



ORIGINAL PAPER

Transformation to a Patient Centred Medical Home in an Urban Aboriginal Community Controlled Health Service: A Qualitative Study Using Normalisation Process Theory

Anton Clifford-Motopi^{1,2} | Karen Gardner³ | Renee Brown (Nununcal)¹ | Antoinette White (Palawa Iningai)¹ | Patrice Harald (Gangalu)¹ | Danielle Butler^{1,4} | Saira Mathew^{1,2} | Julie Mackenzie¹ | Richard Mills¹ | Martie Eaton¹

¹The Institute for Urban Indigenous Health Ltd, Windsor, Queensland, Australia | ²Poche Centre for Indigenous Health, Faculty of Health and Behavioural Sciences, The University of Queensland, Toowong, Queensland, Australia | ³Academic Unit of General Practice, Australian National University, Canberra, Australian Capital Territory, Australia | ⁴National Centre for Epidemiology and Population Health, Australian National University, Canberra, Australian Capital Territory, Australia

Correspondence: Anton Clifford-Motopi (a.clifford@uq.edu.au)

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ABSTRACT

Rationale: The Patient-Centred Medical Home (PCMH) is a model of team-based care that is patient centred, coordinated, accessible, and focused on quality and safety. To learn how this model of healthcare works in an Indigenous primary health care setting in Australia, we explored the experiences of health staff in an urban Aboriginal Community Controlled Health Service (ACCHS) transitioning to an adapted model of a PCMH. Normalisation Process Theory (NPT) was applied to better understand factors enabling and inhibiting implementation of the PCMH, and the work required to deliver it.

Aims and Objectives: Applying NPT, we aimed to examine enablers and barriers to implementing a PCMH in an ACCHS setting and identify practical strategies to strengthen its implementation and delivery.

Methods: We employed semi-structured interviews with 19 health staff in an urban ACCHS to explore mechanisms that inhibit and promote the implementation and delivery of a PCMH in their setting. Interview data were analysed using thematic analysis that mapped codes against NPT constructs (Coherence, Cognitive Participation, Collective Action and Reflexive Appraisal) to generate themes.

Results: Five key themes and 14 sub-themes related to NPT constructs were identified. Broadly, health staff found the model of the PCMH to be coherent, engaged with others to adapt their roles, and worked collectively to embed new practices. Characteristics and practice norms of the clinic already aligned with the PCMH model were key enablers. Barriers were related to inadequate resourcing and ill-defined roles. Stronger leadership and support, practical learning resources for staff, workforce mapping to better define staff roles, and training to address gaps in staff skills were strategies identified for strengthening implementation of a PCMH and sustaining its delivery in the ACCHS setting.

Conclusions: Applying NPT revealed the characteristics and practice norms of Indigenous community controlled health care as key enablers of implementing a PCMH in an urban ACCHS. Less than optimal resourcing and workforce development emerged as barriers needing to be resolved to strengthen implementation and delivery of a PCMH in this setting.

1 | Introduction

The Institute for Urban Indigenous Health (IUIH) is a community-controlled health organisation that delivers culturally appropriate primary healthcare (PHC) services across Southeast Queensland (SEQ) in Australia for Aboriginal and Torres Strait Islander people [1]. IUIH supports universal PHC by providing a range of extensive services that result in a 'one stop shop' for their patients [1]. Since its establishment in 2009, IUIH has responded to community-driven needs and a rapidly growing Aboriginal and Torres Strait Islander population in SEQ with built in best-practice systems evaluation for continuous quality improvement and to make changes in service delivery as required [2, 3].

The IUIH System of Care Version 2 (ISoC2)—also known as the 'Pod Model'—is an innovative service reform building on the existing IUIH System of Care [2]. ISoC2 re-centres the IUIH model of care around connections with clients and their families to better meet the health and wellbeing needs of the growing Aboriginal and Torres Strait Islander population in SEQ and their increased demand for PHC services. The model is adapted from a patient-centred medical home (PCMH) developed by an Alaskan Native community-controlled health service [4]. Evidence from studies shows PCMHs to be effective for improving patient experiences, preventive health care delivery [5] chronic disease management [6] and quality of care [7]. The defining features of a PCMH include multidisciplinary team-based care, voluntary enrolment of patients with a care team, patient education and self-management, the use of technology to support patient care (including data-driven improvement), and service planning and coordination. ISoC2 represents many of these key features, but with innovation and adaptation to strengthen patient access, engagement, agency and relationships with providers [2, 8].

In 2019, IUIH implemented ISoC2 in the Caboolture clinic, an urban Aboriginal Community Controlled Health Service (ACCHS) located in the Moreton Bay region of its network of services. To our knowledge, this is the first time an adapted model of a PCMH has been implemented in an ACCHS. It was therefore important to understand the change process, including enablers and barriers to implementing ISoC2 and the work required by health staff to deliver it. Obtaining this understanding from the experiences of health staff was critical to identify practical strategies to improve ISoC2's acceptability and feasibility for routine delivery. Qualitative methods were selected to undertake this research as they are a humanistic approach for capturing a rich and in-depth account of a person's experiences while being responsive to their insight [9]. In healthcare research, qualitative methods have been applied to describe lived experiences, explore healthcare needs, develop explanatory health models and design interventions [10].

Normalisation Process Theory (NPT) is a sociological toolkit that helps to explain the interactions between contexts, people and objects in the complex process of implementation [11]. It guides practitioners in identifying implementation related factors that either promote or inhibit new practices being embedded and sustained in health care and helps to identify what might need to change. NPT can also be used to explain and

guide the process of implementing complex health interventions in healthcare settings [12]. In particular, NPT appears to offer a valuable set of conceptual tools to aid understanding of implementation as a dynamic process (the implementation of new ways of thinking, acting and organising in health care), and the structural problems of integrating new systems of practice into existing organisational and professional settings [12]. NPT conceives implementation as the process of making new practices routine (embedding) and sustaining them in their social and organisational contexts (integration). It assesses the context for change (Potential and Capability) and four key constructs that describe distinct kinds of work through which implementation is operationalized [13]. These are coherence, cognitive participation, collective action, and reflexive monitoring. Coherence refers to the sense-making work that people do when they are faced with operationalising a new practice. Cognitive participation is the relational work people do to engage in and participate in a new practice. Collective action is the operational work that people do to enact the new practice. Reflexive monitoring is the appraisal work that people do to assess and understand the ways that a new set of practices impact them and others. In examining the implementation of ISoC2 in Caboolture clinic, we apply these NPT constructs to firstly, examine enablers and barriers to implementing ISoC2 and the 'work' required to deliver it, and secondly, identify practical strategies to improve the acceptability and feasibility of ISoC2 in Caboolture clinic and other clinics in the IUIH network.

2 | Methods

2.1 | Ethical Considerations

This study was approved by the University of Queensland Human Research Ethics Committee (#UQ HREC A #2019000612) and conducted in accordance with guidelines for the ethical conduct of research in Aboriginal and Torres Strait Islander communities [14]. All participants provided written informed consent before their participation in the study.

2.2 | Methodological Approach

Our study employed a qualitative design with individual semi-structured interviews and ethnographic field notes as the data collection methods. The study was led by the IUIH, the largest ACCHOs in SEQ, and addressed their obligation to meet the needs and priorities of Aboriginal and Torres Strait Islander community members for better access to health care and strengthened relationships with providers [2]. All IUIH operations have overarching community governance and ownership. This has practical expression through a board of directors that combines community-elected and independent skills-based directors, underpinned by a community accountability framework. An ISoC2 working group, comprising Aboriginal and Torres Strait Islander and non-Indigenous researchers, clinicians, managers and community liaison officers, provided technical and cultural oversight for the implementation of ISoC2. The research team working alongside the ISoC2 working group included

Aboriginal (R.B., P.H., and A.W.) and non-Indigenous (A.C.M., D.B., S.M., and M.E.) researchers, clinicians, and service delivery managers. The Consolidated Criteria for Reporting Qualitative Research (COREQ) checklist was used to guide the implementation and reporting of study methodology [15] (File S1).

2.3 | ISoC2

ISoC2 builds on the strengths of the existing IUIH model of care through adaptations designed to strengthen access, relationship-based care, patient engagement and agency and improve health outcomes, by directing resources within the service to deliver greatest impact and scaling the service model to cater for growing patient demand [2]. A key feature of ISoC2 is the provision of health care by a 'pod team', comprising an administrative coordinator, Aboriginal Health Worker (AHW), Registered Nurse (RN) and General Practitioner (GP). The differences in the care components between the PCMH model and IUIH's current model of care and ISoC2 are summarised in File S2.

2.4 | Setting

This research took place on Gubbi Gubbi Country, and we acknowledge their continuing connections to land, sea and community and the ongoing sovereignty of Aboriginal and Torres Strait Islander peoples. ISoC2 was implemented in the Moreton Aboriginal and Torres Strait Islander Community Controlled Services (MATSICHS) Caboolture clinic, in January 2019. Caboolture is an outer northern suburb of Brisbane with a high proportion of Aboriginal and Torres Strait Islander residents relative to the Australian population. This clinic services around 2000 Aboriginal and Torres Strait Islander people. Within the IUIH network of clinics this service was the first site to have their premises redesigned and workforce reconfigured to support the ISoC2 model of care.

2.5 | Participants

Eligible participants were clinical, administrative and management staff of Caboolture clinic. Staff were purposively recruited via practice wide emails and staff meetings inviting them to be interviewed about their experiences of delivering ISoC2 and barriers and enablers to its implementation. We recruited all 12 staff of pod teams delivering ISoC2 and seven health and management staff working across pod teams. In total, 19 staff were recruited, including four General Practitioners (GP); three Registered Nurses (RN); three Aboriginal Health Workers (AHWs); three Administration Officers; two Practice Managers, two Social Health workers; one Community Liaison Officer (CLO); and one Deadly Choices Worker (i.e., an Aboriginal community health promotion worker).

2.6 | Data Collection

Ethnographic notes from monthly ISoC2 working group meetings and semi-structured interviews with health staff were the methods

of data collection. Interview questions were developed by two members of the research team (A.C.M. and D.B.) from notes recorded during a series of meetings and workshops with operational and clinical staff undertaken during the initial stages of implementing the pod model. The questions were refined and finalised in collaboration with senior management responsible for implementing ISoC2. Interview questions asked staff about their current roles and responsibilities, understanding and experiences of ISoC2 and its core components, and their perceptions of the impact of ISoC2 on communication, team cohesion, connection to clients, client access and engagement, and care processes. A male non-Indigenous researcher (A.C.M.) with doctoral qualifications in public health and a female Aboriginal researcher (P.H.) with a postgraduate degree in health research conducted interviews. Both were employed as researchers in the ISoC2 research team and responsible for the qualitative component of the evaluation of ISoC2 within IUIH. Interviewers were unknown to participants, except for a GP and manager who they had brief contact with in monthly ISoC2 working group meetings. During interviews, ISoC2 was referred to as the 'pod model' to be consistent with terminology staff used when talking about it with each other and their patients. Interviews were conducted in a private room in the clinic, 36–70 min duration, and audio recorded. Interview recordings were transcribed verbatim by an external transcription service. Names or personal information were deidentified to ensure anonymity. Participants were informed on the patient information consent form they could obtain a copy of their interview transcript for review, but none took up this option. NVivoPro 12 Software was used for data management.

2.7 | Data Analysis

Inductive thematic analysis using a system of open and axial coding was applied to generate themes [16]. Peer checking was employed to aid credibility and confirmability of data analysis, whereby four transcripts were independently coded by another researcher (P.H.). Once agreement was reached about the codes, each transcript was reviewed and coded by one researcher (A.C.M.). Codes were organised into preliminary axial codes which were presented to participants and refined in response to feedback and discussion. Axial codes were then mapped against the four NPT constructs—Coherence, Cognitive Participation, Collective Action and Reflexive Appraisal [13]—to develop a table of subthemes related to mechanisms that inhibit and promote the implementation and embedding of the pod model in everyday work. During this mapping process, three researchers (A.C.M., D.B., and K.G.) met on two occasions to discuss the meaning of subthemes and verify their congruence with NPT constructs. These meetings resulted in the re-coding of some data and renaming of some subthemes. Through multiple discussions of the narrative accounts provided in the data, the researchers reached agreement on themes mapped against NPT constructs.

3 | Results

Table 1 presents the results of mapping themes and their subthemes against NPT core constructs.

TABLE 1 | Key themes and sub-themes mapped against NPT constructs.

NPT core constructs	Key theme and sub-themes
Context Potential: <i>Leadership and collective commitment to support and</i> Capacity: <i>pre-existing norms, processes etc. that make it possible to implement ISOC2.</i> Implementation Coherence: <i>Work that people do when they are faced with operationalising a new practice. Does the intervention make sense to participants, and can they differentiate it from other work?</i> Cognitive participation <i>The relational work people do to engage in and participate in a new practice. Do participants understand the impact on their role and can make changes to their individual practice?</i> Collective action <i>The operational work that people do to enact the new practice. Can participants work collectively to implement the intervention and embed change in everyday practices?</i> Reflexive monitoring <i>The appraisal work that people do to assess and understand the ways that a new set of practices impact them and others</i>	Commitment from leadership and intention to support - Alignment of resources, social roles, norms and processes Building a shared understanding of the pod model - Distinguishing the pod model from previous ways of working - Sharing a focus on team-based care - Understanding and appreciating the model - Believing in the pod model Engaging individuals in the pod model - Understanding changes required for individual practice - Understanding roles within teams - Valuing the pod model practice Planning, problem solving and adapting to make the pod model workable in practice - Rationalising staff and resources - Reorganising work roles and responsibilities - Building on existing clinic characteristics and practice norms Recognising value and benefits and seeking evidence - Observing changes and benefits - Client and peer feedback - Wanting measurable evidence of improvements

4 | Context

4.1 | Potential and Capacity: Commitment From Leadership and Intention to Support

Contextual integration involves integrating an intervention into the existing social, cultural, or political environment of an organisation [17]. Both the potential for implementation as demonstrated by leadership commitment and support, as well as contextual capacity in relation to the alignment of pre-existing norms and processes are critical for uptake.

Leadership commitment and support was demonstrated through the role of the ISOC2 working group in supporting staff to implement the pod model, and the inclusion of health staff from Caboolture clinic on the working group to ensure that the perspectives of staff responsible for delivering the pod model informed its implementation.

When staff talked about how things were before implementation of the pod model, it became clear that some characteristics and practice norms of the clinic were already aligned with the pod model. Clinic characteristics included the diverse range of services and health staff, and a well-functioning Electronic Health Record (EHR) system that staff credited with

streamlining communication about a client's progress in the care pathway. These pre-existing clinic characteristics meant that many structural elements important for implementation of the pod model were already present.

Practice norms aligned with the pod model were orientations toward interdisciplinary teamwork, preventive and holistic care, and family-centred practice. These practice norms enabled implementation of the pod model as they built on existing work behaviours and duties and were familiar to staff and clients.

5 | Implementing the Pod Model

5.1 | Coherence: Building a Shared Understanding of the Pod Model

To invest in the pod model, staff needed to be able to distinguish its practices favourably from their previous ways of working. This required coherence work in understanding the reasons for, and potential benefits of its implementation.

Staff provided divergent accounts when they compared the pod model to previous practice. Some staff emphasised their

increased workload when comparing the work in the pod model to their previous way of working.

I think it's quite similar to before because we're working within the same model. I'm just doing more.

[RN]

Other staff described doing the same work as before but in a different way. They commonly highlighted two positive adjustments made in working differently: more sharing of responsibility and ownership for client care among a team of workers.

It gives the whole team a lot more ownership of the patient and does let me – it means that things that I don't need to do, don't have to get done by me. Gives a lot more opportunity for that and a lot more opportunity for other people to know the patient well so that if I'm away, all that sort of stuff, we're not left with a patient that doesn't have a team that knows them well.

[GP]

Some staff expressed a need for orientation, information and training from management to help new and existing staff to understand the pod model and how to implement it in their daily work.

I think in our HR side of things and when we employ new staff, I don't think IUIH's explaining to new, or even current staff for that matter, how things work and the need to be working more flexibly.

[Social health care worker]

Coherence work requires that staff understand their roles and responsibilities around the set of practices required to implement and deliver an intervention [11]. Staff frequently emphasised the importance of their role and that of other staff in delivering the pod model.

We need everyone in the team doing their role from the doctor to nurse, admin and the health worker as well. So there is that connection from patient to clinic to staff as well. If we don't have one of them (staff) here or doing their job then patient care is missing or not at full capacity.

[AHW]

A shared understanding of the importance of teamwork was evident in the increased communication between staff. As one RN explained:

When I came in there wasn't as much conversation between health workers to doctors. There could be some between doctors and nurse, but it wasn't as team-based.

[RN]

5.2 | Cognitive Participation: Engaging in the Pod Model

When staff talked about their role within the pod model, they often used the term 'we' or described their role in the context of the 'team', therefore highlighting their understanding of the importance of team-based care to the pod model. Staff commonly expressed an appreciation for the unique insight and knowledge that other roles brought to the pod team and how this contributed to their better understanding of client needs.

A health worker has more of an understanding of what's going on within the community, what needs there are. Certainly more aware of barriers of accessing health care and that sort of thing. And the nurse within our pod she may pick up some things when she is seeing clients, that I might not be aware of. We are all sort of using our focus I guess to gather information to help each other look at a wider sort of picture.

[GP]

Most staff conveyed their personal beliefs about the importance of teamwork to continuity of care when making sense of the benefits of the pod model for improving healthcare delivery and patient outcomes. Some staff also expressed belief in the pod model, which was important for legitimating their commitment to continue to deliver it over time.

But it does show that the patients are getting better continuation of care not just with the same doctor, but with the three; nurse, Aboriginal health worker and doctor, looking after them in that one pod. So it makes sense to keep going with it.

[Admin worker]

5.3 | Collective Action: Adapting to Make the Pod Model More Workable in Practice

The rationalising and reorganising of work was needed to deliver the pod model, and this required ongoing effort from staff. Pod meetings were perceived to be an effective way of enacting the practical work of delivering and adapting the pod model over time. In pod meetings there were group discussions, shared decision making, differentiation and articulation of roles and responsibilities, and the allocation of tasks to specific workers. Daily huddles and weekly pod meetings brought team members together to discuss issues, share clients' stories and resolve barriers to working together.

We have our meetings at the end of the day so we will—our pod will be reception, nurse, doctor, health worker, we have a meeting at the end of the day and bring up—like did you have any troubles today, how are things working, what's going on with the patients we've seen, the actual pod, so that seems to be working together pretty well.

[AHW]

The newness of the pod model, however, meant there was uncertainty among staff as to how to coordinate efforts to operationalise it in the clinic. As one RN stated,

From my understanding it's quite new rolling it out and we're still picking out the bits and pieces, trialling what works, what doesn't work.

[RN]

To support their efforts to operationalise the pod model, staff wanted a more planned approach and support from management.

We need to have a plan from management for how we're going to manage it [pod model] as a team rather than an off-you-go.

[GP]

Our findings also revealed that staff faced several key barriers to incorporating the pod model in their daily work, including a lack of pod-specific resources, limited skills and expertise in social health, time pressures and staff shortages. Staff lent daily support to implementing the pod model by working together to find practical strategies to reduce the impact of these barriers.

Reception will make the initial appointment, but then it falls back onto the team or the pod because they will go through their calendar in the morning and reduce or lengthen, if they can, appointments to make gaps for other clients coming into the clinic so things can keep working.

[Receptionist]

Pod teams were most able to deliver ISoC2 when staff and resources were sufficient to meet client needs and demands for care. In most cases this required that all pod teams had a full complement of staff and the resources to manage clients presenting without booked appointments and/or with social health crises. When delivering the pod model under these circumstances, staff were better able to perceive its value and benefits and work together to deliver it.

It does rely on full staffing. I think that's the big key thing, it works well when everyone's here to share the load. It can get very messy when we're short. But it would be messy if we're short a staff member in the practice. I think it's a bit more obvious with the pod model when there's one away.

[Practice Manager]

Staff commonly reported having the necessary professional skill set to deliver ISoC2, except in the area of social health care. This was partly addressed by the inclusion of a social health care worker as an important and integral member of pod teams.

I think having your person (social health care) who you're referring the social health stuff to present in those meetings was very helpful, because that's often the thing that

needs the most coordination around it. It's more the social health side.

[GP]

The increased involvement of the social health care worker in patient care enhanced integration of social health and medical care. This increased client demand for social health care because their social health needs were more likely to be identified now there was a person attached to pod teams specifically for social health care, referral, and support.

I'm not keeping up with my care coordination this week because I've dealt with a lot more crisis this week. I'm not keeping up with all my crisis this week because I've taken on some counselling jobs because we don't have enough counsellors to keep up with the increased need for counselling.

[Social health care worker]

To increase the availability of specialist social health skills, clinic staff wanted additional social health care workers. Alternatively, the approach adopted by management was to develop skills in social health among existing staff of pod teams. Specifically in relation to first responses to these presentations (e.g., mental health first aid skills) as well as building the foundation of trauma informed care, as relevant to the scope of practice of clinicians within the pod team.

5.4 | Reflexive Monitoring: Appraising the Model, Recognising Value and Benefits and Seeking Evidence

The appraisal work undertaken by staff during implementation of the pod model related to recognising the value and benefits of the pod model by observing the impact of changes and reflecting on client and peer feedback, as well as problem-solving barriers and planning for contingencies. Staff feedback suggested that a more inclusive and culturally safe clinic environment, more regular communication between staff, strengthened relationships between staff and clients, and improved client satisfaction had been achieved.

Staff also sought objective evidence of the impact of the pod model, to determine the extent to which the benefits they observed translated into quantifiable improvements in client care and outcomes. As one GP stated when discussing changes in the follow-up and review of clients:

[...] it's (follow-up and review) probably improved in making one person in a pod team responsible rather than the whole of clinic. And probably reduces my worry of the potential for clients to fall through the gaps, I guess. But that is just the sense I have. You need hard data to show that.

[GP]

Staff turnover and shortages were commonly reported contingencies that made it difficult to deliver the pod model as intended.

There's the model and there's what happens, and I think we're sitting somewhere in-between what the model was meant to be of one nurse, one health worker, one doctor per patient, and I think we're sliding back a little bit towards the old way of whoever happens to be free, just as a function of time and who's available.

[GP]

6 | Discussion

This study examined the experiences of health staff of an urban ACCHS (Caboolture Clinic) during its transition to a PCMH model of care (the pod model). NPT theory assisted to explain factors that enabled and inhibited implementation of the pod model and identify generative mechanisms of its implementation. Our findings show that the context for implementation was broadly supportive and that, on balance, staff found the model to be coherent, engaged with others to adapt their roles, and worked collectively to incorporate and embed new practices into routine delivery. Weaknesses in implementation were identified in relation to resourcing and roles, and where these were identified, strategies were developed by the IUIH to enhance and sustain implementation and delivery of the pod model in Caboolture clinic and other clinics in the IUIH network. These are discussed below.

6.1 | Strengthening a Shared Understanding of the Pod Model

Staff were able to build a shared understanding of the pod model and perceived value in it. Their prior experience of team-based care derived from working in an ACCHS provided a good foundation for this. This shared understanding contributed to a shared sense of purpose to improve team-based care delivery. Other studies have highlighted the importance of a shared sense of purpose for building coherence among staff delivering a new intervention [18].

Critical for building coherence is understanding how a new model is different and more beneficial from a current model. It was evident that many staff could differentiate the new team-based pod model from existing IUIH practice, but where staff struggled to differentiate it, they were less positive towards delivering it. This finding is consistent with diffusion of innovation theory [19] and the results of other studies that posit differentiating a new intervention positively from previous practice is an enabler of its implementation and delivery [18].

In response to these findings, the ISoC2 working group overseeing implementation of the pod model in the IUIH have developed an Operational Manual designed to assist staff to distinguish the pod model from previous practices (differentiation), understand their specific tasks and responsibilities (individual specification) and build a shared understanding (communal specification) of how best to implement it in their setting. The manual is a practical learning resource that sets out the governance, purpose, components and workforce role descriptions of the pod model, along with practical steps and activities for implementing it at a clinic level [20].

Learning resources are an enabler of PCMH implementation [21], with qualitative evidence that they contribute to the implementation process by encouraging quality improvement and the sharing of information and knowledge among staff [22].

6.2 | Supporting Staff to Resolve and Minimise Barriers to Delivering the Pod Model

'Legitimation' relates to participants belief that an intervention or related activity is the right thing to do and should be part of their work [13]. The belief staff had in the worth of the model was linked to their willingness to collect evidence of its effectiveness or benefit to clients (reflexive monitoring), and to address resource issues impacting its routine delivery, such as staff shortages (collective action: skill set workability). This highlights the importance of coherence and its relationship to other NPT constructs [23]. Indeed, an understanding of the pod model for staff developed through the doing.

Overcoming barriers were central to staff being able to legitimate the pod model in their daily work. As with other studies reporting barriers to PCMH implementation [21], staff shortages and time pressures were persistent and required an adaptive response, such as workflow workarounds to maintain the integrity of the pod model. The lack of pod-specific client resources, and staff with skills and expertise in social health care, also required an adaptive response by staff, primarily due to delays in management working with the clinic and pod teams to resolve these barriers. These delays were a source of frustration for staff who struggled to legitimate the pod model in their daily work, especially when providing health care to clients with multiple or complex social health needs. This situation was somewhat of a paradox given the focus of the pod model on staff working collectively to coordinate care based on the health and wellbeing priorities of clients [2]. In response to these challenges, workforce mapping was undertaken by management and service staff to better define roles within the pod team, identify skills gaps that could be filled (through targeted training or redistributing to specific roles) by existing pod staff, as well as gaps that required specialised skills external to the pod team.

The lack of resources to orientate clients and staff to the pod model's way of working was consistent with the findings of interviews with clients [24]. In particular, the lack of guidelines and resources for allocating a client to a pod team. For patients, transition to a PCMH typically begins with their empanelment—assignment to individual primary care providers (PCP) and care teams taking into account their needs and preferences for care [25]. Empanelment sets the stage for other components of effective PCMH practice by assisting clinics to manage patient load and demand more efficiently while connecting patients to a team of workers to improve provider-patient relationships and continuity of care [26]. One study implementing empanelment as a component of PCMH in an Alaskan Indigenous community-controlled health service found that patients able to select their care team based on their needs and preferences were more likely to report being satisfied with the empanelment process and empowered, versus those assigned to a care team by the clinic [5]. Guidelines for

allocating a client to a pod team (i.e., client empanelment) have been developed for staff and a welcome pack explaining the pod model is now available for clients.

Staff were most motivated and able to deliver the pod model when it was adaptable to fit into existing workflows and clinical routines. Pre-existing practice norms and clinic characteristics aligned with the pod model facilitated the adaption process by minimising and simplifying adaptations required. The leadership and influence of the senior GP in supporting other staff to implement the pod model reflected that of a practice champion [27]. Consistent with evidence, their role as practice champion positively influenced buy-in from other staff [28]. Their senior role in the practice was used as leverage by management to legitimise new ways of working and thinking at the practice level and encourage staff to be patient and accepting of changes. However, a breakdown in communication or misunderstanding between management and staff regarding implementation of the pod model had the potential to decrease staff buy-in. This is not surprising given that other qualitative studies have identified effective communication as an enabler of practice level buy-in to a PCMH [21, 29]. In particular, staff in our study wanted to know how their feedback was being used (and why, when it wasn't) to inform planning and implementing the pod model.

A critical development in operationalizing the pod model to address the skill shortages in social health has been the evolution of an additional role, the Health and Well-Being Worker (HWW). As with the AHW, lived and embodied Indigenous knowledges are central to the role of the HWW [30], but with less focus on technical clinical skills and greater emphasis on supporting patients to navigate the health system to address their needs and priorities. A programme of training and support is provided to pod teams to transition the role of AHW to that of a HWW. Additionally, specific training programmes and modules in trauma informed care and mental health first aid have been developed to build the skills and capacity of all staff in pod teams to address the social and cultural determinants of health. While the approach to developing capacity and reconfiguring workforce change is needed for sustaining the integrity of the pod model over the long-term, this inevitably led to delays to addressing the concern in the short to medium-term, with subsequent risk to staff accepting and enacting changes.

6.3 | Facilitating Real Time Reflexive and Objective Monitoring and Appraisal of the Pod Model

The value and benefits of the pod model staff identified through individual and group reflection and feedback is consistent with reflexive monitoring (10). To support this process a pod transformation tool has been developed to facilitate real time reflexive monitoring and appraisal. The tool includes indicators related to components of the pod model and is designed to be used in weekly pod meetings in conjunction with other operational and reflection tools. Additionally, to address the need of staff for objective measures of the performance of the pod model, data related to its implementation and effectiveness is now routinely collected and fed back to clinics and pod teams using existing CQI processes [1]. This process is facilitating a

shared understanding of the performance of the pod model (coherence), group problem solving (cognitive participation), and action to progress discrete components and activities of the pod model, including for example, the assigning of clients to a pod and use of daily huddles (collective action).

6.4 | Strengths and Limitations

This is one of a small number of qualitative studies exploring implementation of a PCMH in an ACCHS in Australia. While the study makes a unique, qualitative contribution to the PCMH literature, there are limitations. This study is a pilot of one ACCHS undergoing to transformation to a PCMH. Therefore, the learnings may not be generalisable to other ACCHS implementing a PCMH. The interviews were conducted at one point in time, 1 year post commencement of PCMH implementation. Therefore, reporting on the process of change by participants was retrospective and did not allow for observation of changes enacted over time. However, interviewing multiple staff across diverse roles and attending the ISoC2 Implementation Working Group meetings for verification and feedback helped to triangulate data, validate the findings, and provide a more comprehensive and accurate story of the change process.

Using a theory-driven approach to implementation is a strength of this study, but it also posed some challenges. NPT was useful to better understand and explain barriers and enablers to implementation and delivery of a PCMH in an urban ACCHS which in turn led to the identification of practical strategies for optimising its implementation and delivery in this setting. A challenge in its application, however, was the overlapping nature of the four constructs, meaning that qualitative data could be coded into more than one construct. We also were sometimes uncertain if we were coding data into the correct construct. Coding data inductively using a thematic analysis before applying constructs of NPT, however, helped to reduce uncertainty since the data were examined for issues relating to implementation before applying NPT.

7 | Conclusion

This study found that the core components of ISoC2 and practice norms of Indigenous community controlled health care were key enablers to staff in an ACCHS doing the work required to implement and deliver a PCHM. This provides qualitative evidence that these models are flexible enough to be adapted to the needs and preferences of staff and clients in individual ACCHS settings. For other ACCHS implementing a PCMH in their settings, the barriers identified in this current study, highlight the importance of workforce development and adequate resourcing early in the implementation process, namely, leadership training and support, workforce mapping to better define staff roles, and practical learning resources for clients and staff. Our subsequent study evaluating the implementation of ISoC2 in additional sites within the IUIH network will include exploring to what extent such strategies enable ISoC2 to respond to workforce challenges and reinforce relational care that is central to its design.

Author Contributions

A.C.M., R.B., D.B., P.H., A.W., S.M., R.M., M.E., and J.M. with the ISOc2 working group conceptualised the project design and methodology. A.C.M. and P.H. conducted interviews. A.C.M., K.G., and D.B. conducted data analysis. A.C.M. composed the first draft of the manuscript. All authors critically revised the draft and contributed to writing the manuscript, and read and approved the final manuscript.

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Ethics Statement

Ethics approval for this project and relevant study protocol was obtained from the University of Queensland Human Research Ethics Committee (2019000612). The research was performed in accordance with the Declaration of Helsinki and ethics approval. Participants provided written informed consent before their participation in the study.

Conflicts of Interest

The authors declare no conflicts of interest.

Data Availability Statement

The data are not publicly available due to privacy or ethical restrictions. The data that support the findings of this study are available from the Institute for Urban Indigenous Health, but restrictions apply to the availability of these data, which were used under license for the current study, and so are not publicly available. Data are however available from the authors upon reasonable request and with permission of the Institute for Urban Indigenous Health.

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Supporting Information

Additional supporting information can be found online in the Supporting Information section.