10.1071/PY23163

*Australian Journal of Primary Health*

**Supplementary Material**

# Aboriginal and Torres Strait Islander community members' experiences of care in an urban Aboriginal Community Controlled Health Service transforming to a Patient Centred Medical Home

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**Supplementary Table S1: Comparison of care components for models of care**

| Care components | PCMH | IUIH Standard care | ISoC2 |
|---|---|---|---|
| Leadership[1] | Leaders fully engaged with the process of change at all levels of the organisation | Community governance and accountability structure | Community governance and accountability structure<br>Distinct operational working group to support model transformation |
| Patient Enrolment[2] | Assigned to a clinic or 'teamlet' of PCP/PCP assistants | Administration staff or patients assign to preferred GP provider | Voluntary patient-initiated enrolment with a core multidisciplinary care team, a "Pod" |
| Team based care | Provider working with a team of other providers; may have 2-3 PCP/PCP assistants in a 'teamlet' | Provider working together with teams but work independently | Pod members working collaboratively |
| | | Care planning scheduled intermittently | Care planning throughout patient journey |
| Care pathways[3] | Various, in Australia mostly from GP to | First contact with administration staff | Dynamic pathway where Pod members work |

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| | other services | and then to RN/AHW, followed by the GP. GP then refers to other allied or specialist services | collaboratively to customise a pathway to meet patient needs |
| Scope of practice | Various, specific and expanded roles | Traditional discipline and specific roles | Expanded, intersecting scope of practice particularly of non-GP provider. |
| Relationship-based care and continuity of care | Primarily between PCP/'teamlet' and patient<br>Supports shared decision making | Primarily between GP and patient<br>Usually supports shared decision making | Patient and Pod<br>Routine use of goal setting and patient-led decision making tools |
| Use of technology for data-driven care coordination and quality improvement | Shared electronic health record<br>Variable use of data for quality improvement[4] | Shared electronic health record.<br>Data-driven continuous quality improvement in care | Shared electronic health record<br>Data-driven continuous quality improvement in care<br>Data-driven stratification of healthcare resources according to patient needs (cultural, |

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| | | | emotional, social and physical) |
| Access and availability | Use of multiple modalities with extended hours | Use of multiple modalities but mostly face to face | Use of multiple modalities: face to face, telephone and home visits with extended hours |
| Funding sources[5] | Multiple often blended payments | Blended payments | Blended payments |

Notes: Abbrev. AHW, Aboriginal and Torres Strait Islander health worker; GP, general practitioner; IUIH, Institute for Urban Indigenous Health; PCMH, patient-centred medical home; PCP, primary care physician; RN, registered nurse. 1. ACCHS have a specific governance structure, see section on public involvement for further details. The operational working group overseeing ISoC2 includes clinicians and managers from participating sites, personnel responsible for workforce development and service implementation, and research and evaluation partners. 2. In ISoC2, a 'pod' comprises an administrative coordinator, AHW, RN and GP working together throughout the patient's care journey. 3. In most circumstances in Australia, including in Health Care Homes (the PCMH implemented in some services in Australia over the last 5 years), most patients will see a GP prior to other providers. 4. In the PCMH model panel registry typically used to manage and improve care. 5. PHC in Australia is funded predominantly through fee-for-service, while PCMH models often have a blended payment (capitation, pay for performance and fee-for-service), while ACCHS have blended payment as the standard funding model.