

Facilitating uptake of Aboriginal Adult Health Checks through community engagement and health promotion

Corresponding Author:

Michelle DiGiacomo BA, MHSc(Hons), PhD

Postdoctoral research fellow

Centre for Cardiovascular and Chronic Care

Curtin Health Innovation Research Institute

Curtin University of Technology

39 Regent Street

Chippendale New South Wales 2008

Telephone: +61 2 83997830

Fascimile: +61 2 83997834

Email: m.digiacom@curtin.edu.au

Penny Abbott MBBS, MPH, FRACGP

General Practitioner

Aboriginal Medical Service Western Sydney & University of Sydney

2 Palmerston Road, Mt. Druitt Village, New South Wales, 2770

Email: pennyab@amsws.org.au

Joyce Davison

Aboriginal Health Worker

Aboriginal Medical Service Western Sydney & University of Sydney

2 Palmerston Road, Mt. Druitt Village, New South Wales, 2770

Email: joyce@amsws.org.au

Louise Moore EN

Aboriginal Health Worker

Aboriginal Medical Service Western Sydney & University of Sydney

2 Palmerston Road, Mt. Druitt Village, New South Wales, 2770

Email: louise@amsws.org.au

Patricia M Davidson RN, BA, MEd, PhD

Professor of Cardiovascular and Chronic Care

Curtin Health Innovation Research Institute

Curtin University of Technology

39 Regent Street

Chippendale NSW 2008

Email: p.davidson@curtin.edu.au

Keywords: Indigenous health, health promotion, health assessment, primary care

Abstract

Background: Adult Health Checks (AHCs) for Aboriginal and Torres Strait Islander people (MBS Item 710) promote comprehensive physical and psychosocial health assessments. Despite the poor uptake of health assessments in Aboriginal and Torres Strait Islander people, a small number of successful implementation initiatives have been reported. In order to ensure uptake of these screening initiatives, there remains a need to demonstrate the feasibility of models of implementing AHCs.

Aims: The aim of this paper is to address the process issues and overarching outcomes of a two-day targeted screening and assessment program to increase the uptake of Adult Health Checks at an Aboriginal Community Controlled Medical Service.

Method: Clients of an urban Aboriginal Medical Service (AMS) were invited to undertake an Adult Health Check during a two-day screening initiative. On-site GPs, nurses, and Aboriginal Health Workers worked within a team to facilitate screenings at an AMS. Barriers and facilitators to the initiative and strategies for quality improvement were discussed by the team. A review of medical notes was undertaken six months following the screening days to document uptake of recommendations.

Results: Forty clients undertook Adult Health Checks as part of the initiative. In total, 113 diagnostic tests, interventions, specialist referrals, and medication initiatives were enacted at 6 months as a result of screening day visits. Benefits to individual clients, the community, the AMS, and staff were identified.

Conclusions: The screening day demonstrated feasibility and acceptability of this approach and provides support for its implementation in other health facilities. Importantly, this service was provided in a culturally sensitive framework and within an interdisciplinary, team work model. This targeted approach increased uptake of assessment items and provided opportunities for health advice and risk factor modification.

Facilitating uptake of Aboriginal Adult Health Checks through community engagement and health promotion

Introduction

The Enhanced Primary Care (EPC) program was incorporated into the Medical Benefits Scheme (MBS) in November 1999 by the Australian Department of Health to encourage more preventive care and improve coordination of care for older Australians and those with chronic conditions ¹. Since then the program has been expanded to include Aboriginal and Torres Strait Islander health assessment MBS items comprising child health checks, adult health checks and health assessments for older Aboriginal people. The health checks promote comprehensive physical and psychosocial health assessments to ensure that Aboriginal and Torres Strait Islander people receive culturally targeted primary health care commensurate with their needs. Such systematic assessments have the potential to diagnose and address undetected disease and provide better treatment of existing disease, thereby reducing morbidity and health care costs². The adult health check (Item 710) allows biannual health assessments of Aboriginal and Torres Strait Islander people aged 15–54 years. It is linked to Medicare item numbers allowing follow-up of issues arising from the adult health check by practice nurses and Aboriginal Health Workers (AHWs), and also allows referral to allied health services under Medicare ³ ⁴.

There has been poor uptake of health assessments in Aboriginal and Torres Strait Islander people since their introduction in 1999 ⁵. Early reports indicated that only 1% of all health assessments were done among Indigenous people, despite their significantly lower health status ⁶. Reported barriers to conducting health assessments with Aboriginal and Torres Strait Islander patients in general practice reflect system, provider, and patient issues. System and provider barriers include the absence of

systems identifying Aboriginal and Torres Strait Islander patients, little awareness of Aboriginal and Torres Strait Islander specific GP-mediated health interventions among practice staff , lack of time and workforce to conduct assessments, low numbers of Indigenous health professionals, walk-in appointment style at Aboriginal Medical Services , racism and problems with cross-cultural communication and physical space constraints ⁷⁻⁹.

Other barriers to Aboriginal people accessing health services for health assessments, for example, may reflect their own perceptions of cultural barriers at the available services ¹⁰. Some Aboriginal people do not feel comfortable attending services because of educational, cultural, linguistic and lifestyle factors ¹¹. The decision to access services may depend upon community control of the service and availability of Aboriginal and Torres Strait Islander staff ¹⁰. Difficulties with reading, speaking, or writing English in remote areas may impede Aboriginal people attending health services, particularly if Aboriginal health staff are unavailable ⁸. Aboriginal people may lack awareness of the health assessment item, which is potentially mediated by the quality of communication between patients and providers ⁶. Some Aboriginal people report difficulty communicating with services providers including difficulty understanding and/or being understood by service providers. Further, many Aboriginal people report the importance of peer support and community engagement in health care interactions ¹². The process of comprehensive assessment can also be confronting for some individuals and impractical at times. Many patients attend primary care for and are focused on an acute problem(s) and may find it hard to also undertake an AHC opportunistically, particularly if the GP has a busy clinic day. Therefore, tailoring the implementation of the AHC process to address these barriers is important in addressing the adverse health outcomes of Aboriginal Australians ¹³.

One of the important aspects of the AHC is that they address planning and communication with patients that encompasses physical, psychological and lifestyle factors. ¹⁴. This is significant within the

world view of Aboriginal people and a further issue in this process is consideration of community and country¹⁵. The need for comprehensive screening, risk identification, and recall systems to ensure clients are flagged for routine and other planned follow-up episodes of health care is particularly important among Aboriginal and Torres Strait Islander peoples. In spite of the challenges in implementation, recall and reminder systems have been associated with improvements in delivery of preventive services in other Aboriginal communities¹⁶.

Introducing enabling processes can assist in engaging individuals and their adhering to screening and treatment recommendations. Aboriginal Community Controlled Health Services (ACCHSs) are incorporated Aboriginal organisations that are initiated by and based in an Aboriginal community and governed by its locally elected Aboriginal Board of Management¹⁷. These organisations provide comprehensive primary health care that aim to improve access to healthcare for Aboriginal Australians via holistic, integrated, and culturally appropriate services¹⁷. Aboriginal people view health as encompassing not only physical wellbeing of individuals but the social, emotional and cultural wellbeing of the whole community¹⁸. A central factor in engaging Aboriginal people is doing so in a culturally appropriate manner and being sensitive to social and cultural contexts^{19 20}. A culturally appropriate service incorporates local language(s), beliefs, gender and kinship systems, thereby making service delivery settings more acceptable to the Indigenous community²⁰. Furthermore, providing health services in a non-judgemental, non-threatening environment is an important consideration²¹.

With these issues in mind, AHC programs for Aboriginal people have been implemented and reported. In one instance, a Well Persons Health Check/AHC was implemented for 20 months in rural and remote Indigenous communities in Queensland. This program demonstrated high prevalence of largely preventable health problems and indicated need for a sustainable early detection strategy for the region². Likewise, AHCs were found to be a useful strategy for evaluating and addressing chronic disease

risks and related health problems over 14 months in a non-community controlled, urban Indigenous primary health care facility in Queensland²². AHC ‘events’ to improve early detection of disease in Aboriginal people have also been employed²³. To address the needs of the diverse communities, brief intensive periods of assessments were held in remote areas, while in more populated areas, a monthly screening day was instituted. Although unpublished, this program reveals that ‘AHC events’ can be viable and feasible strategies for ACCHSs²³.

Although few, these accounts of AHC implementation indicate that strategies are being implemented in communities to maximise uptake of these EPC items. However, the need to achieve more widespread and commonplace usage of these items remains- as does the importance of sharing successful operational strategies. In particular, there remains a need to demonstrate the feasibility of smaller scale AHC events that can be enacted within and by communities, including ACCHS settings. We sought to assess the impact of a two-day targeted screening and assessment program to increase the uptake of Adult Health Checks (Item 710) at an Aboriginal community controlled Medical Service. The aim of this paper is to address the process issues and overarching outcomes of the days rather than the findings of individual participants’ screenings. Although not a research report, observations of this clinic-based event provide useful information for clinicians and quality improvement in primary care.

Methods

This project took place at an AMS, based in an outer metropolitan location, which provides a comprehensive range of services including clinical medical services, dental, child & maternal, chronic care, mental health/emotional and social wellbeing, alcohol and drug services, eye care, hearing, and health promotion. All current and previous participants in a diabetes cooking class at an Aboriginal Medical Service were mailed a flyer inviting them to attend one of two consecutive AHC screening days at the AMS. Clients were also referred to the AHC screening days by general practitioners and

AHWs. Clients were given a brief description of the AHC and their consent gained before commencing screening procedures.

The screening took place in a large open-plan boardroom of an Aboriginal Medical Service. To promote privacy, erected partitions formed four stations at which designated health professional personnel performed assessments and recorded data. Clients attending the screening day had access to fresh fruit and water and were given a ticket in a raffle of a grocery hamper containing healthy foods.

The AHC days served additional purposes at the AMS, including providing an opportunity to train staff in conducting the assessment. Screening team members consisted of three registered nurses (RNs,) one Aboriginal student nurse, and two Aboriginal Health Workers. Additionally, availability of a diabetes educator and a smoking cessation counsellor provided participants with opportunities for health promotion consultations. In consultation with the GPs, Aboriginal Health Workers undertook a preliminary assessment of clients and determined their suitability for the AHC. The Adult Health Check visit consisted of health history review with a senior registered nurse, blood pressure assessment, blood glucose level, HbA1C where indicated, urinalysis, height, weight, vision, and final review and action planning with a GP. The screening by the RN involved a targeted approach of assessing drug and alcohol history, sexual health history, depression using the Patient Health Questionnaire (PHQ-2)²⁴, medication compliance using items from the Morisky scale²⁵, social circumstances, and medical history. It is important to undertake a culturally appropriate assessment, in particular addressing the impact of social, economic and psychological factors on health, as well as the ability to access services. Therefore the initial assessment mapped services according to evidence-based recommendations for immunisations, sexual health screening as well as potential adverse health behaviours, such as alcohol and drug usage. Compliance with these recommendations was noted and if not attended, was flagged for attention of the GPs. Appropriate sections of an AHC form were

completed upon visiting each station. Following this, clients met with a GP for discussion, review of findings, and negotiation of an action plan. A fluorescent green sticker with the words 'Adult Health Check' was used to signal appropriate billing upon account resolution and to facilitate follow-up on issues identified in the screening process. Following the screening days, the project team discussed the barriers and facilitators encountered and strategies for quality improvement.

This paper seeks to report on the evaluation of the screening days. A review of medical notes was undertaken by the senior RN six months later to identify adherence with recommended strategies and appointments undertaken as a result of client attendance at the AHC screening days. A case study using medical notes was selected to depict one client's journey throughout the AHC experience.

Results

Forty clients of the AMS, ranging in age from 23 to 66 years, were screened as part of the AHC over the 2-day initiative. One client has not had ongoing contact with the AMS following the screening, while the remaining 39 returned for follow-up and regular visits. Figure 1 presents the amalgamated data reflecting numbers of diagnostic tests, interventions, specialist referrals, and medication initiatives enacted at 6 months as a result of screening day visits. These results reflect multiple opportunities for early diagnosis and management of a range of conditions as well as opportunities to provide better treatment of existing disease, for example changing type, mode, or dose of medication. Box 1 contains a case study depicting one client's journey through the adult health check screening process and follow-up. The screening was undertaken in a collaborative and non-threatening environment and we consider that the community-focus of the initiative and high involvement of AHWs was crucial to its success¹². Many clients engaged in discussion with each other and on several occasions, clients shared with one another their strategies for smoking cessation and increasing physical activity, suggesting a level of comfort and appreciation of the communal approach to screening, while protecting individual's

records and clinical details. Table 1 summarises the challenges and facilitators to the screening day based upon the review of case notes and critical reflection among the project team.

Benefits of holding an Adult Health Check Screening Day

Based upon the reflection of the project team we have identified that the Adult Health Check Screening Days had benefits beyond improving the health of individual participants, as listed below:

1) **Benefits to the community:** The marketing of the Adult Health Check Screening Day appeared to be successful in increasing personal health awareness, facilitating brief interventions and referrals and reinforcing the concern that the AMS has for the health and wellbeing of the community. The facilitating, non-threatening environment of the screening made individuals feel comfortable in accessing specific referrals such as smoking cessation and cervical screening. Furthermore, the nature of information collected during the AHC represents an opportunity for patients and health professionals to discuss issues, such as drug and alcohol use, sexual health, and social and emotional wellbeing that may otherwise be potentially difficult to broach in a normal consultation. It is also likely that the community focus of this intervention was more conducive to the world-view of Aboriginal people, in contrast to the individualistic focus of a one-on-one consultation with a health professional.

2) **Capacity development for health professionals:** The team environment and mixed skills of the health professionals meant that new skills and relationships were forged. AHWs learned skills from specialists, such as diabetes educators regarding counselling on healthy diets, and were able to work with other health professionals at the AMS which enabled them to strategise on how the team can more efficiently implement AHCs in the future. AHWs also worked with non-AMS health professionals, the majority of whom were engaging with the AMS for the first time. Through shared AHW-led consultations, the AHWs assisted non-Indigenous health professionals' learning of implementing culturally appropriate interventions, particularly demonstrating ways of communicating with clients. The non-Indigenous health professionals imparted practical tips for various testing options such as

objective assessment of functional status using the six minute walk test. The relationships forged on the day facilitated relationships between the AMS and local area health service facilities, identifying opportunities for future collaboration.

3) **Financial incentives:** The complexities of Indigenous health mean that addressing the needs of individuals within a standard consultation can be challenging. Remuneration for the time undertaken in screening and referral is an important consideration.

Discussion

Implementing effective systems is crucial in addressing barriers to screening in Indigenous communities. Undertaking comprehensive screening is very challenging within the busy usual working day of general practice. Prospective planning and dedication of a system to undertake this process coordinated by AHWs appears to be successful in our setting. This paper described the implementation of a targeted 2-day Aboriginal Adult Health Check Screening program which aimed to identify risks (for CVD, diabetes) in an urban Aboriginal community and highlight the need for health professional intervention and referral in relevant cases.

Setting the program in an AMS, being coordinated by Aboriginal Health Workers, and providing transportation facilitated community members' engagement in the screening days. These key elements of providing culturally appropriate care furthermore acted to overcome potential barriers involving access, the need for confidentiality, and supporting clients during potentially confronting encounters. Having a focus on the community and creating a convivial and non-threatening setting were important factors in ensuring the acceptability of the screening days.

As in many other successful Aboriginal Health initiatives, the role of the AHW in outreach to communities is underscored²⁶. The screening day demonstrated the feasibility and acceptability of this

approach and provides support for its implementation in other health facilities. This targeted approach increased uptake of assessment items and provided opportunities for health advice and risk factor modification. Importantly, this service was provided in a culturally sensitive framework and within an interdisciplinary, team work model. Ensuring the involvement of AHWs, culturally appropriate health information and community engagement through peer leaders was important in engaging the local community. Future evaluation specifically linking screening activities to achieving treatment targets and clinical outcomes is recommended.

Conclusion

Workforce issues and service delivery patterns can contribute to lower uptake of programs and incentives to decrease chronic conditions. This is commonly the case in busy general practice settings where there is often an emphasis on acute conditions. Importantly, screening days/events are useful in shifting the perspective of health professionals and community members of the importance of screening and prevention. In addition, the process of screening can be intrusive and confronting to some individuals. Based on our preliminary experience, it would appear that designating days and allocating specific space and staff time using an interdisciplinary approach in a community controlled setting can assist in increasing the uptake of AHCs in Aboriginal Australians.

How this fits in with Quality in Primary Care:

What do we know?

- Adult Health Checks (AHCs) promote comprehensive physical and psychosocial health assessments to ensure that Aboriginal and Torres Strait Islander people receive culturally targeted primary health care commensurate with their needs.
- Reports of AHC implementation in primary care indicate they are useful and have the potential to diagnose and address undetected disease and provide better treatment of existing disease, thereby reducing morbidity and health care costs.

- Despite such benefits, a range of barriers to accessing AHCs have been noted including workforce and workplace-related constraints.

What does this paper add?

- This paper demonstrates the feasibility and utility of holding AHC screening days at an urban AMS and shares solutions to barriers in participation
- AHC screening days undertaken in the primary care setting of an Aboriginal Health Service can have a range of benefits for individual clients, the broader community, the organization, and staff.
- The AHC initiative can build capacity in staff, promote teamwork, and support relationships and future collaboration between AMS and non-AMS health facilities.

Acknowledgements

MD is a postdoctoral fellow funded by the National Health & Medical Research Council (NHMRC) 533547.

Competing Interests

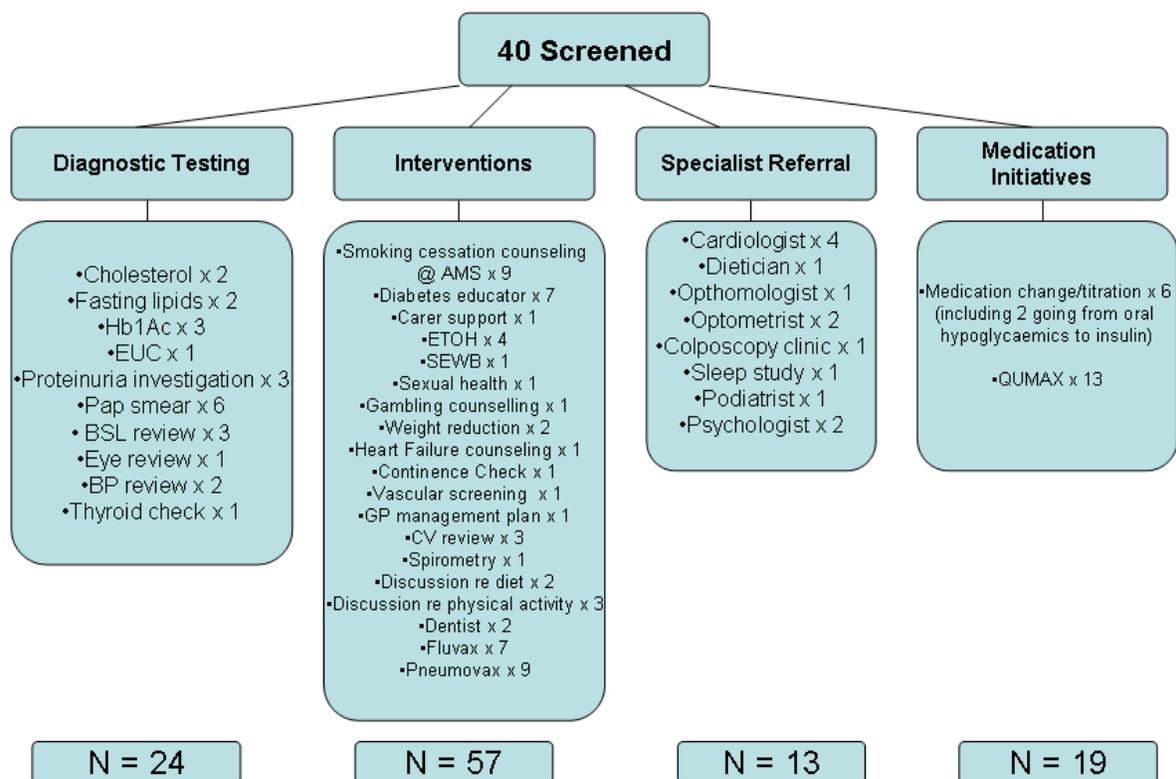
The authors declare that they have no competing interests. The paper has not been submitted elsewhere for publication.

References

1. Commonwealth Department of Health and Aged Care. Primary care initiatives, Enhanced Primary Care package. In: Commonwealth Department of Health and Aged Care Canberra, editor: Australian Government, 1999.
2. 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):136-147.
3. Department of Health and Ageing. New Medicare Checks for Indigenous Australians. In: Department of Health and Ageing, editor. Canberra, 2004.
4. Mayers NR, Couzos S. Towards health equity through an adult health check for Aboriginal and Torres Strait Islander people. *MJA* 2004;181(10):531-532.
5. 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).
6. Wilkinson D, McElroy H, Beilby J, Mott K, Price K, Morey S, et al. Uptake of health assessments, care plans and case conferences by general practitioners through the Enhanced Primary Care program between November 1999 and October 2001. *Australian Health Review* 2002a;25(4):1-11.
7. Kehoe H, Lovett R. Aboriginal and Torres Strait Islander health assessments: barriers to improving uptake. *Australian Family Physician* 2008;37(12):1033-1038.
8. Trewin D, Madden R. The Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples 2003. In: Australian Institute of Health and Welfare and Australian Bureau of Statistics, editor, 2004.
9. Anderson I, Ewen S, Knoche D. Indigenous medical workforce development: Current status and future directions. *Medical Journal of Australia* 2009;191(10):580-581.
10. Ivers R, Palmer A, Jan S, Mooney G. Issues Relating to Access to Health Services by Aboriginal and Torres Strait Islander People, Discussion paper 1/97: Department of Public Health and Community Medicine, University of Sydney, 1997.
11. Bell K, Couzos S, Daniels J, Hunter P, Mayers N, Murray R. Aboriginal Community Controlled Health Services. *General Practice in Australia 2000*. Canberra: Commonwealth Department of Health and Aged Care, 2000:74-103.
12. Abbott P, Gordon E, Davison J. Expanding roles of Aboriginal health workers in the primary care setting: Seeking recognition. *Contemporary Nurse* 2007;26(1):66-73.
13. Anderson I, Crengle S, Kamaka ML, Chen TH, Palafox N, Jackson-Pulver L. Indigenous health in Australia, New Zealand, and the Pacific. *Lancet* 2006;367(9524):1775-85.
14. Wagner E. Population-based management of diabetes care. *Patient Education and Counselling* 1995;16:225-30.
15. Davidson P, Abbott P, Davison J, DiGiacomo M. Improving medication uptake in Aboriginal and Torres Strait Islander peoples. *Heart, Lung and Circulation* 2010;in press.
16. Bailie R, Togni S, Si D, Robinson G, d'Abbs P. Preventive medical care in remote Aboriginal communities in the Northern Territory: a follow-up study of the impact of clinical guidelines, computerised recall and reminder systems, and audit and feedback *BMC Health Services Research* 2003;3(15).
17. National Aboriginal Community Controlled Health Organisation (NACCHO). Memorandum and articles of association. In: National Aboriginal Community Controlled Health Organisation (NACCHO), editor, 2006.

18. National Aboriginal Health Strategy Working Party. Ways Forward: National Aboriginal and Torres Strait Islander Mental Health Policy National Consultancy Report. *The National Aboriginal Health Strategy (1989)*: Department of Health and Ageing, 1989.
19. Mohajer N, Bessarab D, Earnest J. There should be more help out here! A qualitative study of the needs of Aboriginal adolescents in rural Australia. *Rural and Remote Health* 2009;9:1-11.
20. Hayman N, White N, Spurling G. Improving Indigenous patients' access to mainstream health services: the Inala experience. *Medical Journal of Australia* 2009;190:604-606.
21. McGrath P, Patton M, Holewa H, Rayner R. The Importance of the 'Family Meeting' in Health Care Communication with Indigenous People: Findings from an Australian Study. *Australian Journal of Primary Health* 2006;12(1):56-64.
22. Spurling G, Hayman N, Cooney A. Adult health checks for Indigenous Australians: the first year's experience from the Inala Indigenous health service. *Medical Journal of Australia* 2009;190(562-564).
23. Adult Health Checks: Comprehensive early detection for chronic conditions in Aboriginal people: Making prevention everybody's business (Maari Ma Health for GWAHS). NSW Health Expo; 2007; NSW.
24. Kroenke K, Spitzer R, Williams J. The Patient Health Questionnaire-2: validity of a two-item depression screener. *Medical Care* 2003;41(11):1284-92.
25. Morisky D, Green L, Levine D. Concurrent and predictive validity of a self-reported measure of medication adherence. *Medical Care* 1986;24(1):67-74.
26. Weston R, Brooks R, Gladman J, Senior K, Denley L, Silove D, et al. Ethical research in partnership with an Indigenous community. *Australasian Psychiatry* 2009;17(1):S51 — S53.

Figure 1. Consequent initiatives at six months post-Adult Health Check Screening Day



- QUMAX refers to The Quality Use of Medicines Maximised for Aboriginal and Torres Strait Islander People Program (QUMAX). This program commenced in July 2008 and is funded by the Commonwealth Government Department of Health and Ageing as part of an agreement with the Pharmacy Guild of Australia, developed in collaboration with the National Aboriginal Community Controlled Health Organisation (NACCHO).
- EUC= urea, creatinine and electrolytes, BSL=blood sugar level; BP= blood pressure; CV=cardiovascular

•

Box 1. Case Study

Daphne is a 49 year old Aboriginal woman who received an invitation to attend the Adult Health Check screening day at the AMS as she was known to have diabetes. Although she had previously been a regular patient, she had not attended the AMS for one year. Daphne has documented ischaemic heart disease, history of coronary angioplasty, and asthma.

Daphne reported being in good health overall, was a non-smoker, and undertaking regular physical activity. At the screening day, cardiovascular assessment identified that Daphne had fatigue, shortness of breath and chest pain on exertion. Her blood pressure was 140/95mmHg, waist circumference 91cm, **body mass index** 29, blood sugar level 18.2mmol/L, and total cholesterol 4.81 mmol/L. Subsequent to the Adult Health Check, the following appointments and services were organized: cervical screening, mammography, ophthalmology review, continence check, and cardiology review. Subsequently, her medications were adjusted to improve her blood pressure control, lipid profile, and her diabetes management, including commencement of insulin treatment. Since this health assessment, Daphne has remained in close contact with the AMS and is working with AHWs to achieve better management of her vascular risk factors.

Table 1 Barriers and facilitators to the screening day

Barriers	Facilitators
Space constraints and equipment shortages	<ul style="list-style-type: none"> ▪ Use of large multipurpose room and partitions to designate clinical stations ▪ Planning within the AMS for allocation of resources
Need for confidentiality	<ul style="list-style-type: none"> ▪ Scheduling of clients and awareness among staff ▪ Briefing regarding cultural competence
Time limitations of GPs	<ul style="list-style-type: none"> ▪ AHWs and nurses commencing health check using a health station model ▪ GP designated to AHC day - specifically completing AHC on patients who did not have a regular GP and were unlikely to come back for follow-up
Skill mix and scope of practice	<ul style="list-style-type: none"> ▪ Collaborators with expertise in diabetes, smoking cessation, cardiac rehabilitation, heart failure and health psychology from local health services were invited to participate on the day ▪ Increased skill and awareness of AMS staff resultant of screening day training
Inability of invited clients to access screening day	<ul style="list-style-type: none"> ▪ Transport provided
Screening may be confronting for clients	<ul style="list-style-type: none"> ▪ Community-focussed activity ▪ Took place in AMS with cultural safety ▪ Background music and social setting ▪ Healthy refreshments provided