

‘We can work together, talk together’: an Aboriginal Health Care Home

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Abstract

Objective. The aim of this study was to identify an Aboriginal community’s aspirations for health service improvement during implementation of the Commonwealth’s Health Care Homes (HCH) reform.

Methods. This study was a qualitative study consisting of Aboriginal-controlled phenomenological enquiry in a large Aboriginal community in north-central Arnhem Land.

Results. A representative sample of 60 Aboriginal health service users identified shortcomings in their current experience of primary health care, including low cultural security. These shortcomings reduced access to care. Participants described several ways that care could be reorientated to match their needs during HCH implementation. Principally, patients voiced the need for: (1) restructuring care teams to foster culturally secure relationship-based care; and (2) reorientating the Aboriginal Health Practitioner role from acute care to strength-based competencies as the focal point of care continuity: self-management support, care coordination and navigation, health coaching and cultural mentorship for non-Aboriginal staff.

Conclusions. For HCH to be successful, service providers need to engage with service users to identify and implement patient-centred strategies to improve access, acceptability and patient activation.

What is known about the topic? Success of the Commonwealth’s HCH reform is contingent on improving care access and patient activation to better manage chronic conditions

What does this paper add? This is the first opportunity that this Aboriginal community has had to articulate their aspirations for high quality healthcare. Beyond the strong alignment with the HCH building blocks, their care preferences posit practical and achievable workforce and delivery system reforms that may improve primary health care in other remote Aboriginal communities.

What are the implications for practitioners? The long-term success of the HCH reform will require iterative engagement with service users to identify and implement patient-centred strategies to improve access and acceptability of care. Service model alignment with patient care preferences will improve patient activation and is particularly important when working with vulnerable populations.

Additional keywords: health reform, health service co-design, Indigenous health, patient-centred care, primary health care.

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Introduction

The Commonwealth’s Health Care Homes (HCH) reform is arguably the most significant primary care reform since the

inception of Medicare. The aims of HCH are to improve access and team-based comprehensive primary health care (PHC) for patients with chronic conditions, with the goal of improving

patient outcomes and thereby reducing more costly acute care. Blended funding to participating general practices and Aboriginal Medical Services (AMS) is intended to drive value in care, as opposed to volume of care, and to deliver improved clinician satisfaction (the ‘quadruple aim’).^{1,2}

An aspirational target of 200 implementation trial sites in 10 Primary Health Network regions was announced in the Federal Budget in May 2017.¹ Notably, AMS sites featured prominently. Although Aboriginal and Torres Strait Islander peoples constitute 2.5% of the Australian population, as of January 2018 25 of 192 (13%) of the HCH implementation sites commencing the trial were an AMS.³

The HCH care model is based on the 10 ‘building blocks’ of high-performing primary care that include team-based care, comprehensiveness, care coordination and data-driven health care improvement (Fig. 1).⁴ Given longstanding AMS features of enhanced access, team-based comprehensive PHC and participation in national quality improvement initiatives, AMS were strongly aligned with the HCH model at reform outset.⁵

However, improved outcomes will depend on the acceptability of the HCH model to patients. The aim of this study was to consult health service users in a large remote Aboriginal community in the Northern Territory regarding their care preferences to inform successful HCH implementation.

Methods

The study was conducted in the Arnhem Land community of Maningrida (population ~3000), comprising eight major language groups. Maningrida, established in 1957, has a short contact history and retains many cultural strengths, including Aboriginal languages, connections and responsibilities to Country and kin (colloquially referred to as *Gurrutu*).⁶ The health centre provides nurse-led PHC (from 0900 to 2000 hours on weekdays) predominantly on a ‘walk-in’ basis, and after-hours emergency care to residents of the township and surrounding homelands. Team-based care is provided by up to three general practitioners (GPs) and 14 nurses, most of whom are

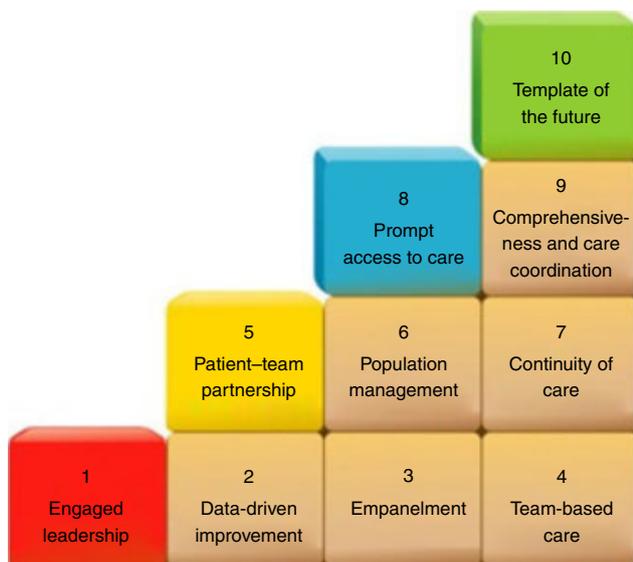


Fig. 1. Building blocks of high-performing primary care.⁴

allocated to portfolios of care, including acute care, midwifery, child health, chronic disease, rheumatic heart disease, mental health and men’s health. Four Aboriginal Health Practitioner (AHP) positions are funded, but three are currently vacant. Annual turnover of non-Aboriginal staff in remote Northern Territory clinics exceeds 100%.⁷

This study used phenomenological methods to: (1) explore current patient experiences of PHC delivery; and (2) identify how HCH implementation could improve patients’ care experiences. Before the study, we collaborated with Maningrida’s Aboriginal Health Board and an advisory group of Aboriginal Elders who guided the research process. Specifically, they helped determine the sampling frame, interview guide, analysis, interpretation and dissemination of findings.

Participant recruitment was led by Aboriginal Elders, ensuring representation from all major language groups, following cultural protocols. A semistructured interview guide was developed and focus groups were undertaken in participants’ first language cofacilitated by a bilingual Aboriginal advisory group member and a researcher (GS; a long-term resident and trusted clinician within the community who was known to all research participants). This approach enabled immediate translation and verification of participants’ comments. Focus groups continued until no new major themes emerged and all major language groups were consulted. Participants were unpaid, but advisory group members received a store voucher in compensation for their time. All sessions were recorded digitally, transcribed and coded using NVivo version 11 (QSR International, Melbourne, Vic., Australia). A subset of transcripts was independently and inductively coded by two researchers (GS, RK) to verify the coding structure and coding validity. Second-round coding was deductive and identified desired PHC service improvements. Findings were cross-checked for accuracy of interpretation with the original participants.

Ethics approval for the study was received from the Northern Territory Department of Health and Menzies School of Health Research Human Research Ethics Committee (HREC2016–2609).

Results

Twelve 1-h focus groups were conducted between August and November 2016, involving 60 participants from all major language groups, proportionate to the number of speakers. Thirty-four women and 26 men participated, of whom 15 had previously worked in the health centre (Table 1).

Current experience of PHC

Although acknowledging hard-working individuals in the health centre, participants voiced dissatisfaction with the current model of care. Despite the centre’s operating hours, patients described

Table 1. Number of focus group participants by sex and age group

	Female	Male	Total
Age (years)			
15–25	4		4
26–50	17	11	28
≥50	13	15	28
Total	34	26	60

poor access and acceptability of care because of long waiting times, high staff turnover and disagreement about what constituted an after-hours emergency.

There is a lot of people, waiting, waiting, waiting then they go home. (Client409)

Sometimes we go to the health centre. Sometimes no. Because we don't know the new doctors, we only know the old doctors and nurses. (Client883)

When every night we call for them they say no, come tomorrow. I said to them 'eh it's emergency he's breathing too fast and short wind' and they didn't turn up at night time. They didn't turn up for us. I didn't know he had bad heart. (Client919)

Concerns were also expressed regarding the cultural security of the health service.

Yeah, but after that the medical language as well, the nurse or doctor has to learn about Aboriginal culture as well, both ways. (Client223)

They don't care about Aboriginal people. That's what I feel and see. I feel like I'm not treated as equal. (Client873)

HCH opportunities for improvement

Despite these experienced shortcomings, respondents identified practical ways they thought PHC delivery could be improved (Table 2). These improvements were a combination of reorientating the roles of extant health staff to deliver culturally secure relationship-based care and identifying ways that community members could increase their participation in the delivery and clinical governance of PHC. The results are presented in Table 2, aligned with the building blocks of high-performing primary care.

Discussion

We undertook an Aboriginal-controlled community consultation to identify opportunities for service improvement during HCH implementation. Participants identified clear shortcomings in their current care experience, and also identified practical and achievable ways that care could be reorientated to meet their needs. In their view, care could be improved by restructuring care teams to foster culturally secure relationship based care and increasing Aboriginal participation in the clinical governance and delivery of PHC. These community aspirations aligned with the HCH 'building blocks' and exemplar First Nations services internationally.^{4,8}

However, the 10 HCH building blocks require cultural adaptation to match participants' aspirations for high-quality care. For example, central to the continuity, empanelment, partnership and teamwork HCH building blocks is the Aboriginal construct of *Gurrutu*, the relationship between an individual, their kin and their Country.^{6,9} Informed by *Gurrutu*, participants want PHC service delivery reorientated to a relationship focus (instead of disease focus) by forming language group-based panels serviced by teamlets comprising a remote nurse and language-congruent AHPs working to the top of their licence.

This reorganisation of care would be expected to improve access, acceptability of care and improve work satisfaction (Fig. 2).

Workplace satisfaction is highly relevant because of high staff turnover.^{2,7} Turnover is expensive and undermines long-term therapeutic relationships required for effective chronic conditions care and for developing trust in a complex cross-cultural setting.¹⁰ The community's preference for a relationship-based model of care may also help attract and retain like-minded clinicians. In this regard, the Commonwealth's HCH initiative creates some flexibility through funding team-based care instead of face-to-face GP consultations. The Commonwealth's HCH evaluation in remote Aboriginal PHC sites may reveal service reforms, such as those voiced by participants in this study.

In contrast with the Commonwealth's HCH implementation focusing only on patients with chronic conditions, the present study identified a desire for a population-wide service model. This is consistent with the policy position of peak organisations,¹¹ the successful Patient Centred Medical Home model of care in the US¹² and the population health approach used in the Aboriginal PHC sector.^{5,13,14} Should the HCH evaluation demonstrate value, expanding eligibility to all patients, by mandating and accrediting against HCH practice standards, warrants consideration.

In addition, in this community, comprehensiveness incorporated broader social and cultural determinants of health, including environmental health, health promotion, preventive care, trauma-informed care and integrating traditional healing practices. Again, this is consistent with successful First Nations services internationally.⁸ Further work is required to identify mechanisms and opportunities for Aboriginal Health Boards to expand their activities into these areas.

We identified two principal service-level implications. First, PHC teams need to be restructured to foster culturally secure relationship-based care. This requires transitioning nursing roles from narrow disease-focused portfolios to generalist panel managers working alongside AHPs in small teamlets within the broader PHC team. We suggest a model where one PHC nurse manages a patient panel of up to 400 people assisted by AHPs at a ratio of one AHP per 100 patients (Fig. 2). The patient panels would be supported by shared clinical resources (GP, midwife and a psychologist) and shared professional supports (AHP educator, AHP mentors and community Elders).

Breaking down the service population to manageable panels would, by design, reduce waiting times and enhance continuity of care. Second, the AHP role requires recognition and strengthening as the focal point of care continuity: delivering self-management support, care coordination and navigation, health coaching, primary after-hours assessment of the unwell and cultural mentorship for non-Aboriginal staff. Although language-group based AHPs would enjoy the support of Elders, on-site professional development and clinical mentorship are also required to sustain AHP involvement.

The contribution of this study to the AHP literature is significant. Policy failings have resulted in a decline in AHP numbers in remote PHC settings in the Northern Territory.^{15,16} The current training, registration requirements and role are acute-care focused at the expense of the more apt PHC roles described herein. Despite the absence of AHPs working in this

Table 2. Alignment of identified service improvements with the Commonwealth's Health Care Homes (HCH) building blocks
AHP, Aboriginal Health Practitioner; GP, general practitioner; PHC, primary health care

HCH building block and illustrative quotes	Service improvement
1. Engaged leadership	
We have to get a good working group. We have opinions and ideas, really good ideas where we can work together in terms of achieving what we need for a really great health centre. (Client982)	Establish formal health advisory group
Working together. It has to come from both sides, doctor, senior roles you know or else you be creating false expectations in the working group. You need bit of mixture within that working group. (Client892)	Iterative community input into service planning
2. Data-driven improvement	
Trust to come back again next time. If I'm going back to same doctor they will help me to get better. That would be better. (Client502)	Track the proportion of patient episodes with their care team
Work, training, culture, training you know and educate them to help Aboriginal people. (Client889)	Patient-centred indicator (e.g. cultural competency training completion)
3. Empanelment	
We want to keep it going simple. If we keep to the language groups speaking to their own mob and vice versa. (Client982)	Language group-based patient panels and teamlets
4. Team-based care	
Same nurse all the time. That is the best way, the only way. Once you change another nurse, she doesn't know you. (Client548)	Teamlet comprising panel nurse and AHPs
Teamwork, we all work together, Black and White together, working together. (Client392)	Teamlets supported by GP and specialist or allied health services
Aboriginal people. Well some, they don't speak well. Somebody will stay with them and talk to them, translating. (Client785)	New AHP roles:
We just like keep an eye on them from that medicine you know, to give them every morning, lunch, and afternoon. (Client008)	Health coaching
So you are just getting assist in getting all the information. (Client392)	Self-management support
They need to be explained proper so when they leave the clinic [they know the story]. (Client982)	Care coordination/navigation
	Cultural mentorship for non-Aboriginal staff
5. Patient-team partnership	
Just change it the way that they need to respect community, like <i>Gurrutu</i> way, and start showing respect you know, and care and love for that patient – that person will feel comfortable and happy. (Client873)	<i>Gurrutu</i> -informed care (relationship focus)
Give them [non-Aboriginal staff] a chance, teach them, make sure they understand not to do this and that. (Client502)	Cultural committee to oversee recruitment and performance review of non-Aboriginal staff
6. Population management	
Yeah like its better way to teach them you know so they can stay healthy, so they can get the right food you know. Not only your food but also our bush tucker. (Client392)	Population approach
You know there is a red list [priority patients] here that need to be properly checked up. (Client982)	Prevention focus, including cultural strengths Risk stratification
7. Continuity of care	
You want to go back to your family then come back. You've got to have a home base help all the time as well. And then it's a clear message that someone cares. (Client223)	AHP the focal point of continuity within teamlets
If you want health workers, your piece of paper – that's built a wall, that stops people from getting this job. (Client112)	On-site, problem-based training for AHPs
We will talk to our families, we will find the people [AHPs] for you, the smart ones. (Client268)	AHP support from Elders, AHP educators and AHP mentors
They need to know they are going to get paid and support right through, mentorship as well and succession plans and if you are talking about succession we need to be providing that you know. (Client982)	
8. Prompt access to care	
So they [AHP] can have like thermometer, stethoscope so they can check up, hear their chest, whether they are breathing fast, or the temperature is up and then they can call the clinic. (Client392)	After-hours panel AHP for primary assessment
One house then the next you should go and check all the people, some people they don't want to go clinic, they are scared to go. (Client317)	Outreach PHC delivery

(continued next page)

Table 2. (continued)

HCH building block and illustrative quotes	Service improvement
<p>9. Comprehensiveness and care coordination</p> <p>Traditional healing should be part of the clinic too, get Elders to be part of the clinic, ‘Witch doctor’ to be there to look at what happens. (Client889)</p> <p>Keep your house clean, keep your family clean, look after them, keep them safe from bad things. (Client247)</p> <p>We need to talk about social well-being and emotions. So we still need support too, for the family members, sadness and sorrow business and also personal problem. (Client247)</p>	<p>Traditional healing</p> <p>Environmental health</p> <p>Trauma-informed care</p>
<p>10. Template of the future</p> <p>We can work together, talk together. And then we can be one. Together we can be one. (Client672)</p> <p>There should be a working group with them so to address the issues the people are seeing from the outside. (Client982)</p>	<p>Gurrutu-informed care</p> <p>Strong Aboriginal participation in the delivery, and governance of PHC</p>

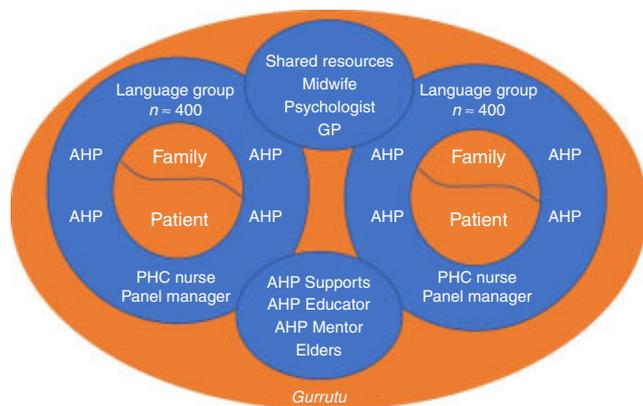


Fig. 2. Template of the future: language group-based teamlets. AHP, Aboriginal Health Practitioner; GP, general practitioner; PHC, primary health care.

community, participants strongly support the AHP profession and readily identified prospective trainees. However, AHPs must work in culturally supported, strengths-based roles, not as an ‘emergency’ technician. We note that our findings are consistent with the views of the AHP profession regarding the strengths they can bring to the PHC team.^{15,17,18} Further, the present study highlights the strong contribution that AHPs can make to the aims and objectives of the Commonwealth’s HCH. Indeed, it is hard to imagine sustainable success in the absence of Aboriginal participation in PHC delivery.^{16,18}

Strong community participation throughout the research process contributes to the internal validity of the findings of this study. Generalisability to other Aboriginal PHC settings is less certain, but features such as disease-focused portfolios of care provision and high staff turnover are pervasive across the remote PHC sector.⁷ Nevertheless, a key finding of this study is the clear benefit of engaging service users to identify and potentially codesign PHC service improvements. This approach is mandated by Australian safety and quality service standards and, we suggest, has merit beyond Aboriginal health.^{19,20}

Conclusion

The Commonwealth’s HCH initiative is a welcome reform with potential to stimulate significant innovation in PHC. However,

service providers are advised to match their delivery of care to the expressed needs of their service users in order to have a greater chance of achieving the aims and objectives of the HCH.

Competing interests

All authors declare that they have no material conflict of interest associated with this research.

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