 2052 • AUSTRALIA

PARTICIPANT REVOCATION OF CONSENT FORM

Cultural respect in General Practice in Sydney

Principle Investigator: Professor Mark Harris

I hereby wish to **WITHDRAW** my consent to participate in the project described above and understand that such withdrawal **WILL NOT** jeopardise my relationship with the University of New South Wales or La Perouse/Botany Bay Aboriginal Corporation.

.....
Signature

.....
Date

.....
Please print name

If revoking your consent to participate, this page should be forwarded to:

Heike Schütze
Centre for Primary Health Care & Equity
L3 AGSM
University of New South Wales
SYDNEY 2052
(Forms can also be faxed to the above on 9385 8404)

Appendix 4: Participant Information Sheet - Individual / Focus Groups (South-eastern Sydney)



UNSW research centre for primary health care and equity



THE UNIVERSITY OF
NEW SOUTH WALES
SYDNEY • 2052 • AUSTRALIA

Participant Information Statement – Individual/Focus groups (south-eastern Sydney)

Cultural respect in general practice in Sydney

Principle Investigator: Professor Mark Harris

What's this study all about and who are we asking to take part?

You are being asked to be part of this study because you live or work in an area which has been identified as having a substantial Aboriginal and Torres Strait Islander population. The study will conduct research into the barriers and enablers for Australian Aboriginal and Torres Strait Islander peoples who attend mainstream general practice in urban Sydney. Its focus is on improving access to health care and therefore health outcomes for Australian Aboriginal and Torres Strait Islander peoples. The study will assess the existing cultural appropriateness of health care offered to Australian Aboriginal and Torres Strait Islander patients in mainstream general practice, and feedback to practices to facilitate change.

What will happen during the study?

Participation in the Cultural respect in General Practice in Sydney Project will involve:

1. *Your agreement to participate* – A member of your local Aboriginal Community or the Research Team will first contact you to ask whether you would be interested in being part of this project. If you agree, you will be asked to provide your written agreement to participate.
2. *Interview / focus group* – You will be asked to take part in a focus group to determine your experiences and views on any programs available through general practice in your area targeting the health of Aboriginal and Torres Strait Islander peoples.

What happens with my information?

The information you provide will help us to improve the quality of care provided to Aboriginal and Torres Strait Islander patients in general practice. Any information you provide where any individual or organisation can be identified will remain confidential and will not be disclosed without the written permission of the individual or organisation, except as required by law. The information collected from you will be put together with information from other participants as combined overall results. The findings of this research as well as any tools developed will be shared with the local Aboriginal and Torres Strait Islander communities, general practices, and other health care providers. We plan to present the results as a PhD thesis, conference presentations, journal papers and as recommendations to policy makers. All information will be presented in such a way that no individual or organisation can be identified.

Where can I get more information?

If at any time you would like more information please contact Ms Heike Schütze on 9385 1103.

What if I do not want to participate?

Your decision whether or not to participate will not prejudice your future relations with the University of New South Wales or La Perouse/Botany Bay Aboriginal Corporation. If you decide to participate, you can withdraw your consent and discontinue participation at any time without prejudice.

Is this study approved?

This study has been reviewed and approved by the Human Research Ethics Committee of the University of New South Wales and the Aboriginal Health and Medical Research Council. Any complaints may be directed to any of the following:

Ethics Secretariat, University of New South Wales, Sydney, NSW 2052. Ph 9385 4234, Fax 9385 6648, Email ethics.sec@unsw.edu.au;

The Chairperson, Aboriginal Health and medical Research Council Ethics, P.O. Box 1565, Strawberry Hills, NSW 2012. Ph 9698 1099, Fax 9690 1559, Email ahnrc@ahnrc.org.au.

Any complaint you make will be investigated promptly and you will be informed out the outcome.

Yours sincerely,



Professor Mark Harris

Appendix 5: USP Assessment Checklist

UNSW research centre for primary health care and equity



THE UNIVERSITY OF
NEW SOUTH WALES
SYDNEY • 2052 • AUSTRALIA

USP Assessment

Practice ID _____

Date completed _____ Your name _____

1. Identification

1.1 Were you asked if you were Aboriginal on your first / follow up* visit? (delete that which is not required) Y _____ N _____ *(go to 2)*

1.2 How? (tick all that apply)

Indigenous status question is on registration form	_____
Asked by reception	_____
Asked by GP	_____
Asked by Nurse	_____
Other (specify)	_____

2. Literacy check

2.1 Were you asked if you need help filling in any paperwork? Y _____ N _____

3. Practice environment

3.1 Does the practice have posters, brochures or other information visible to encourage patients to self-identify as Aboriginal? Y _____ N _____ *(go to 3.2)*

Describe _____

3.2 Does the practice have Aboriginal symbols of welcome such as an Aboriginal flag on the entrance door or Aboriginal artwork? Y _____ N _____ *(go to 4)*

Describe _____

The Consultation

4. (Nurse)

4.1 Was the nurse seen? Y _____ N _____ (go to 5)

4.2 What did the nurse do? _____

4.3 How long did you spend with the nurse? _____

4.4 Did the nurse explain things to you in a way you understood? Y _____ N _____

Explain _____

4.5 Did you feel you could relate to the nurse? Y _____ N _____

Explain _____

5. (GP)

5.1 How long did you have to wait to be seen? hours _____ minutes _____

5.2 Asked about previous medical history? Y _____ N _____

5.3 Asked about current medications? Y _____ N _____

5.4 Was blood pressure taken? Y _____ N _____

5.5 Was weight taken? Y _____ N _____

5.6 Was a waist measurement taken? Y _____ N _____

5.7 Asked about smoking? Y _____ N _____

5.8 Asked about nutrition? Y _____ N _____

5.9 Asked about alcohol? Y _____ N _____

5.10 Asked about exercise/physical activity? Y _____ N _____

5.11 Asked if you have had any Aboriginal health checks? Y _____ N _____

5.12 Were any blood tests ordered? Y _____ N _____

5.13 Were any scripts ordered? Y _____ N _____

5.14 Were any referrals made? Y _____ N _____

5.15 How long did you spend with the GP? hours _____ minutes _____

5.16 Did the GP explain things to you in a way you understood? Y _____ N _____

Explain _____

5.17 Did you feel you could talk with and be understood by the GP? Y _____ N _____

Explain _____

5.18 Were you told to make a follow-up appointment? Y _____ N _____

6. Other health professional

6.1 Did anyone else see you? Y _____ N _____ (go to 7)

6.2 Who and what did they do? _____

6.3 How long did you spend with them? _____

6.4 Did they explain things to you in a way you understood? Y _____ N _____

Explain _____

6.5 Did you feel you could engage with them? Y _____ N _____

Explain _____

7. Indigenous PIP

7.1 Were you asked to register for the Indigenous PIP? Y _____ N _____ (go to 8)

7.2 Was it explained to you in a way you understood? Y _____ N _____

7.3 Did you feel forced into signing? Y _____ N _____

7.4 *Comments* _____

8. PBS Co-payment

8.1 Were you asked to register for the PBS Co-payment? Y _____ N _____ (go to 9)

8.2 Was it explained to you in a way you understood? Y _____ N _____

8.3 Were you able to register once you asked for it? Y _____ N _____

8.4 *Comments* _____

9. How comfortable you felt

9.1 **Making the appointment** Not at all Minimally Somewhat Moderately Very

Comments _____

9.2 **Walking in** Not at all Minimally Somewhat Moderately Very

Comments _____

9.3 **At reception** Not at all Minimally Somewhat Moderately Very

Comments _____

9.4 **In waiting room** Not at all Minimally Somewhat Moderately Very

Comments _____

9.5 **With the GP** Not at all Minimally Somewhat Moderately Very

Comments _____

9.6 **With the nurse** Not at all Minimally Somewhat Moderately Very N/A

Comments _____

9.7 **With other health professional** Not at all Minimally Somewhat Moderately Very N/A

Comments _____

9.8 **Making follow-up appointment** Not at all Minimally Somewhat Moderately Very N/A

Comments _____

Appendix 6: Practice Summary and Patient Audit

Practice Summary & Patient Audit

Practice ID _____ Audit Date _____
Timepoint Baseline _____ Post Intervention _____

PRACTICE SUMMARY

1. Practice Demographics

GP	F/T (M)	F/T (F)
	P/T (M)	P/T (F)
PN	F/T (M)	F/T (F)
	P/T (M)	P/T (F)
Practice Staff	F/T (M)	F/T (F)
	P/T (M)	P/T (F)

2. Practice Software Y (name) _____ N _____

3. Practice registered for Indigenous PIP Y _____ N _____ x _____

4. No. of staff having undergone cultural awareness training in the last 12 months?

- (a) GP _____
- (b) Practice Nurse _____ N/A
- (c) Other medical /allied health staff _____ N/A
- (d) Practice Manager _____ N/A
- (e) Receptionist _____ N/A

Name of the program and organisation that delivered the training?

PATIENT RECORD AUDIT

Note: Data on Aboriginal and Torres Strait Islander patients and MBS Item No. data can be obtained from clinical software such as Medical Director, Pracsoft and/or from the PEN Clinical Audit Tool.

5. Patient Indigenous status recording

Total no. of patients aged 18 or over	_____	100 %
No. identified as Aboriginal	_____	%
No. identified as Torres Strait Islander	_____	%
No. identified both Aboriginal and Torres Strait Islander	_____	%
No. identified as neither	_____	%
No. refused	_____	%
No. unidentified	_____	%

6. No of Indigenous-identified patients aged 18 or over _____

7. No of consultations (between audit dates) _____

8. No of health checks in the past 6 months

- 701 Brief Health Assessment of less than 30 minutes duration
- 703 Standard Health Assessment lasting more than 30 minutes but less than 45 minutes
- 705 Long Health Assessment lasting more than 45 minutes but less than 60 minutes
- 707 Prolonged Health Assessment lasting more than 60 minutes
- 715 Aboriginal and Torres Strait Islander people Health Assessment
- 10986 Healthy Kids Check provided by a practice nurse or registered Aboriginal Health Worker
- 10987 Follow up service provided by a practice nurse or registered Aboriginal Health Worker, on behalf of a Medical Practitioner, for a patient who has received a health assessment
- 81300 Patients referred by a GP for health services provided by an eligible Aboriginal health worker

MBS Item No.	No. undertaken													
	18-19		20-29		30-39		40-49		50-59		60-65		65+	
	M	F	M	F	M	F	M	F	M	F	M	F	M	F
701														
703														
705														
707														
715														
10986														
10987														
81300														

9. How many (if any) patients in the practice have registered for:

Measure	No. undertaken													
	18-19		20-29		30-39		40-49		50-59		60-65		65+	
	M	F	M	F	M	F	M	F	M	F	M	F	M	F
Indigenous Health Incentive														
PBS Co-payment measure														
Both														

Appendix 7: GP and practice staff self-complete questionnaire

UNSW research centre for *primary health care and equity*



THE UNIVERSITY OF
NEW SOUTH WALES
SYDNEY • 2052 • AUSTRALIA

Self-complete questionnaire (Practices)

1. Demographics

1.1 Gender: Female Male

1.2 Age: <25 25-34 35-44 45-54 55-64 65+

1.3 Working status: Full-time Part-time (if part-time, specify hours per week _____)

1.4 Role: GP Practice Nurse Practice Manager Practice Staff

1.5 Ethnicity (specify): _____

2. Identification

2.1 At registration, are new patients asked if they need help filling in registration form?

Y _____ N _____ Don't Know _____

2.2 How are patients identified as being of Aboriginal and Torres Strait Islander backgrounds in your practice? Tick all that apply

NEW patients	EXISTING patients
Indigenous status question is on registration form _____	Indigenous status question is on registration form _____
Asked by reception _____	Asked by reception _____
Asked by GP _____	Asked by GP _____
Asked by Nurse _____	Asked by Nurse _____
Other (specify) _____	Other (specify) _____
Patients are not asked their indigenous status _____	Patients are not asked their indigenous status _____
Don't Know _____ (go to 2.5)	Don't Know _____ (go to 2.5)

2.3 How well do you think your current identification process works in identifying NEW Aboriginal and Torres Strait Islander patients? *Please circle one response*

Not at all Very Poor Poor Good Very Well Don't know
(Identifies 0%) (Identifies 25%) (Identifies 50%) (Identifies 75%) (Identifies 100%)

How could this be improved? _____

2.4 How well do you think your current identification process works in identifying EXISTING Aboriginal and Torres Strait Islander patients? *Please circle one response*

Not at all Very Poor Poor Good Very Well Don't know
(Identifies 0%) (Identifies 25%) (Identifies 50%) (Identifies 75%) (Identifies 100%)

How could this be improved? _____

2.5 Is the patient's Indigenous status recorded on the patient medical record?

Y _____ N _____ Don't Know _____

3. Community Engagement

3.1 Does your practice currently engage with the local Aboriginal and Torres Strait Islander organisations? Y _____ N _____ (*go to 3.2*) Don't Know _____ (*go to 3.2*)

If 'Yes', describe the organisations and the engagement _____

3.2 In the last 12 months, has your practice had any contact with Aboriginal-specific health organisations or staff about the medical care of Aboriginal and Torres Strait Islander patients at your practice (e.g. Aboriginal Medical Service (AMS), Division of General Practice outreach worker)?

Y _____ N _____ (*go to 3.5*) Don't Know _____ (*go to 3.5*)

If 'Yes', describe the organisations and the engagement _____

3.3 How often has this contact been, with 0 being very rarely and 5 being quite often? *Please circle one response*

1 2 3 4 5 Don't know (*go to 3.5*)

3.4 How adequate do you feel this is? Please circle one response

Not at all adequate A little adequate Somewhat adequate Adequate Very adequate Don't know

3.5 In the last 12 months, have you undertaken Aboriginal and Torres Strait Islander cultural awareness training for this practice?

Y _____ N _____ (go to 4)

3.6 How useful do you think this was to your work? Please circle one response

Not at all useful A little useful Somewhat useful Useful Very useful Don't know (go to 4.0)

Explain how you were or were not able to use this training _____

4. Your views

4.1 Thinking about providing culturally appropriate care to Aboriginal and Torres Strait Islander patients this practice, what do you think the

a) enablers are? _____

b) barriers are? _____

4.2 Are you aware of the Aboriginal-specific MBS item numbers available for Aboriginal and Torres Strait Islander patients for health checks, allied health visits and chronic disease management? Y _____ N _____ (go to 4.3)

What are your views on this? _____

4.3 Are you aware of the PBS co-payment measure available for Aboriginal and Torres Strait Islander patients which enables patients with or at-risk of chronic disease to receive their medications at a reduced rate if they do not hold a Health Care Card or for free if they do hold one?

Y _____ N _____ (go to 4.4)

What are your views on this? _____

4.4 Is your practice registered for the PIP Indigenous Health Incentive?

Y _____ (go to 4.6) N _____ Don't know _____

If 'No', what are the reasons for not registering for the PIP Indigenous Health Incentive?

4.5 Would you be interested in applying for the PIP Indigenous Health Incentive so that you could provide the PBS co-payment measures to Aboriginal and Torres Strait Islander patients and receive the PIP incentive if accreditation was not required?

Y _____ N _____ Don't know _____

4.6 What are your views on the PBS co-payment measures available to Aboriginal and Torres Strait Islander patients being tied to practices registering for a PIP payment?

Next two questions for follow-up only:

4.7 In what ways has this study improved the acceptability of your practice to Aboriginal and Torres Strait Islander patients, if any?

4.8 How have your own attitudes, understanding and skills changed regarding appropriate health care service delivery for Aboriginal and Torres Strait Islander peoples, if at all?

Both Baseline and Follow-up:

4.9 What other comments would you like to make?

THANK YOU FOR TAKING THE TIME TO COMPLETE THE SURVEY.

Appendix 8: Example of a baseline Practice Feedback Report

UNSW research centre for primary health care and equity



THE UNIVERSITY OF
NEW SOUTH WALES
SYDNEY • 2052 • AUSTRALIA

Practice Feedback Report

for

Practice: [suppressed]

GP: [suppressed]

18/09/2013

This is a report of the outcomes of the Unannounced Standardised Patient (USP) visit to your practice, as well as a clinical audit of your Indigenous identification and recording systems and Aboriginal and Torres Strait Islander patient health assessments.

INTRODUCTION

This report contains results of the unannounced standardised patient visit to your practice as well as feedback on your recording systems and the clinical audit of Aboriginal and Torres Strait Islander patient health assessments.

The report aims to provide you with feedback about:

- The completeness of your patient Indigenous identification methods and record keeping. Where possible, your results are compared to the average result of all participating practices.
- The current level of cultural appropriateness of your practice as assessed by a member of the local Aboriginal Community.

ELIGIBILITY CRITERIA

Only records of patients who met the inclusion criteria were audited. The criteria were:

- Aged 18 years or over
- Had attended the practice within the past two years

Total no. of eligible patients in your practice n = 15,246

ASKING AND RECORDING INDIGENOUS STATUS

The best practice guidelines for collecting Indigenous status in health data sets are:

- Australian Institute for Health and Welfare. National best practice guidelines for collecting Indigenous status in health data sets. Cat. no. IHW 29. Canberra: AIHW; 2010
- RACGP. RACGP Standards for general practices 4th edition. Melbourne: The Royal Australian College of General Practitioners; 2010.

Current guidelines recommend that all new and existing patients are asked their Indigenous status. Information systems should record Aboriginal and/or Torres Strait Islander or non-Indigenous status information using the national categories for recording Indigenous status as set out below.

1. Aboriginal but not Torres Strait Islander origin
2. Torres Strait Islander but not Aboriginal origin
3. Both Aboriginal and Torres Strait Islander origin
4. Neither Aboriginal nor Torres Strait Islander origin
9. Not stated/inadequately described

The following table show the number and percentage of patients in your practice with the Indigenous status recorded.

Indigenous Identification status	Your practice	Average all practices (n=6)
	%	%
Aboriginal	0.1	0.3
Torres Strait Islander	0	0
Both Aboriginal and Torres Strait Islander	0.1	0.1
Neither	54.3	30.4
Refused / Inadequately stated	0	9.8
Unidentified	45.5	59.3

Points For Reflection

Asking and recording Indigenous Status

- Although your new patient registration form asks patients "Are you an Aboriginal or Torres Strait Islander? Y/N," this does not allow differentiation between cultural groups. Some people who are both Aboriginal and Torres Strait Islanders will not be confined to answering that they are either Aboriginal or Torres Strait Islander. Similarly, some Aboriginals do not being "lumped in" with Torres Strait Islanders and visa versa as they are both very different and distinct ethnic groups.
- Some Aboriginal or Torres Strait Islander patients do not feel safe identifying on a form at reception. Some do not understand why they are being asked their ethnicity. It is recommended that all patients who do not answer the question are asked discreetly by reception. Additionally, some patients will only ever want to identify to the doctor and it is recommended that doctors also check the Indigenous status of all their patients.
- The unannounced standardised patient (USP) did not fill in the Indigenous status question at reception to see if reception or the doctor would check. The USP was not asked her Indigenous status and her Indigenous status was incorrectly recorded on the medical record as "Non ATSL."

Literacy

- Not all patients who reside in urban areas are literate. Many illiterate patients are too ashamed or embarrassed to disclose their illiteracy. Literacy should never be assumed. Reception should discreetly offer all patients if they need help with any paperwork. After being presented with the New Patient Registration Form, the USP made an excuse that she had forgotten her glasses and then fidgeted for a while to see if she would be offered any assistance. She was not offered assistance.

PBS CO-PAYMENT MEASURE

The Closing the Gap (CtG) Pharmaceutical Benefits Scheme (PBS) Co-payment Measure aims to improve access to PBS medicines for Aboriginal and Torres Strait Islanders living with, or at risk of, chronic disease by providing PBS medicines at lower prices or free of charge. Aboriginal and Torres Strait Islander patients of any age are eligible if they have, "an existing chronic disease or are at risk of chronic disease and in the opinion of the prescriber:

- would experience setbacks in the prevention or ongoing management of chronic disease if they did not take the prescribed medicine and
- are unlikely to adhere to their medicines regimen without assistance through the measure."

[Source: Australian Government Department of Human Services. Closing the Gap—PBS Co-payment Measure. Available from <http://www.medicareaustralia.gov.au/provider/pbs/prescriber/closing-the-gap.jsp> [Accessed 21 June 2012].

The following table shows the number of patients registered for the Indigenous Health PIP and/or the *CiG* Co-Payment Measure.

	Your practice	Average all practices (n=3)
Indigenous Health Incentive	0	0
PBS Co-payment measure	0	0
Both	0	4 (range 0-6)

Points For Reflection

- Your practice is able to provide *CiG* scripts as it is registered for the Indigenous Health Practice Incentive Payment. This service could greatly benefit your Aboriginal and Torres Strait Islander patients by removing any financial barriers that may impede medication compliance.

THE PRACTICE ENVIRONMENT

The following table shows an assessment of visual symbols of welcome.

	Your practice	% all practices (n=6)	
Brochures/posters encouraging self identification	No	Yes 0%	No 100%
Aboriginal artwork/flag	No	Yes 17%	No 83%
Acknowledgement to country	No	Yes 0%	No 100%

POINTS FOR REFLECTION

- Many Aboriginal and Torres Strait Islander peoples feel ill at ease when presenting to Western organisations as such as mainstream health services. Feedback from the USP and focus groups with Aboriginal and Torres Strait Islander peoples from the local community and has highlighted the importance of visual symbols to Aboriginal and Torres Strait Islander patients to demonstrate that they are welcome at the practice. This can be achieved in a number of way: having “black faces” (Aboriginal and Torres Strait Islander staff members) employed at the practice; displaying Aboriginal and Torres Strait Islander art work, health posters or the Aboriginal and Torres Strait Islander flag. Many practices cannot employ extra staff and do not put up art work or posters. A solution for all practices is an acknowledgement to country in the window, reception area or the waiting room. For example, “*We acknowledge the people of the Eora nation as the traditional owners of this land and pay our respect to Elders past and present.*” This is usually displayed with the Aboriginal and Torres Strait Islander flags.

HOW THE USP FELT

The following table shows the USPs level of comfort for various aspects whilst at your practice.

	Your practice					% all practices (n=6)				
	Not at all	Minimally	Somewhat	Moderately	Very	Not at all	Minimally	Somewhat	Moderately	Very
Making initial appointment			x			0	0	33	0	67
Walking in			x			0	0	67	33	0
At reception		x				33	33	0	17	17
In waiting room	x					33	0	50	17	0

POINTS FOR REFLECTION

- The USP reported that she was put on hold for eight minutes when she telephoned to make the appointment. The USP reported that the receptionist had difficulty understanding her and she had to spell her name for the receptionist four times and that the receptionist still got it wrong although the name used was a simple common name.
- The USP reported that reception ignore everyone walking in and out. The USP reported that patients are required to take a ticket and are treated like a number. The USP reported that the ticket machine is not immediately visible when entering the practice and it was only when she was standing at the reception desk and being ignored by reception that she glanced at a monitor on the wall and saw a ticket number being displayed so realised she was supposed to get a ticket and went searching for the machine. She reported that she felt this process is cold and impersonal for a medical practice.

HEALTH ASSESSMENTS

The best practice guidelines for Aboriginal and Torres Strait Islander health assessments are:

- NACCO/RACGP. National guide to a preventative health assessments for Aboriginal and Torres Strait Islander people. 2nd Edition. South Melbourne: The Royal Australian College of General Practitioners; 2012.

Current guidelines recommend that Aboriginal and/or Torres Strait Islander patients undertake a health assessment (MBS Item 715) annually. The minimum time allowed between services is nine (9) months. Practitioners may perform Health Assessments under other item numbers. The following table shows the number of health assessments carried out on Aboriginal and Torres Strait Islander patients in the past 2 years.

Consultations and Health Checks	Your practice	Average all practices (n=6)
Indigenous Patients	34	12 (range 0-22)
No of consultations past 2 years	154	95 (range 0-250)
Aboriginal and Torres Strait Islander Health Check Assessments (MBS Item 715)	1	1 (range 0-2)
Health Check Assessments – (MBS item numbers 703, 705, 707, 10986, 10987, 81300)	0	0

Points For Reflection

- Aboriginal and Torres Strait Islander peoples represent about 2.5% percent of the total Australian population, yet contribute 3.6% of the total burden of disease. Chronic diseases account for 80% of the difference in the burden of disease observed between the Aboriginal and Torres Strait Islander peoples and other Australians. Due to the higher rate and earlier onset of chronic disease, annual health assessments are recommended for Aboriginal or Torres Strait Islander patients to detect disease early or prevent disease.

(Pages 7 and 8 for the participating GP only)

THE CONSULTATION

(the following pages are ONLY to be given to the participating GP)

The following table shows the USPs account of various areas covered in the consultation.

	Your practice	% All practices (n=6)	
Asked about previous medical history?	Yes	Yes 100%	No 0%
Asked about current medications?	Yes	Yes 100%	No 0%
Was blood pressure taken?	Yes	Yes 100%	No 0%
Was weight taken?	No	Yes 0%	No 100%
Was a waist measurement taken?	No	Yes 0%	No 100%
Asked about smoking?	Yes	Yes 100%	No 0%
Asked about nutrition?	No	Yes 17%	No 83%
Asked about alcohol?	No	Yes 0%	No 100%
Asked about exercise/physical activity?	Yes	Yes 50%	No 50%
Asked if you have had any Aboriginal health checks?	No	Yes 0%	No 100%
Were any blood tests ordered?	No	Yes 17%	No 83%
Were any scripts ordered?	No	Yes 33%	No 67%
Were any referrals made?	No	Yes 33% (chest x-ray)	No 67%
Did the GP explain things to you in a way you understood?	Yes	Yes 100%	No 0%
Did you feel you could talk with and be understood by the GP?	Yes	Yes 100%	No 0%
	Your practice	Average all practices (n=6)	
Time spent waiting for GP	47 minutes	20 minutes (range 3-47)	
Time spent with GP	18 minutes	17 minutes (range 7-40)	

POINTS FOR REFLECTION

- Smoking and BP were assessed which are important risk factors. Aboriginal and Torres Strait Islander peoples have higher rates of obesity and diabetes related to overweight and poor diet, with onset at a younger age than other Australians. Thus it is important to routinely assess and monitor weight, waist circumference, nutrition, alcohol and physical activity. Referrals to dieticians or lifestyle change services should be considered. Physical activity was assessed.

The following table shows the USPs level of comfort during the consultation.

	Your practice					% all practices (n=6)				
	Not at all	Minimally	Somewhat	Moderately	Very	Not at all	Minimally	Somewhat	Moderately	Very
With the GP					x	0	17	17	33	33

POINTS FOR REFLECTION

- The USP reported that she felt very comfortable with the doctor and felt that he was nice and down to earth. The doctor provided her with a printout of the consultation notes so that she could take it another GP. The doctor had written instructions down for the USP regarding her medication change so that she wouldn't forget the instructions. The doctor had also provided his mobile number and offered to make a house call for follow up.
- The USP reported that if given a choice, she would see the doctor again in another venue but would not return to that practice again.

Appendix 9: Evaluation of the implementation of the intervention (Practice 101)

NPT Domain	Questions to consider within the NPT framework	NPT evaluation	Data Source
Coherence	Could participants easily describe the intervention?	<p>The participants understood that a USP presented as a patient and feedback was provided on whether or not the USP had their Indigenous status identified and how they rated their experience as a patient in the practice.</p> <p>The GP understood that the study aimed to increase his awareness regarding the provision of appropriate healthcare to Aboriginal and Torres Strait Islanders: <i>"Well I guess I am a good person for this study because I don't know anything about this, these people"</i>, GP 101102</p>	FN FN
	Could they clearly distinguish it from other interventions?	<p>The GP was surprised to learn the USPs were the study patients as he felt the consultations were straight forward and he was expecting more complex scenarios.</p> <p>Once participants received the baseline Practice Feedback Report showing the results of the clinical audit and the USP visit, and received the CA training explaining the health disparities between Indigenous and other Australians, they fully understood that they needed to change their Indigenous status Identification systems and the practice environment, and to provide targeted care.</p>	FN FN
	Did participants think the intervention had a clear purpose?	<p>The GP felt that Indigenous status identification and increased awareness would lead to targeted care: <i>"I suppose if the doctor you know have more knowledge about this group of population it might help...and also the, the disease pattern...and in the management of it"</i>, GP 101102.</p>	I
	Did participants have a shared sense of its purpose?	<p>The Practice Manager did not see Indigenous health as a priority and believed that the practice did not have any Indigenous patients.</p> <p>The GP felt that the intervention would increase his knowledge and help him provide more targeted care.</p>	FN FN, I
	What benefits did participants think the intervention would bring and to whom?	<p>The GP felt that the intervention would benefit him by increasing his awareness and enabling targeted care: <i>"Oh that definitely give us the um awareness...there is this group population that you know that should be look after...as a doctor we should um you know look into that more, more thoroughly and be more focused with this population"</i>, GP 101102.</p>	I

NPT Domain	Questions to consider within the NPT framework	NPT evaluation	Data Source
	Were participants likely to value these benefits?	(No data)	
	Did participants believe it would fit with the overall goals and activity of the organisation?	(No data)	
Cognitive participation	Did participants think the intervention was a good idea?	The GP and reception staff felt they didn't have any or very few Aboriginal patients, but thought that the intervention was a good way to learn about giving the best possible care to any current or future Indigenous patients.	FN
	Did they see the point of the intervention easily?	Once the participants received the Cultural Awareness training they understood why Indigenous status identification was important.	FN
	Were they prepared to invest time, energy and work in it?	The GP was eager to facilitate appointments for interviews and training. During the training sessions he took notes, as did the receptionist. The receptionist that did receive training as part of the intervention said she was going to make a conscious effort to identify patient's Indigenous status. The reception staff seemed keen and willing to take to take part in the training offered in the intervention but were not able to because the Practice Manager would not allow them to, which resulted in them being excluded from the study.	FN FN FN
Collective action	How did the intervention affect participants work?	As part of the intervention, staff were trained to actively ask all new and existing patients their Indigenous status. The GP needed to change his work by adding this to all his consultations. He remarked that he had been remembering to consciously ask patients their Indigenous status but forgot for a while. The receptionist that received the training stated that she needed to change her work by following up on new patients who did answer the Indigenous status question on the New patients Registration Form and by asking all existing patients their Indigenous status. The receptionist stated that ever since she had received training as part of the intervention, she asked all patients their Indigenous status, even though none of the other reception staff were doing this. She said she had no control over updating the New Patient Registration Form according to Best Practice Guidelines as this was the Practice Manager's decision.	I FN

NPT Domain	Questions to consider within the NPT framework	NPT evaluation	Data Source
	Did it promote or impede their work?	The GP felt overall the study increased knowledge and awareness and therefore improved clinical practice: <i>"I think the education of the doctors...influence the clinical practice, so I think it is a good study because it does educate the doctor and make him aware"</i> , GP 101102.	I
	What effect did it have on consultations?	The GP needed to add Indigenous status identification to the history taking and be conscious of providing targeted care. Shortly after the Intervention, the GP stated that he had had patients identify as Aboriginal but had no yet done their health checks.	FN, I FN
	Did staff require extensive training before they could use it?	Yes because prior to the intervention they were unaware of why Indigenous status was recorded.	I, S, FN
	How compatible was it with existing work practices?	New patients were already asked to self-identify their Indigenous status via a registration form prior to the Intervention; staff needed to expand on this by prompting patients to answer the question if it had not been answered on the form and by asking existing patients as well. However, because the reception staff were excluded from the study, this could not be performed on a practice level.	FN
	What impact did it have on division of labour, resources, power, and responsibility between different professional groups?	The Practice Manager did not allow his reception staff to take part in the intervention. As he was not in charge of the GPs, the GP was free to continue. Despite not being allowed to receive the full training in the intervention, one receptionist who had already received some training continued to ask all patients their Indigenous status even though she was the only receptionist in the practice who did this, but only did so when so other staff were around. The GP learnt that Identification was not just the role of the reception staff but was part of his role in providing appropriately targeted care.	FN FN
	Did the intervention fit with the overall goals and activity of the organisation?	The potential for increased patient numbers was an important factor for the Practice Manager.	FN

NPT Domain	Questions to consider within the NPT framework	NPT evaluation	Data Source
Reflexive Monitoring	How did participants perceive the intervention after it had been in use for a while?	<p>The GP felt that the strengths of the intervention were, "<i>Personal involvement of researcher, teaching, communication, USP usage, repeated reflections by way of reports, audio recording pre/post</i>" and that there were no weaknesses, GP 101102.</p> <p>The receptionist that received some training stated that she tried to ask all patients their Indigenous status as a matter of routine.</p>	S(R) FN
	Did they perceive it as being advantageous for patients or staff?	<p>Yes, the GP reflected that, "<i>This research is very important to make health care equal,</i>" GP 101102.</p> <p>The GP said, "<i>I think the education of the doctors...influence the clinical practice, so I think it is a good study because it does educate the doctor and make him aware,</i>" GP 101102.</p>	S I
	Did participants see what effects the intervention has had?	<p>Yes, the GP reflected that he was "<i>...more directed to A/TS Islander people's health need,</i>" GP 101102.</p> <p>The GP reflected that the training was very beneficial to the receptionist that did receive it: "<i>I think one or two of them has been educated by you Heike and that has been very good,</i>" GP 101102.</p> <p>The GP saw that he had identified some Indigenous patients and should focus on targeted care for them: "<i>I do put up the poster, up um in front of the patient for a while and then I did pick up a few, two or three patients...I think I should follow that up some more closely now so what illness they would have in particular, yeah their needs,</i>" GP 101102.</p>	S I I
	Could users/staff contribute feedback about the intervention after it had been in use?	Yes the GP provided feedback during the practice visits and via the follow-up survey and GP Reflection form.	FN, S, S(R)
	Could the intervention be adapted / improved on the basis of experience?	Yes, the GP changed the position of his 'Are you Aboriginal' sign in his office and was trying to work out how to get one up in the reception area and bypassing the Practice Manager.	FN

KEY: A= Audit, FN= field notes, I= interview, S= survey, S(R)= GP Reflection Survey, U= USP

Appendix 10: Evaluation of the implementation of the intervention (Practice 102)

NPT Domain	Questions to consider within the NPT framework	NPT evaluation	Data Source
Coherence	Could participants easily describe the intervention?	The GP misunderstood the point of the study. She felt it was just to enhance her cultural awareness (although she refused to take part in the CA training offered in the study): <i>"I decided to do it when I was appointed to a rural AMS to enhance my cultural awareness...and my cultural awareness training has been minimal (but maybe I misunderstood the purpose of this study)"</i> , GP 102101. <i>"I guess I didn't fully understand the audit"</i> , GP 102101.	S S(R) FN
	Could they clearly distinguish it from other interventions?	The GP could not accept that she needed to change anything that she did. She realised that there was already an effective Indigenous status identification system in place at reception, but would not acknowledge that she also had a role to play in identifying patients and providing targeted care.	
	Did participants think the intervention had a clear purpose?	(No data)	
	Did participants have a shared sense of its purpose?	The GP felt the intervention would enhance her cultural awareness: <i>"I decided to do it when I was appointed to a rural AMS to enhance my cultural awareness"</i> , GP 102101.	S
	What benefits did participants think the intervention would bring and to whom?	The GP felt that the intervention would benefit her by increasing her awareness in regards to providing appropriate care to Aboriginal patients: <i>"I've been considering doing some remote work up north, so I thought this might be good to help me know, you know, know if I should do anything different"</i> , GP 102101.	FN
	Were participants likely to value these benefits?	(No data)	
	Did participants believe it would fit with the overall goals and activity of the organisation?	No, the GP felt that the Practice Principal did not see Indigenous health as a practice priority. <i>"I have to be honest I think my boss wasn't that keen to go after the PIP...for Aboriginal care"</i> , GP 102101.	I

NPT Domain	Questions to consider within the NPT framework	NPT evaluation	Data Source
Cognitive participation	Did participants think the intervention was a good idea?	The GP was keen to sign up for the study as she had an interest in Aboriginal health. Although she felt that the practice did not have any Aboriginal patients she did want to know about providing appropriate care to Aboriginal patients and felt that the intervention would provide this knowledge. No other member of the staff wanted to sign up for the study as they felt they did not have any Aboriginal patients and they were not willing to undertake any more activities at work if they didn't have to.	FN FN
	Did they see the point of the intervention easily?	(No data)	
	Were they prepared to invest time, energy and work in it?	No. The GP did not want to undertake the Cultural Awareness training or have practice facilitation visits. The GP impatiently asked the researcher how long it would take at each visit. The GP stated: <i>"I also now realise [the study] involved more of my time than I was lead to believe"</i> GP 102101. No other member of staff would take part in the intervention.	FN S FN
Collective action	How did the intervention affect participants work?	As part of the intervention, the GP was trained to actively ask all new and existing patients their Indigenous status. The GP needed to change how she did her work by following up on patients Indigenous status during the history taking and not just relying on reception to identify patients' Indigenous status. The GP did not incorporate this change into her work.	FN
	Did it promote or impede their work?	(No data)	
	What effect did it have on consultations?	The GP was provided training about the various Aboriginal-specific MBS item numbers and demonstrated how to perform an Aboriginal Health Assessment on the USP at follow-up.	USP
	Did staff require extensive training before they could use it?	Yes because prior to the intervention the GP was unaware of the different health care needs of Aboriginal and Torres Strait Islander Australians.	FN
	How compatible was it with existing work practices?	New and existing patients were already asked to self-identify their Indigenous status via a registration form; the GP needed to expand on this by prompting patients to answer the question if it had not been answered on the form and by asking existing patients.	FN

NPT Domain	Questions to consider within the NPT framework	NPT evaluation	Data Source
	What impact did it have on division of labour, resources, power, and responsibility between different professional groups?	There was a very good Indigenous status identification system in place at reception and the practice relied on reception identifying patients. As part of the intervention, the GPs and nurses would have also had to follow up on patient's Indigenous status, which they did not do.	FN
	Did the intervention fit with the overall goals and activity of the organisation?	No, the Practice Principal did not see Indigenous health as a priority.	FN
Reflexive Monitoring	How did participants perceive the intervention after it had been in use for a while?	The GP did not engage with the intervention and felt that it did not benefit her in any way.	FN, I
	Did they perceive it as being advantageous for patients or staff?	The GP did not think the intervention had any affect and felt that Indigenous status identification was driven was practice accreditation: <i>"We're going through all our patients up dating all our records to make sure everything is, but you know I don't know what's motivated, that's probably um accreditation rather than anything else"</i> , GP 102101.	I
	Did participants see what effects the intervention has had?	No. The GP would not recognise that the 'Are you Aboriginal sign' that the receptionist pointed to in order to explain to the USP why they were being asked their Indigenous status was provided as part of the intervention. The GP said she did not have a change in attitudes, understanding and skills on a local level, only as a result of her rural AMS work. <i>"...not much locally but um in the country I'm learning all the time working in Aboriginal health, but not much locally yeah, nothing's happened really locally in Sydney"</i> , GP 102101.	FN I
	Could users/staff contribute feedback about the intervention after it had been in use?	Yes the GP provided feedback via the follow-up survey and GP Reflection form.	S, S(R)
	Could the intervention be adapted / improved on the basis of experience?	Not without the GP acknowledging that she had a role to play in Indigenous status identification.	FN, S

KEY: A= Audit, FN= field notes, I= interview, S= survey, S(R)= GP Reflection Survey, U= USP

Appendix 11: Evaluation of the implementation of the intervention (Practice 103)

NPT Domain	Questions to consider within the NPT framework	NPT evaluation	Data Source
Coherence	Could participants easily describe the intervention?	<p>The participants understood that a USP presented as a patient and feedback was provided on whether or not the USP had their Indigenous status identified and how they rated their experience as a patient in the practice.</p> <p>The GP and reception staff understood that the study aimed to increase their awareness regarding providing appropriate healthcare to Aboriginal and Torres Strait Islanders: <i>"Oh it will educate me so I know what may be more appropriate..."</i>, GP 103101.</p> <p><i>It would make us all more aware of what's going on because we've got no idea what any, any of that stuff is about...I guess it would just make it better because then we'd be more aware of things"</i>, Receptionist 103503.</p>	<p>FN</p> <p>I</p> <p>I</p>
	Could they clearly distinguish it from other interventions?	<p>After they received the baseline Practice Feedback Report which showed the results of the clinical audit and the USP visit, and received the CA training, they fully understood that they needed to change their Indigenous status Identification systems and the practice environment, and to provide targeted care.</p>	<p>FN</p>
	Did participants think the intervention had a clear purpose?	<p>The GP did not think that there were any Aboriginal patients in the practice, but felt that the intervention would help her be prepared in case she did get any in the future: <i>"I don't think we have any Aboriginal patients, but it is good to know what to do just in case I get some"</i>, GP 103101.</p> <p>The receptionists felt it would increase their awareness: <i>"It would make us all more aware of what's going on because we've got no idea what any, any of that stuff is about...I guess it would just make it better because then we'd be more aware of things"</i>, Receptionist 103503.</p>	<p>I</p> <p>I</p>
	Did participants have a shared sense of its purpose?	<p>The GP felt that the intervention would increase her knowledge so that she could be prepared to provide appropriate care to any Indigenous patients she might receive in the future; the receptionists felt it would increase their awareness.</p>	<p>I</p>
	What benefits did participants think the intervention would bring and to whom?	<p>The GP and reception staff were initially all keen to sign up for the study, their reason being that they wanted to ensure that if they did get an Aboriginal patient that the patient would be treated appropriately.</p>	<p>FN, I</p>

NPT Domain	Questions to consider within the NPT framework	NPT evaluation	Data Source
	Were participants likely to value these benefits?	(No data)	
	Did participants believe it would fit with the overall goals and activity of the organisation?	The GP and reception staff felt that the care provided to patients was an important focus of the practice.	FN
Cognitive participation	Did participants think the intervention was a good idea?	The GP and reception staff felt that they did not have any Aboriginal patients, but thought that the intervention was a good way to learn about providing appropriate care to any future Indigenous patients.	FN, I
	Did they see the point of the intervention easily?	Once the participants received the Cultural Awareness training they understood why Indigenous status identification was important.	FN
	Were they prepared to invest time, energy and work in it?	The GP and staff approached the Practice Principals to allow the reception staff to undertake the training offered in the intervention because they were keen to participate and felt that it was important for them to participate. They willingly undertook all training and facilitated appointments. The Practice Principals agreed even though they did not take part in the study themselves. The reception staff and GP said that they planned to actively ask all patients their Indigenous status. The practice staff asked the Practice Principals if they could put up the signage and artwork as prompts to facilitate Indigenous status identification.	FN FN
	Collective action	How did the intervention affect participants work?	As part of the intervention, staff were trained to actively ask all new and existing patients their Indigenous status and they needed to incorporate this change into their work. The reception staff and the GP remarked that they were working towards routinely asking all patients their Indigenous status, even though time pressures were sometimes an issue: <i>"Um just remembering to do it all the time with, with every, every single person. Sometimes when it's really busy, like it's hard to remember...yeah, just getting into the habit of doing it"</i> , Receptionist 103501. <i>"We have been remembering to ask and people have been asking about the signs"</i> , Receptionist 103502.
Did it promote or impede their work?		(No data)	

NPT Domain	Questions to consider within the NPT framework	NPT evaluation	Data Source
	What effect did it have on consultations?	The GP needed to change by adding Indigenous status identification to the history taking and be conscious of providing targeted care. However, she did forget to ask patients their Indigenous status.	FN, I
	Did staff require extensive training before they could use it?	Yes because prior to the intervention they were unaware of why Indigenous status was recorded.	I, FN, S
	How compatible was it with existing work practices?	There was already an existing registration process in place in the practice. The staff needed to change by adding Indigenous status as part of the registration process and history taking. They placed the 'Are you Aboriginal' sign in the waiting room, at reception, and in every consultation room in order to facilitate this by having the signs as a prompt for themselves and patients.	FN
	What impact did it have on division of labour, resources, power, and responsibility between different professional groups?	Prior to the intervention, reception staff believed GPs identified patient's Indigenous status, and visa-versa. Both staff and GPs had to learn that both were responsible for carrying out the task.	FN, I
	Did the intervention fit with the overall goals and activity of the organisation?	Yes - the care provided to patients was an important focus of the practice.	FN
Reflexive Monitoring	How did participants perceive the intervention after it had been in use for a while?	Overall the staff felt that they had gained knowledge, that more patients were being asked their Indigenous status, and that the tools they were provided with in the intervention assisted them to identify patients Indigenous status: <i>"I think the practice has been welcoming in trying to learn about it so that's good.... Um and I think more of the doctors and staff have been asking patients if they're Aboriginal and Torres Strait Islander so that's good too"</i> , Receptionist 103502. <i>"When people ask about the sign on the front desk...we know what to tell them"</i> , Receptionist 103503.	I I
	Did they perceive it as being advantageous for patients or staff?	The GP felt that the intervention helped her to provide targeted care: <i>"assist me/enable me to provide specific ATSI care"</i> , GP 103101. <i>"Now we have a better understanding of why it's important to know why, like people's Aboriginal and Torres Strait Islander status..."</i> , Receptionist 103501.	S I

NPT Domain	Questions to consider within the NPT framework	NPT evaluation	Data Source
	Did participants see what effects the intervention has had?	<p>The GP felt that she had gained awareness: <i>"... it's helped me in terms of being aware. I still don't remember to ask actually I just don't remember, but this [the 'Are you Aboriginal sign] has been a big help because people will read that when they sit down and tell me", GP 103101.</i></p> <p>The reception staff realised that patients' Indigenous status was being identified: <i>"More patients are being asked if they are Aboriginal and Torres Strait Islander", Receptionist 103502.</i></p>	I I
	Could users/staff contribute feedback about the intervention after it had been in use?	Yes the GP and staff provided feedback during the practice visits and via the follow-up survey; the GP also provided feedback via the GP Reflection form.	FN, S, S(R)
	Could the intervention be adapted / improved on the basis of experience?	Yes – the practice put the 'Are you Aboriginal' sign up in every consulting room resulting the in the Practice Principals, who did not participate in the study, being prompted to identify patient's Indigenous status.	FN

KEY: A= Audit, FN= field notes, I= interview, S= survey, S(R)= GP Reflection Survey, U= USP

Appendix 12: Evaluation of the implementation of the intervention (Practice 104)

NPT Domain	Questions to consider within the NPT framework	NPT evaluation	Data Source
Coherence	Could participants easily describe the intervention?	<p>The participants understood that a USP presented as a patient and feedback was provided on whether or not the USP had their Indigenous status identified and how they rated their experience as a patient in the practice: When the GP found out after the consultation that the patient was the USP she exclaimed: <i>"Was that patient doing my assessment? I had no idea. I would never have picked it? Really?"</i>, GP 104101.</p> <p>The GP understood that the study aimed to increase her awareness regarding providing appropriate healthcare to Aboriginal and Torres Strait Islanders: <i>"I'm new to this country so am not familiar with all the benefits available. In Canada, our First nations people have special services...I don't know if you have that here"</i>, GP 104101.</p>	FN I
	Could they clearly distinguish it from other interventions?	<p>Once participants received the baseline Practice Feedback Report showing the results of the clinical audit and the USP visit, and received the CA training explaining the health disparities between Indigenous and other Australians, they fully understood that they needed to change their Indigenous status Identification systems and the practice environment, and to provide targeted care. The Operations Manager also realised the important role reception had to play in Indigenous status identification and making patients feel at ease and comfortable within the practice.</p>	FN
	Did participants think the intervention had a clear purpose?	<p>The GP and Operations Manager felt that the study would increase their awareness regarding providing appropriate healthcare to Aboriginal and Torres Strait Islander patients: <i>"Uh I think the elevated awareness and the understanding of what is necessary to, to cater to the Aboriginal and Torres Strait Islanders um will improve I guess the look and feel of the practice and by that um how comfortable Aboriginal and Torres Strait Islanders would feel in our practice"</i>, Practice Manager 104301.</p>	I
	Did participants have a shared sense of its purpose?	<p>The Practice Manager was, <i>"...open to doing you know whatever is necessary really to ensure that you know any patient of one of our practices has the right access to health care and um has the tailored health care that they need"</i>, Practice Manager 104301.</p>	I

NPT Domain	Questions to consider within the NPT framework	NPT evaluation	Data Source
		The GP felt that the intervention would increase her knowledge and help her provide more targeted care.	FN
	What benefits did participants think the intervention would bring and to whom?	<p>The GP felt that the intervention would increase her knowledge so that she could provide appropriate care to her Indigenous patients.</p> <p>The Operations Manager felt that the intervention would help improve the practice environment so that Aboriginal and Torres Strait Islander patients were more comfortable in the practice.</p> <p>The Operations Manager realised that the Cultural Awareness training provided in the intervention fulfilled the practices requirements for Cultural Awareness training for the IHPIP.</p>	I I I, FN
	Were participants likely to value these benefits?	<p>The GP felt strongly about removing culturally inappropriate care as a barrier to health care for Aboriginal and Torres Strait Islander patients: <i>"I think it's really, really important um that if there are cultural barriers in providing health care that we need to identify what those are and figure out what we can do to um to remove them to at least um at least that that as a barrier is gone. Um I don't know why those um those um particularly poor health [out]comes exist, I don't understand enough about it but I think that if it's...because of culturally inappropriate care I think that's at least what we can do to try and fix something"</i>, GP 104101.</p>	I
	Did participants believe it would fit with the overall goals and activity of the organisation?	The Operations Manager valued Quality Improvement and felt that the intervention could help improve the quality of care his practice offered to Aboriginal and Torres Strait Islander patients.	FN
Cognitive participation	Did participants think the intervention was a good idea?	The GP and Operations Manager felt that there were very few Aboriginal patients at the practice, but thought that the intervention was a good way to learn about giving the best possible care to any current or future Indigenous patients.	FN
	Did they see the point of the intervention easily?	The GP was already aware of the health disparities between Indigenous and other Australians; once the Operations Manager received the Cultural Awareness training they understood why Indigenous status identification was important.	FN

NPT Domain	Questions to consider within the NPT framework	NPT evaluation	Data Source
	Were they prepared to invest time, energy and work in it?	<p>The GP and Operations Manager readily facilitated appointments for interviews and training.</p> <p>The GP said that she planned to routinely ask all patients their Indigenous status and provide appropriately targeted care.</p> <p>The GP and Operations Manager were eager to have a visit from the Medicare Local representative to learn more about the various Indigenous-specific MBS Items numbers available and the PBS Co-payment measure.</p> <p>Although the Operations Manager was happy to facilitate appointments for himself, he would not invite the other members of the practice to participate.</p>	<p>FN</p> <p>FN</p> <p>FN</p> <p>FN</p>
Collective action	How did the intervention affect participants work?	<p>As part of the intervention, staff were trained to actively ask all new and existing patients their Indigenous status. The GP remarked that she had been remembering to consciously ask patients their Indigenous status but it was not yet usual routine: <i>"The posters are up. I am remembering to ask some patients about their status but it's a bit variable, depending on how busy things are"</i>, GP 104101.</p> <p>The intervention did not affect the reception staff because the Operations Manager did not invite them to take part in the study and said that he would relay the training to his staff, although he did not do this by the time the follow-up data was collected.</p>	<p>I</p> <p>FN</p>
	Did it promote or impede their work?	(No data)	
	What effect did it have on consultations?	The GP needed to change by routinely asking all patients their Indigenous status and be conscious of providing targeted care. She made a conscious effort to do this.	FN
	Did staff require extensive training before they could use it?	Yes. Prior to the intervention the Operations Manager was unaware of the barriers surrounding Indigenous status identification. The GP was unaware of the specific services available for Indigenous Australians.	I, S, FN
	How compatible was it with existing work practices?	New patients were already asked to self-identify their Indigenous status via a registration form; staff needed to change their work by expanding on this by prompting patients to answer the question if it had not been answered on the form and by asking existing patients as well. This was done by the GP but not by reception staff as they did not participate in the study because the Operations Manager did not invite them to take part in the intervention.	FN

NPT Domain	Questions to consider within the NPT framework	NPT evaluation	Data Source
	<p>What impact did it have on division of labour, resources, power, and responsibility between different professional groups?</p>	<p>The Practice Manager would not extend the invitation to participate in the study to the other GPs or reception staff as he was aware that only one GP and one staff member needed to have Cultural Awareness training to fulfil the requirements to register for the IHPIP. He would not put up the 'Are you Aboriginal' sign up at reception to serve as a prompt for reception staff and patients, although it was displayed in all the consulting rooms. Therefore reception staff relied on patient's self-identifying on Patient Registration Form or in the consultation room.</p> <p>The GP felt that the restriction on staff being involved in the study limited the overall level of change within the practice.</p>	<p>FN</p> <p>I</p>
	<p>Did the intervention fit with the overall goals and activity of the organisation?</p>	<p>The Operations Manager was focused on Quality Improvement in the Practice. It also fulfilled the practices requirements for Cultural Awareness training for the IHPIP.</p>	<p>FN</p>
<p style="writing-mode: vertical-rl; transform: rotate(180deg);">Reflexive Monitoring</p>	<p>How did participants perceive the intervention after it had been in use for a while?</p>	<p>The GP felt that the strengths and weaknesses of the intervention were: <i>"Strengths - identifying how many patients have had their status recorded. Weaknesses - none"</i>, GP 104101.</p>	<p>S(R)</p>
	<p>Did they perceive it as being advantageous for patients or staff?</p>	<p>The Operations Manager reflected: <i>"I think it's ...been...a helpful and beneficial um you know study that um we've been lucky to be involved in"</i>, Practice Manager 104301.</p> <p>The GP said, <i>"I think my knowledge has changed um about um language that might be considered appropriate...I hope that I've learned how to um make um an Aboriginal or Torres Strait Islander person more comfortable um in my practice"</i>, GP 104101.</p>	<p>I</p> <p>I</p>
	<p>Did participants see what effects the intervention has had?</p>	<p>The GP said, <i>"I've had some patients that I've had for a long time actually self-identify as Aboriginal"</i>, GP 104101.</p> <p>The GP stated that patients were noticing the 'Are you Aboriginal' sign in her consulting room and were volunteering their Indigenous status <i>"I have a sign up directly across from where the patient sits ...and they notice the sign and they start talking to me about it. Um so that definitely has gotten some response"</i>, GP 104101.</p>	<p>I</p> <p>I</p>

NPT Domain	Questions to consider within the NPT framework	NPT evaluation	Data Source
		<p>The GP also saw the effect that the training had had on another staff member in her old practice that was also taking part in this study: "...in my old practice certainly one of our receptionist[s] undertook Cultural Awareness training and it really um it really had an impact on her and I think it was a really positive thing. Um she talked to me afterwards about all the things that she had no idea about that she didn't know even though she been sort of educated in this country and grown up in this country and, and she'd learned so much", GP 104101.</p> <p>The Operations Manager reflected that the study had "Increased our awareness of the issues the ATSI patients encounter when seeking medical care" and that "I have a greater understanding of the issues surrounding care to this segment of the community", Practice Manager 104301.</p>	I S
	<p>Could users/staff contribute feedback about the intervention after it had been in use?</p>	<p>Yes the GP and Operations Manager provided feedback during the practice visits and via the follow-up survey; the GP also provided feedback via the GP Reflection form.</p>	FN, S, S(R)
	<p>Could the intervention be adapted / improved on the basis of experience?</p>	<p>Yes – the Operations Manager put the 'Are you Aboriginal' sign up in every consulting room resulting the in the GPs who did not participate in the study, being prompted to identify patient's Indigenous status</p>	I

KEY: A= Audit, FN= field notes, I= interview, S= survey, S(R)= GP Reflection Survey, U= USP

Appendix 13: Evaluation of the implementation of the intervention (Practice 201)

NPT Domain	Questions to consider within the NPT framework	NPT evaluation	Data Source
Coherence	Could participants easily describe the intervention?	The participants understood that a USP presented as a patient and feedback was provided on whether or not the USP had their Indigenous status identified and how they rated their experience as a patient in the practice.	FN
	Could they clearly distinguish it from other interventions?	When the receptionist received the baseline Practice Feedback Report showing the results of the clinical audit and the USP visit, she saw that she was already prompting patients to complete their Indigenous status and felt that she did not need to change anything else. The Practice Manager would not ask patients and felt that this was the GPs responsibility.	FN
	Did participants think the intervention had a clear purpose?	The GP though the intervention would increase his awareness, highlight areas requiring improvement and help implement any changes required regarding providing appropriate care to Aboriginal and Torres Strait Islander patients: <i>"Well me and my staff might actually learn something and uh, and um identify things that needs improvement and implement that"</i> , GP 201101. The Receptionist and Practice Manager felt that the intervention would help the GP provide appropriately targeted care to Aboriginal and Torres Strait Islander patients.	I I
	Did participants have a shared sense of its purpose?	The GP felt that the intervention would help increase his awareness regarding the provision of appropriately targeted care to Aboriginal and Torres Strait Islander patients.	I
	What benefits did participants think the intervention would bring and to whom?	The GP had a keen interest in Indigenous health felt that the intervention would help increase his and the staff's awareness and help identify and implement any changes needed in the practice to help improve the quality of care offered to Aboriginal and Torres Strait Islander patients. The Practice Manager and Receptionist felt that all patients were the same at the reception level but thought that the intervention would help the GP provide more targeted care.	FN, I I
	Were participants likely to value these benefits?	(No data)	

NPT Domain	Questions to consider within the NPT framework	NPT evaluation	Data Source
	Did participants believe it would fit with the overall goals and activity of the organisation?	(No data)	
Cognitive participation	Did participants think the intervention was a good idea?	The GP felt that the intervention would raise his and the staff's awareness, and help identify and implement any changes required to improve the quality of care offered to Aboriginal and Torres Strait Islander patients.	I
	Did they see the point of the intervention easily?	(No data)	
	Were they prepared to invest time, energy and work in it?	The Practice Manager and Receptionist willingly undertook all training and facilitated appointments. The GP did not take part in any training sessions although both he and the Practice Manager indicated that he had read through the Practice Feedback report and they had discussed it together. The Receptionist and Practice Manager did not make any changes to their usual routines identifying patient's Indigenous status. The receptionist understood she had a role to play in identifying patient's Indigenous status; the Practice Manger felt it was up to patients to self-identify and that the GP was the person responsible for providing the care to the patient.	FN FN, I
Collective action	How did the intervention affect participants work?	The reception was already checking patient's Indigenous status and following up with patients who did not answer the Indigenous Identifier question, so the intervention did not affect her work. The Practice Manager would not make any changes to how she identified Indigenous-status identification. As part of the intervention, she would have needed to follow up patients who did not answer the Indigenous-status identification question on the patient registration form, but she did not incorporate this change into her work. The GP did not engage in the intervention and hence the intervention did not affect his work (he would have needed to routinely ask all patients their Indigenous status and then provide the appropriately targeted care accordingly).	FN, I FN, I
	Did it promote or impede their work?	(No data)	FN

NPT Domain	Questions to consider within the NPT framework	NPT evaluation	Data Source
	What effect did it have on consultations?	None because the GP did not engage in the intervention.	FN
	Did staff require extensive training before they could use it?	The staff already had well-established identification systems in place so the training they would have needed in that regard was minimal. However, they had little Cultural Awareness training prior to the intervention and felt that provision of culturally appropriate care was the sole responsibility of the GP. Prior to the intervention, the GP had completed Cultural Awareness training and had had experience working with Aboriginal and Torres Strait Islander patients; hence he did not require extensive training.	FN, I, S FN, I, S
	How compatible was it with existing work practices?	The practice had established Indigenous-status identification systems in place and the receptionist did not need to make any changes to her working routine; the Practice Manager needed to follow up with patient's who did not complete the Indigenous-status question on the registration form but felt that it was up to the patient to self-identify because she believed asking patients their ethnicity was a very personal question.	FN, I, S
	What impact did it have on division of labour, resources, power, and responsibility between different professional groups?	Had she engaged in the intervention, the Practice Manager would have needed to learn that she had a role to play in identifying patients Indigenous-status and that it was not just the responsibility of the GP and the patient.	FN, I
	Did the intervention fit with the overall goals and activity of the organisation?	(no data)	
Reflexive Monitoring	How did participants perceive the intervention after it had been in use for a while?	The GP felt that the strengths of the intervention were: <i>"Strengths - the unannounced visits which audited out systems. Weaknesses - none identified"</i> , GP 201101.	S(R)
	Did they perceive it as being advantageous for patients or staff?	As a result of the Practice Feedback Reports given in the intervention, the GP said: <i>"We tightened up on identification procedures. We are now auditing our care of our ATSI patients"</i> , GP 201101.	S
	Did participants see what effects the intervention has had?	The receptionist and Practice Manager felt that they were <i>"more aware"</i> as a result of the intervention, Receptionist 201501, Practice Manager 201301.	S

NPT Domain	Questions to consider within the NPT framework	NPT evaluation	Data Source
		The participants felt that they had gained awareness. The GP felt that they had improved their identification systems.	I, S S
	Could users/staff contribute feedback about the intervention after it had been in use?	Yes the GP and staff provided feedback via the follow-up survey; the GP also provided feedback via the GP Reflection form.	S, S(R)
	Could the intervention be adapted / improved on the basis of experience?	Yes – the practice could put up the 'Are you Aboriginal' sign at reception and in the consulting room as a prompt to the staff, GP and patients.	FN

KEY: A= Audit, FN= field notes, I= interview, S= survey, S(R)= GP Reflection Survey, U= USP

Appendix 14: Evaluation of the implementation of the intervention (Practice 202)

NPT Domain	Questions to consider within the NPT framework	NPT evaluation	Data Source
Coherence	Could participants easily describe the intervention?	The GPs and reception staff understood that the study aimed to increase their awareness regarding providing appropriate healthcare to Aboriginal and Torres Strait Islanders. They understood that a USP presented as a patient and feedback was provided on whether or not the USP had their Indigenous status identified and how they rated their experience as a patient in the practice	FN
	Could they clearly distinguish it from other interventions?	Once participants received the baseline Practice Feedback Report showing the results of the clinical audit and the USP visit, and received the CA training explaining the health disparities between Indigenous and other Australians, they fully understood that they needed to change their Indigenous status Identification systems and the practice environment, and to provide targeted care.	FN
	Did participants think the intervention had a clear purpose?	The GPs and staff felt that the intervention would increase their awareness, highlight areas requiring improvement and help implement any changes required regarding providing appropriate care to Aboriginal and Torres Strait Islander patients: <i>"...well it will serve as a prompt for us to think about the issue um and uh and to think about what we could do better in terms of identification, in terms of making the practice uh, uh friend, friendly to Aboriginal people and uh about you know what, what is the kind of Aboriginal clientele that we see because I don't think we are really aware of how, how um a big a part of our work it is"</i> , GP 202102. <i>"Oh definitely improve the acceptability...make it a more friendly place to visit"</i> , Practice Manager 202301.	I
	Did participants have a shared sense of its purpose?	The GPs and staff felt that the intervention would help increase their awareness regarding the provision of appropriately targeted care to Aboriginal and Torres Strait Islander patients.	I
	What benefits did participants think the intervention would bring and to whom?	The GPs and staff felt that the intervention would help improve the quality of care offered to Aboriginal and Torres Strait Islander patients: <i>"...to improve us in the way that we treat and talk to Aboriginal and Torres Strait Islanders"</i> , Receptionist 202502.	FN

NPT Domain	Questions to consider within the NPT framework	NPT evaluation	Data Source
		<i>"I guess if people know that we've had training here, I guess if we um are meeting criteria's that need to meet, it makes it easier for them to come to the practice", Practice Nurse 202401.</i>	I
	Were participants likely to value these benefits?	(No data)	
	Did participants believe it would fit with the overall goals and activity of the organisation?	Yes - The new Director had a keen interest in Aboriginal and Torres Strait Islander health, and the Practice Manager was focused on quality improvement in general.	FN, I
Cognitive participation	Did participants think the intervention was a good idea?	The GPs and staff felt that the intervention would raise their awareness and help identify and implement any changes required to improve the quality of care offered to Aboriginal and Torres Strait Islander patients.	I
	Did they see the point of the intervention easily?	Once the participants received the Cultural Awareness training explaining the health disparities, they understood why Indigenous status identification and appropriately targeted care was important.	FN
	Were they prepared to invest time, energy and work in it?	The GPs, Practice Manager, Nurses and Receptionists willingly undertook all training. The Practice Manager made a concerted effort in order to have the staff attend sessions even though coordinating group training during consulting hours was a difficult task. The Practice Feedback Reports were discussed at the Practice Staff and Clinical meetings. Aboriginal Artwork was placed on the entrance door and at reception. The 'Are you Aboriginal' sign was put up at reception, in the waiting room, in the treatment room and in every consulting room as prompts to facilitate Indigenous status identification.	FN FN FN
Collective action	How did the intervention affect participants work?	The nurses did not make any changes to Indigenous status identification. The Practice Manager highlighted to staff that completing the Indigenous status section in the Patient Registration form was a priority area and staff were retrained to check that the information had been completed on the form.	FN, I FN, I, S
	Did it promote or impede their work?	(No data)	
	What effect did it have on consultations?	It appears that GPs were able to provide more targeted care to patients because a lot more patients were enrolled into the PBS Co-payment scheme.	A

NPT Domain	Questions to consider within the NPT framework	NPT evaluation	Data Source
	Did staff require extensive training before they could use it?	Prior to the intervention, the Practice Manager and one GP had had considerable experience working with Aboriginal and Torres Strait Islander patients, however, most of the remaining staff were unaware of why Indigenous status was recorded.	FN, I, S
	How compatible was it with existing work practices?	There was already an existing registration process in place in the practice. The reception staff needed to change by prompting patients that had not answered the Indigenous-status question to do so. GPs needed to add Indigenous status as part history taking. The 'Are you Aboriginal' signs were placed at reception, in the treatment room and in every consultation room in order to facilitate this by having the signs as a prompt for themselves and patients.	FN, I
	What impact did it have on division of labour, resources, power, and responsibility between different professional groups?	Prior to the intervention, the onus to identify patient's Indigenous status lay solely with the patient self-identifying at reception. The GPs and staff had to learn that they had a role to play in identifying patients Indigenous-status. GPs also had to learn that it was not solely up to reception to obtain the information.	FN, I
	Did the intervention fit with the overall goals and activity of the organisation?	The Results of the Practice Feedback Reports and the recommendations provided as part of the intervention were discussed at both the reception and clinical staff meetings. The new Director had a keen interest in Aboriginal and Torres Strait Islander health, and the Practice Manager was focused on quality improvement in general.	FN, I FN, I
	Reflexive Monitoring	How did participants perceive the intervention after it had been in use for a while?	One GP felt that the strengths of the intervention was: "...getting direct feedback from the experience of a patient through the USP method" and the weakness was that "...some of the reception staff were upset by the feedback", GP 202102. The other GP felt that the intervention was "...well designed and served an important purpose of highlighting current shortcomings in looking after patients of Aboriginal/Torres Strait Islander origin at the practice level", GP 202101.
Did they perceive it as being advantageous for patients or staff?		The GPs felt that the Practice Feedback Reports "...made us aware of the difficulties in our systems and lack of staff awareness especially in reception staff," GP 202102 and that, "...it highlighted the need to improve things at the reception level", GP 202101.	S(R)

NPT Domain	Questions to consider within the NPT framework	NPT evaluation	Data Source
	Did participants see what effects the intervention has had?	<p>All participants felt that the staff had gained awareness in regards to patient Indigenous-status identification.</p> <p>The Practice Manager felt that, "...the general awareness has actually assisted all the staff as well and it's also increased the doctors and the clinical staff's knowledge of the different items numbers", Practice Manager 202301.</p> <p>One GP stated that more people were volunteering their Indigenous status: "...certainly the physical changes seems to have, definitely encouraged people to, to um volunteer that they're of Aboriginal background, both Aboriginal people and Torres Strait Islanders...so that's, that's [a] very practical real thing", GP 202102.</p>	<p>S</p> <p>I</p> <p>I</p>
	Could users/staff contribute feedback about the intervention after it had been in use?	<p>Yes the GP and staff provided feedback via the follow-up survey; the GPs also provided feedback via the GP Reflection form.</p>	<p>S, S(R)</p>
	Could the intervention be adapted / improved on the basis of experience?	<p>Yes – the practice could put up the 'Are you Aboriginal' sign at reception and in the consulting room as a prompt to the staff, GP and patients. The practice also decided to concentrate on ensuring the Indigenous status question was completed at reception.</p>	<p>FN</p>

KEY: A= Audit, FN= field notes, I= interview, S= survey, S(R)= GP Reflection Survey, U= USP

Appendix 15: Evaluation of the implementation of the intervention (Practice 203)

NPT Domain	Questions to consider within the NPT framework	NPT evaluation	Data Source
Coherence	Could participants easily describe the intervention?	The GP and reception staff understood that the study aimed to increase their awareness regarding providing appropriate healthcare to Aboriginal and Torres Strait Islanders. They understood that a USP presented as a patient and feedback was provided on whether or not the USP had their Indigenous status identified and how they rated their experience as a patient in the practice.	FN
	Could they clearly distinguish it from other interventions?	Once participants received the baseline Practice Feedback Report showing the results of the clinical audit and the USP visit, and received the CA training explaining the health disparities between Indigenous and other Australians, they fully understood that they needed to change their Indigenous status Identification systems and the practice environment, and to provide targeted care.	FN
	Did participants think the intervention had a clear purpose?	The GP and staff thought that the intervention would increase their awareness and knowledge to provide appropriate healthcare to Aboriginal and Torres Strait Islander patients: <i>"Oh more information for the doctor and uh more awareness for the within the um the receptionists and practice managers"</i> , Receptionist 203501.	I
	Did participants have a shared sense of its purpose?	The GP felt that the intervention would help increase his awareness and knowledge so that he could provide more appropriately targeted care to his Aboriginal and Torres Strait Islander patients.	I
	What benefits did participants think the intervention would bring and to whom?	The GP and Practice Manager felt that the intervention could identify areas for improvement in the practice regarding provision of appropriate healthcare to Aboriginal and Torres Strait Islander patients: <i>"Well it would be good to know for all of us what, what the outcomes are then we can all learn from what we're doing wrong and what, how we can improve and so it will be beneficial"</i> , Practice Manager 203301. <i>"By...educating us with things we are doing wrong with our Indigenous population, whether it's in the waiting room, at the door, in here or in the toilet"</i> , GP 203101.	FN, I

NPT Domain	Questions to consider within the NPT framework	NPT evaluation	Data Source
		The GP felt that the intervention would benefit Aboriginal and Torres Strait Islander patients by demonstrating that there were practices available to them, and also that his own skills providing care would be advanced: <i>"To show that there are people out there that don't discriminate against their, their patients. Patients should be welcome anywhere.....Um to give me a chance to up, up skilling me.."</i> , GP 203101.	I
	Were participants likely to value these benefits?	Yes - The GP knew he had several Indigenous-identified patients and he wanted to ensure he provided the best service to them.	FN
	Did participants believe it would fit with the overall goals and activity of the organisation?	Yes - The GP has a keen interest in Indigenous health, Aboriginal and Torres Strait Islander health, and in quality improvement in general.	FN
Cognitive participation	Did participants think the intervention was a good idea?	The GP and staff felt that the intervention would raise his and the staff's awareness, and help identify and implement any changes required to improve the quality of care offered to Aboriginal and Torres Strait Islander patients.	I
	Did they see the point of the intervention easily?	Once the participants received the Cultural Awareness training they understood why Indigenous status identification was important.	FN
	Were they prepared to invest time, energy and work in it?	The GP, Practice Manager and receptionists willingly undertook all training and facilitated appointments. The GP and staff said that they planned to make a conscious effort to ask patients their Indigenous status. The GP and reception staff said that they planned to actively ask all patients their Indigenous status. The GP and staff put up the signage put up Aboriginal artwork and the 'Are you Aboriginal' sign at reception, in the waiting room and in the consultations room as prompts to facilitate Indigenous status identification.	FN FN FN
Collective action	How did the intervention affect participants work?	As part of the intervention, staff were trained to actively ask all new and existing patients their Indigenous status and they needed to incorporate this change into their work. The reception staff and the GP remarked that they were consciously working towards routinely asking all patients their Indigenous status.	FN, I

NPT Domain	Questions to consider within the NPT framework	NPT evaluation	Data Source
		The Practice Manager said that they were actively asking patients their Indigenous status because the 'Are you Aboriginal' signs were helped patients understand why they were being asked the question and helped reception staff feel comfortable asking the question.	FN
	Did it promote or impede their work?	(No data)	
	What effect did it have on consultations?	The GP was able to provide more targeted care to more of patients.	I
	Did staff require extensive training before they could use it?	Yes because prior to the intervention they were unaware of why Indigenous status was recorded.	FN, I, S
	How compatible was it with existing work practices?	There was already an existing registration process in place in the practice. The staff needed to change by adding Indigenous status as part of the registration and history taking processes. They placed the 'Are you Aboriginal' sign in the waiting room, at reception, and in the consultation room in order to facilitate this by having the signs as a prompt for themselves and patients.	FN, I
	What impact did it have on division of labour, resources, power, and responsibility between different professional groups?	Prior to the intervention, the onus to identify patient's Indigenous status lay solely with the GP. Reception had to learn that they had a role to play in identifying patients Indigenous-status and that it was not just the responsibility of the GP.	FN, I, S
	Did the intervention fit with the overall goals and activity of the organisation?	Yes - The practice priorities included providing the best possible health care to all patients and quality improvement in general.	FN
Reflexive Monitoring	How did participants perceive the intervention after it had been in use for a while?	The GP felt that the strengths of the intervention were: <i>"Strengths - Excellent unbiased interviewer, made me very comfortable"</i> , GP 203101. He felt that it might have benefitted him to be present during the individual staff interviews so that he knew what their responses were.	S(R)
	Did they perceive it as being advantageous for patients or staff?	The GP and staff felt that the staff had gained awareness. The GP saw that more patients were identifying their Indigenous status: <i>"You know I have found six new ATSI patients that I didn't know I had. They said to me, 'How come you don't know we are Aboriginal?' and I told them, 'Well I guess I didn't ask before.' That's really good isn't it?"</i> , GP 203101.	I, S I

NPT Domain	Questions to consider within the NPT framework	NPT evaluation	Data Source
		<p>The Practice Manager said that they are now asking patients their Indigenous status because the 'Are you Aboriginal' signs were up, which was helping patients understand why they were being asked the question and was helping reception staff feel comfortable asking the question.</p> <p>One receptionist commented: <i>"Um most patients have actually read the sign and given me the information without me even asking"</i>, Receptionist 203501.</p> <p>One receptionist remarked that some patients, <i>"...haven't taken it seriously though"</i>, Receptionist 203501.</p>	<p>FN</p> <p>I</p> <p>I</p>
	<p>Could users/staff contribute feedback about the intervention after it had been in use?</p>	<p>Yes the GP and staff provided feedback during practice visits and the follow-up survey; the GP also provided feedback via the GP Reflection form.</p>	<p>FN, S, S(R)</p>
	<p>Could the intervention be adapted / improved on the basis of experience?</p>	<p>Yes, the GP decided to put up the 'Welcome' poster on the front door, at reception, in the hallway and in the consultation room.</p>	<p>FN</p>

KEY: FN = field notes, I = interview, S = survey, S(R) = GP Reflection Survey, U = USP