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

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ABSTRACT

Background. Few studies have examined patient experiences of the Patient Centred Medical Home (PCMH). This qualitative study explores the experiences of patients of an urban Aboriginal Community Controlled Health Service during its transition to a model of a PCMH. **Methods.** Twenty-eight community members who were registered as patients of an urban Aboriginal Community Controlled Health Service were purposively recruited to participate in yarning interviews. Yarns were conducted using a guide containing open-ended questions in the same domains as those used in patient satisfaction surveys at the participating clinic. Data from yarns were analysed by Aboriginal and non-Indigenous researchers using thematic analysis. The interpretations of Aboriginal and Torres Strait Islander researchers were privileged in the analysis. **Results.** Key themes highlighted the importance of relationships, connectedness, and personal growth and empowerment to community members' health and wellbeing, which they described as a journey of healing and recovery. Delays in implementing a process to empanel patients in a care team meant that most community members were unaware a PCMH had been implemented. However, community members commonly reported a more welcoming environment, more contact with the same doctor and more involvement of Aboriginal Health Workers in their care. **Conclusions.** Aboriginal and Torres Strait Islander community members' narratives of their experiences bear evidence of the acceptability of a PCMH model for delivery in Aboriginal Community Controlled Health Services to improve relational care between patients and health staff. A patient-directed empanelment process has been implemented to better connect patients to their care team in the clinic, and the role of the Aboriginal Health Worker reshaped to strengthen connections between patients and their care team in and outside the clinic.

Keywords: Aboriginal Community Controlled Health Service, connectedness, implementation, Patient Centred Medical Home, patient experiences, qualitative research, relational care, yarning.

Background

Aboriginal and Torres Strait Islander peoples in South East Queensland (SEQ) are one the largest and fastest growing Aboriginal and Torres Strait Islander populations in Australia (Australian Bureau of Statistics 2016). The Institute for Urban Indigenous Health (IUIH) is a Regional Community Controlled Health Organisation that leads the planning, development and delivery of health, family wellbeing and social support services to the Aboriginal and Torres Strait Islander population of SEQ (Turner *et al.* 2019). The major benefits of IUIH for the Aboriginal and Torres Strait Islander population of SEQ have included increased access to primary healthcare services (Begg 2017), and major improvements in the quality of clinical care and health outcomes (Kildea *et al.* 2019; Turner *et al.* 2019). To keep pace with Aboriginal and Torres Strait Islander population growth in SEQ, IUIH developed the IUIH System of Care 2 (ISoC2; Butler *et al.* 2022). ISoC2 is based on a model of a Patient Centre Medical Home (PCMH) developed by an Alaskan Native community-controlled health service, and adapted to local context (Driscoll *et al.* 2013). There is international evidence that PCMHs contribute to improvements in patient satisfaction (Jackson *et al.* 2013), clinical outcomes (Driscoll *et al.* 2013) and quality of care (Khanassov *et al.* 2016). Defining features of PCMH models include multidisciplinary team-based care, voluntary enrolment of clients with a team of providers, patient education and self-management, the use of technology to support client care (including data-driven improvement), and service planning and coordination (Kellerman and Kirk 2007). ISoC2 represents many of these key features, but with innovation and adaptation to improve access, strengthen relational care (between health staff and patients, and within the care team), and promote patient engagement and agency (Butler *et al.* 2022).

In 2019, the IUIH implemented ISoC2 at Caboolture clinic, an Aboriginal Community-Controlled Health Service (ACCHS) located in the Moreton Bay region of SEQ. To address the lack of evidence on the process and outcomes of implementing PCMH in Australian primary health care settings (Metusela *et al.* 2021), and more specifically in ACCHS settings (Metusela *et al.* 2020), we conducted a pilot evaluation of ISoC2 at Caboolture clinic to generate real-world evidence on its effectiveness, acceptability and feasibility.

Understanding patient experience is critical to help inform and promote their participation in the PCMH (Allison *et al.* 2014; O'Loughlin *et al.* 2017). However, a relatively small number of PCMH publications focus on the experience of patients: one systematic review of patient-reported experiences of a PCMH identified only 39 studies internationally, of which only one-quarter employed qualitative methods (O'Loughlin *et al.* 2017). Qualitative methods are well suited to capturing a rich and in-depth account of a person's experiences while being responsive to their insights (Miles and Huberman 1994). They are also said to privilege Aboriginal and Torres Strait Islander peoples' voices and rectify power imbalances (Rigney 1999). This current qualitative study privileged the voice and experiences of Aboriginal and Torres Strait Islander community members to contribute qualitative evidence to the evaluation of ISoC2.

This paper, therefore, has three key aims. First, to describe the health care experiences of community members who were patients of Caboolture clinic during its transition to IsoC2. Second, to explore these community members' experiences of receiving ISoC2. Third, to discuss the implications of community members' experiences for strengthening ISoC2 to improve its acceptability for ongoing delivery.

Methods

Methodological approach

This study applied Indigenist research principles articulated by Rigney – resistance as the emancipatory imperative, political integrity, and privileging Indigenous voices (Rigney 1999). The study is led by IUIH, the largest regional Aboriginal Community Controlled Health Organisation in SEQ, and addresses their obligation to meet the needs and priorities of community members for better access to health care and strengthened relationships with providers (Butler *et al.* 2022). All research activities undertaken by IUIH are underpinned by their Cultural Investment Framework and Ways statement to ensure the privileging of Indigenous ways of doing, being and knowing (Institute for Urban Indigenous Health 2018). The research team, assembled by IUIH, included three Aboriginal community-based researchers, and reported to the ISoC2 working group governing the study. At the time of the study, the working group comprised the following staff from IUIH: an Aboriginal Project Officer (Organisational Development), Aboriginal Health Workers, senior clinicians, practice-level and regional-level service managers, and Aboriginal and non-Indigenous researchers. The study methodology privileged Aboriginal and Torres Strait Islander peoples' voices by using methods and tools developed by Aboriginal and Torres Strait Islander people, and having Aboriginal researchers at the forefront of data collection and analysis.

ISoC2

ISoC2 is adapted from an Alaskan Native community-controlled health service, and builds on the strengths of the existing IUIH model of care through adaptations intended to: strengthen access, and relationship-based care, patient engagement and agency; improve health outcomes; increase efficiency by directing resources within the service to deliver the greatest impact; and to scale the service model to cater for growing demand (Driscoll *et al.* 2013; Butler *et al.* 2022). The differences in the care components between the PCMH model and IUIH's current model of care and ISoC2 are summarised in Supplementary Table S1.

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. The study was conducted in Caboolture clinic, an ACCHS located in the Moreton Bay region of SEQ, Australia. Caboolture clinic was the first ACCHS in the IUIH network to have its premises and workforce reconfigured for implementation of ISoC2.

Participant eligibility and recruitment

Eligible participants were Aboriginal and Torres Strait Islander patients of Caboolture clinic aged ≥18 years. An exception was the recruitment of four non-Indigenous women who were the mothers of young Aboriginal children attending the clinic for treatment. Two groups of eligible participants were recruited. First, engaged patients, defined as those with three or more visits to Caboolture clinic in the previous 24 months, were recruited. These patients were recruited from the clinic by research staff with the assistance of clinic staff. Research staff approached patients in the waiting rooms at Caboolture clinic on various days of the week and at varying times of the day over a 3-month period. Patients were informed of the study verbally and invited to participate with the aid of a participant information sheet. Recruitment of engaged patients ceased when no new information was emerging in data analysis.

Second, disengaged patients, defined as those with less than three clinic visits in the previous 24 months, were recruited to examine if their experiences and perspectives differed from those of engaged patients. Disengaged patients were recruited by phone. Clinic staff identified disengaged patients from electronic health records and contacted them by phone to request permission for their phone number to be given to a member of the research team for the purposes of contacting them to invite them to participate in the study. Only patients who consented for clinic staff to give researchers their phone contact were contacted by a member of the research team.

Data collection

Data were collected using a research topic yarning approach – a narrative-based and culturally respectful form of communication for community members to tell their stories in a way that privileges their experiences while conveying meaningful data for research purposes (Bessarab and Ng'andu 2010). Yarns differ from other types of interview methods, in that they are a culturally specified process of sharing knowledge that is reliant upon relationships between researcher and participant to create a collaborative space that is safe and familiar to Aboriginal and Torres Strait Islander peoples (Atkinson *et al*. 2021).

A yarn guide was developed by an Aboriginal Project officer in IUIH's Organisational Development team to frame the research topic yarns in this study. The guide was based on domains in patient satisfaction surveys at Caboolture clinic to ensure they addressed aspects of health care identified by community members as important.

Yarns were conducted by three members of the research team responsible for the evaluation of ISoC2 at Caboolture clinic. Two were female Aboriginal community-based researchers, one with postgraduate qualifications in qualitative research, and the other with undergraduate qualifications in a health-related field. The third was a non-Indigenous male researcher working for the IUIH at the time of the study, and with 20 years' experience undertaking qualitative research with ACCHSs and their communities. All three researchers were unknown to participants. Yarns primarily drew on two types of yarning described by Bessarab and Ng'andu (2010): 'social yarning' around family, culture, community, and country to connect with community members and their stories, and 'research topic yarning' to gather information on community members' experiences and perceptions of receiving health care at Caboolture clinic. In some instances, yarns transitioned into discussions about the research project and its benefits for the community (collaborative yarning). During yarns, researchers constantly checked their understanding of the phenomenon with the participant by paraphrasing and summarising the information they provided.

Yarns involved one researcher and one participant. In a few instances, young children of women participating in a yarn were present. In all yarns, ISoC2 was referred to as the 'pod model' to be consistent with what staff called this model of care when talking about it with each other and their patients.

Yarns were audio recorded and 22–66 min in duration, and transcribed verbatim, including vernacular, for coding and analysis. Two researchers (one Aboriginal researcher and one non-Indigenous researcher) reviewed all transcripts for completeness and accuracy, and removed names or personal information to ensure anonymity of participants. Participants were informed verbally, and on the patient information consent form they could obtain a copy of their interview transcript for review, but none took up this option.

Data analysis

NVivoPro 12 Software was used for data management and to facilitate qualitative analysis. Yarns were analysed using a cyclical approach to thematic analysis. First, an Aboriginal and non-Indigenous researcher examined the transcripts together. Second, these same researchers coded the same two transcripts independently, then met to compare and discuss their initial codes. Third, the remaining transcripts were analysed using a mixed approach, which involved deductive and inductive identification of themes and sub-themes iteratively over several rounds from axial codes (Braun and Clarke 2006). Fourth, axial codes and emerging themes were discussed with Aboriginal and Torres Strait Islander researchers, staff of Caboolture clinic, and members of the ISoC2 working group. Where interpretations differed, those of Aboriginal and Torres Strait Islander peoples were privileged.

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 (National Health and Medical Research Council 2018). All participants provided written informed consent prior to their participants in the study.

Results

Characteristics of community member participants

Twenty-eight community members who were patients of Caboolture clinic participated in a yarn. Some key characteristics of community member participants are summarised in Table 1.

Twenty-four (86%) community member participants identified as Aboriginal and/or Torres Strait Islander peoples, and four participants (14%) were non-Indigenous parents of Aboriginal and/or Torres Strait Islander children. More than two-thirds of community member participants (19 out of 28) named a language group to identify their mob, or in the case of participants who were non-Indigenous, their children's mob. The nine participants who did not name a language group to identify their mob were unable to do so because they were from the stolen generation and/or had only recently discovered their Aboriginal identity.

Community members' experiences of accessing Caboolture clinic

Four key themes emerged describing community members' experiences of accessing Caboolture clinic during its transition to the pod model. Themes are paraphrased in the words of participants to privilege their voices. To preserve participant confidentiality, quotes used to highlight themes are only attributed to the sex and age group of a community member participant.

Theme 1: I connect and feel a sense of belonging through relationships

Relationships were vital for community members to feel connected to people and place, and have a sense of belonging. Community members described establishing and strengthening relationships through their connections to mob, country, community and/or paternal/maternal lineage.

Table 1. Key characteristics of community member participants.

Participants	***n* = 28**
Female	16 (57%)
Aboriginal and/or Torres Strait Islander	24 (86%)
Identified language group/s	19 (68%)
18–34 years of age	8 (29%)
35–54 years of age	9 (32%)
Over 54 years of age	11 (39%)
≥3 clinic visits in previous 2 years	24 (86%)

Knowing country and paternal/maternal lineage made it easier for community members to connect with mob, because it established a relationship with other Aboriginal people from an Aboriginal worldview of interconnectedness.

Community members who identified as stolen generation or had only recently discovered their Aboriginal identity described feeling disconnected, and emphasised the importance of community spaces for meeting Aboriginal and Torres Strait Islander peoples to build connections with mob.

> It's [Caboolture clinic] a good place to yarn up. It's a good place to connect, and know who's here, and who from other areas and different mob that are here. It's a good yarning up place. (Male, >54 years)

Caboolture clinic was considered a welcoming and safe community space to connect with mob, because it 'feels like home' and 'staff are like friends or family.'

> I feel like I've come home. Sometimes it feels like they are my friend. Do you know what I mean? And that's a good thing to have … (Female, 35–54 years)

Importantly, community members described Caboolture clinic as a safe place for them to express their Aboriginal identity and connect with other Aboriginal people without fear of judgement.

> I love it. Everyone is really accepting. A lot of places where I go, when I tell people I am Aboriginal, I feel like they don't accept me, because the colour of my skin is white. But when I come here, I always feel like it doesn't matter what colour my skin is. And thats really good. (Female, 18–34 years)

Clinic staff connected to community members through their stories and health journey. Community members commonly described clinic staff listening to their story, showing empathy, being understanding and non-judgemental, and sharing their life experiences. Community members felt clinic staff knew their story, because they took extra time when it was needed, checked in to make sure they were okay during difficult periods, and knew when to provide firm advice and guidance.

> A lot of doctors you're waiting for hours to see them. All of sudden you're in and out. Where they [doctors at Caboolture clinic] sit you down and check you over and talk to you. Find out how you're feeling. Get that little yarn going. Then, they'll, if they're happy with the conversation, they'll go, okay, I'll see you in a couple of weeks. But it seems like if they're not happy with the conversation, they'll bring you back early. (Male, >54 years)

Theme 2: I feel strong and deadly when I experience personal growth and am empowered

Community members commonly reported feeling strong and deadly when they fulfilled community, family and cultural responsibilities, achieved personal success or became more independent and self-sufficient. For some community members, meeting day-to-day family responsibilities was enough to make them feel strong and deadly, and like role models in their family and community.

> ... strong and deadly means to me providing, living day-to -day basis, working out things even if it is trivial, or physical work in around the house. You know just plan work. I like to think that I can provide through my work ethic as well. (Female, 35–54 years)

Community members who spoke about feeling strong and deadly when they achieved their goals in training, education and community service were motivated by several factors. These included to be financially independent, improve social and economic conditions in their family, increase opportunities for their children, and strengthen their community.

> My input into ... our community. I feel that's deadly, that's strong, and the way that I can assist our mob here in the community ... breaking down those barriers, and making a lot of ground, I suppose, culturally, with our mob. (Male, ≥54 years)

A small number of community members described feeling empowered when they overcame social, emotional and/or psychological challenges. This was described as 'making it through difficult times', 'coming out of a dark place' and 'moving on from pain or loss'. Overcoming life's challenges resulted in emotional and psychological growth, and increased feelings of self-worth.

> Strength, like just don't give up, keep going no matter what. Like people put you down because you're Aboriginal. But the thing is it's just sort of like ... you just keep going and don't stop. You don't give up and my grandkids are my power. My grandkids are my power. (Female, >54 years)

Theme 3: I am on a journey of healing and recovery to improve my health and wellbeing

Health was not an absolute state of being. Rather, health was a journey of healing and recovery that happened in fits and starts over an extended period of time. Becoming healthy was not linear and predictable. The path to health and wellbeing was different for each community member. The metaphor of a journey of healing and recovery emerged as a suitable descriptor of community members' health and wellbeing, because that was how they talked about their experiences of becoming healthy. Their journeys included:

- A recursive, back and forth process.

  'I have good days and bad days, but am working to get better.' (Female, 35–54 years)

- Being unwell, but gradually getting better.

  'I am coming out of a dark place.' (Male, 18–34 years)

- Functioning despite ongoing health challenges and trying to get better.

  'It's a work in progress I could say, it's been pretty shit, but I just take it as the day comes. But, I've been talking to some people that, that's helped me, over at Mental Health.' (Male, 18–34 years)

Health staff helped community members acquire and use resources and skills that were essential in their journey of healing and recovery. Community members also brought their own personal strengths to the journey.

> We're going to have to find different ways to deal with things. So, he doesn't ridicule me for it. He doesn't make me feel bad for it. But he's that strong hand that I do need. So, it's fantastic working with him. He's a great doctor, he knows my kids very well. (Female, 18–34 years)

Theme 4: I need stronger connections from clinic to community for my journey of healing and recovery

The connectedness, belonging and empowerment community members experienced accessing Caboolture clinic were much less evident in their stories of interactions with health staff beyond the walls of the clinic. Contact with health staff outside the clinic was minimal, and primarily occurred through phone contact with reception staff for appointment bookings, reminders and follow up. Some community members also reported Community Liaison Officers (CLOs) 'checking in on me', and 'being there for a yarn'. Although community members valued these interactions with CLOs and considered them important for staying in touch with what was happening at the clinic, they were not enough for those who were disengaged or experiencing long delays between appointments to feel connected to the clinic in the same way that physically accessing the clinic did.

Interviewer:	'How was it for you having to wait a couple of months to see the counsellor?'
Participant:	'I just kind of stayed at home all the time and did nothing. Waited for the support, felt a bit lost.' (Female, 18–24 years)

One community member who accessed the clinic irregularly wanted more promotion and marketing of changes to the clinic in the community.

> I didn't know [about the pod model]. Promote and market it [the clinic] through community programs to get it out there in the community more, so people know and don't feel left out. They will come if they know. (Male, 35–54 years)

Community members wanted the clinic to reach out to them in the community through cultural, outreach and health promotion programs. This was considered especially important for connecting the clinic to younger clients, and clients to hard-to-reach services.

> Well, look, certainly I mean not in terms of me, but in terms of the people I work with, certainly programs that support Aboriginal and Torres Strait Islander young people to engage with the clinic in the community … that would be around health, sex education, culture, identity. (Female, 35–54 years)

Community members' experiences of the pod model

Community members described experiencing care differently since implementation of the pod model. The main differences they experienced were related to improvements in continuity of care and the clinic's physical environment. Relational continuity of care, an ongoing therapeutic relationship between a patient and one or more providers (Alyafei and Al Marri 2020), improved from patients staying with the same doctor or nurse and having more contact with the AHW. In particular, community members with chronic disease and/or complex health issues experienced a more consistent and coherent approach to the management of their condition.

> I stay with the same team more. They notice more if I got problems. (Female, >54 years).

For two community members, a stronger therapeutic relationship with one doctor meant they felt lost if that doctor was absent for extended periods of time or left the service. Encouragingly, however, doctor absence or turnover was mostly counteracted by community members having increased contact and strengthened relationships with the same nurse and/or AHW. The addition of a centralised waiting room was commonly identified as a positive change to the clinic, because it enabled increased contact and strengthened relationships with health staff.

> The second waiting room is great. Well, they [health staff] sort of mingle in. You can get a conversation out of them. I mean, I have more contact, with Aboriginal Health Workers. I feel more a part of the clinic. (Female, >54 years)

Several community members talked about not having to repeat their health story at every clinic visit now that they saw the same health staff or care team. Their experiences were consistent with better informational continuity of care – the use of information on a patient's health history and circumstances to tailor care to their individual needs (Alyafei and Al Marri 2020).

> I'm excited, because I really feel that no matter what problem I've got, I can come here, and I believe the network and the support that they have here now supports me to have a positive outcome and a better life. (Male, 18–34 years)

Despite, community members' experiencing better continuity of care, few attributed this to the pod model, as most were unaware of its implementation, including their allocation to a pod team. Promotion and marketing of the pod model in the community was recommended to spread the word and foster engagement.

> Promote and market it [the pod model] through community programs to get it out there in the community more, so people know. They will come if they know. (Male, 35–54 years)

For one community member, their lack of knowledge about the pod model raised questions as to how it was developed with community input, and the extent to which individuals could choose whether or not to be a part of it.

> I mean, how all right, well, as a client, how would you put that together for us to accept that? I think that's up to the individual. (Male, >54 years)

Discussion

This paper explores the experiences of community members who were patients of an urban ACCHS (Caboolture clinic) during its transition to a PCMH model of care (the pod model). Caboolture clinic is a safe space for community members to connect with mob, which reinforces their Aboriginal and/or Torres Strait Islander identity and sense of belonging in the community. Health staff treat community members like family, which makes the clinic feel like a home. These findings reiterate the importance of Aboriginal community-controlled organisations to Aboriginal and Torres Strait Islander peoples' sense of safety, stability, belonging and connectedness (Baba *et al.* 2014).

The finding that some community members felt lost in between clinic appointments, and disconnected when not regularly accessing the clinic, suggests that, at the time of this study, Caboolture clinic's connectedness with their patients was less prominent outside the walls of the clinic. Community members' recommendations for more outreach visits and community based sociocultural programs is consistent with approaches that put more control over when and how health care is delivered in the hands of the community and individuals, by providing them with multiple points of access to health care. These approaches are especially important for individuals who encounter physical, psychological and/or social barriers to accessing health care, such as those who are disengaged from health care, live in chaotic and stressful environments, and/or with chronic conditions (Whop *et al.* 2012; Davy *et al.* 2016*a*). Access to health care for clients with these barriers and/or characteristics is typically non-linear, with no clearly defined entry or exit points. The journey of these clients into and through healthcare services is more dependent on services and staff connecting to them (O'Sullivan *et al.* 2014).

Community members' experiences of more contact with health staff was supported by the quantitative evaluation of the pod model, which found that patients assigned to a care team were more likely to have continuity-of-care and increased contact with an AHW (Mathew *et al.* 2023). The increased contact with an AHW is particularly encouraging, given the lived and embodied Indigenous knowledges they bring to their health care role (Stajic 2020). AHWs has been shown to increase levels of patient care, satisfaction (Bureau of Health Information 2021) and health outcomes (McDermott *et al.* 2015). Furthermore, that the centralised second waiting room made community members feel more a part of the clinic is encouraging, given evidence that Aboriginal and Torres Strait Islander peoples are more likely to engage with healthcare services that are physically and emotionally welcoming (Davy *et al.* 2016*b*). More specifically, these findings are consistent with evidence that patients of a health service transitioning to a PCMH most value changes that strengthen relationships with health staff (Fontaine *et al.* 2015; Frasso *et al.* 2017).

The finding that most community members did not know about the pod model is consistent with other qualitative studies exploring patient experiences of the PCMH, and has been identified as a barrier to engaging patients in this model of care (Pearse and Mazevska 2018). Community participation is a key characteristic of Indigenous community-controlled health services, and is especially important for ensuring the needs of local Indigenous peoples are identified, understood and addressed (Harfield *et al.* 2018). A key feature of implementation of a PCMH model in an Alaska Native community-controlled health service was ownership by its patients, who were referred to as customer owners (Johnston *et al.* 2013). Patient involvement and input in the implementation of a PCMH has been shown to increase engagement of patients in their care (Fontaine *et al.* 2015) and staff satisfaction (Safety Net Medical Home Initiative 2013).

One key barrier to patient engagement in the current study was the lack of an empanelment process. For patients, transition to a PCMH typically begins with their empanelment – assignment to individual primary care providers and care teams, taking into account their needs and preferences for care (Safety Net Medical Home Initiative 2013). 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 (Bodenheimer *et al.* 2014). One study implementing empanelment as a component of a PCMH in an Alaska Native 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 (Jackson *et al.* 2013). Delays in implementing a patient-initiated empanelment process at Caboolture clinic as part of ISoC2 meant that the community members we interviewed had most likely been assigned to a pod team by clinic staff. Patients not involved in their assignment to a care team are unlikely to be aware of their clinic's transition to a PCMH (Pearse and Mazevska 2018). Guidelines for implementing PCMH empanelment recommend that patients be given the opportunity to select their care team and/or primary care provider as part of the empanelment process (Safety Net Medical Home Initiative 2013).

Implications of key findings

In response to key findings, Caboolture clinic and the IUIH have implemented two key strategies to improve the acceptability of the pod model to community members and optimise its potential to improve relational care. First, an empanelment process has been implemented, comprising a welcome pack for new clients and a process for assisting clients to choose a pod. The welcome pack includes customised information about the specific clinic and the pod model, including what services are available, how to access services, how the pod model works and why the clinic works in this way. The information is provided before or at a client's first appointment. To support clients in their decision, a plain language information brochure and poster outlining the different pods has been developed to assist clients to select a pod that best suits their needs with guidance and support from Aboriginal health staff. This process aims to empower clients to make choices about their health care by building reciprocal and meaningful partnerships with members of their pod team that enable them to plan care together. Given the importance of relationships to community members' connectedness and sense of belonging, it is anticipated that as their relationships with members of their pod develop over time, their connection and sense of belonging to their pod will strengthen, and they will prefer to connect with health staff in that pod for their health care.

Second, the Health and Wellbeing Worker is a new and evolving role in pod teams that has reshaped the role of the AHW role to ensure that the journey of a client through the health and social system, in and outside the clinic, is seamless and empowering. Broadly, in practical terms, the Health and Wellbeing Worker welcomes clients to the clinic and assists them in their choice of Pod, yarns through their sociocultural story, delivers health information and education, and works alongside clients and families in their goal setting and health decision-making. Their role is consistent with a salutogenic model: the creation and maintenance of good health by strengthening the determinants of health rather than focusing on the causes of illness and disease (Lindström and Eriksson 2010). A strength-based approach provides a stronger basis than a deficit narrative for building meaningful health interventions, because it leverages Indigenous strengths, and ways of being, doing and knowing (Bullen *et al.* 2023).

Strengths and limitations

This is one of a small number of qualitative studies exploring patient experiences of a PCMH and, to our knowledge, the only one undertaken with clients of an ACCHS in Australia. Although the study makes a unique, qualitative contribution to the PCMH literature, there are some limitations. Participants were primarily recruited from community members attending the clinic and, as such, their experiences and views may not reflect those of Aboriginal and Torres Strait Islander peoples not attending the clinic. However, we used patient registries to recruit five disengaged patients to gain insight into their experiences and perspectives. Although the perspectives of patients were similar, the small number means it is unlikely that data saturation was reached for this group. Interviews were conducted in a private room in the clinic before or after the participant's medical appointment. Some participants may have been less forthcoming with their responses being interviewed in a clinic setting. However, community member participants described Caboolture clinic as a safe community space, which suggests this is unlikely.

Conclusion

Through yarning with Aboriginal and Torres Strait Islander community members we have explored their experiences of care during implementation of a PCMH (the pod model) in Caboolture clinic – an urban ACCHS. Aboriginal and Torres Strait Islander community members' narratives of their experiences bear evidence of the acceptability of the pod model in an urban ACCHS setting for improving health outcomes through a relational model of care. To optimise the potential of the pod model to further improve relational care, a patient-directed empanelment process has been implemented to better connect patients to their pod team in the clinic, and pod teams have strengthened their connection to patients in and outside the clinic through the inclusion of Health and Well Being Workers who have key roles in establishing relationships, interconnecting patient stories and health interventions, home visits, referral support, and community engagement.

Supplementary material

Supplementary material is available online.

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Data availability. 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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