

Exploring consumer perspectives about the Health Care Home model of primary care provision

A qualitative study

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Background and objective

Australia's health system faces challenges in the management and prevention of chronic disease. Models of primary care delivery, such as the Health Care Home (HCH) model, have been proposed to help meet these challenges. The aim of this study was to explore pre-implementation consumer perspectives of the HCH model.

Methods

Qualitative data were collected from focus groups and semi-structured interviews with 38 general practice patients diversified across rural and urban areas and patient demographics.

Results

The qualitative findings revealed that consumers were confused about the name of the model. They were sceptical about potential hidden costs associated with the model and concerned about hidden agendas and where things in general practice are headed.

Discussion

The findings indicate that consumers may not readily embrace the HCH model. To aid consumer acceptance, the authors recommend the terminology be clarified and the concepts, financial implications and expected outcomes of the model be clearly communicated.

CHRONIC DISEASE is the leading cause of morbidity and mortality in Australia.¹ Twenty-six per cent of the population is living with two or more chronic conditions,² and just over 40% of all consultations with general practitioners (GPs) address chronic disease.³ Despite being recognised internationally as delivering high-quality, efficient care,⁴ Australia's health system faces ongoing challenges in the management and prevention of chronic disease.⁵ Given current and predicted need, alternative integrated models of healthcare delivery that focus on primary care have been proposed to help improve access, quality and continuity of services for patients with chronic or complex healthcare needs.⁶⁻⁸

Arising from recommendations of the Primary Health Care Advisory Group,⁹ an Australian Government-sponsored trial of an alternative primary care funding model, known as the Health Care Home (HCH) model, commenced in July 2017, with the aim of testing the model prior to a national rollout.¹⁰ The trial, which was due for completion in June 2021, enrolled more than 10,000 patients from 10 Primary Health Networks (PHNs) across Australia.¹¹ Formal results are yet to be announced. The emphasis of the HCH model is on team-based coordinated care for patients with chronic and complex conditions. This includes a primary care

team led by the patient's usual general practitioner (GP), shared care-planning flexibility in access to care and improved care coordination.¹¹ Funding for the HCH model is based on annual block payments to practices according to patient complexity assessed by a risk stratification tool.^{10,12}

The HCH model is broadly based on features of the Patient Centered Medical Home (PCMH) model that has been implemented and active in North America for over a decade.¹³ Reports suggest that transitioning to a PCMH-type model requires substantial transformational change.¹⁴ Yet, despite a strong focus on improving patient experience and care, consumer perspectives and experiences regarding the model are under-researched, and current evidence suggests consumers are not well informed regarding PCMH concepts.¹⁵ As the HCH model is premised on consumer engagement, with patients choosing their HCH and self-selecting to be enrolled in the model, it is important to explore consumer perspectives regarding the appropriateness and acceptance of the model to help inform implementation. The upcoming rollout of HCHs presents a unique opportunity to conduct pre-implementation research and disseminate findings to HCH stakeholders.

In 2017, the South Eastern NSW PHN, commissioned the Illawarra and

Southern Practice Research Network (ISPRN) at the University of Wollongong to undertake consultation with key stakeholders concerning motivation and capacity for implementation of the HCH model within the PHN's footprint. PHNs are independent organisations contracted to the Australian Government to increase effectiveness and efficiency of primary healthcare, particularly for patients at risk of poor health outcomes.¹⁶ General practices within the South Eastern NSW PHN footprint are not involved in the current HCH trial. The aim of this study therefore was to explore the pre-implementation knowledge of consumers (who were patients of these general practices not involved in the HCH model), their perspectives on the acceptability and perceived efficacy of the HCH model, and their willingness to engage with it in the future.

Methods

This qualitative research was underpinned by the theoretical approach of pragmatism, which emphasises a practical approach and is used in social and health research, particularly when seeking workable solutions to practice-based problems. As opposed to explanatory approaches to research, pragmatic research seeks to guide action in real-world settings.¹⁷ This approach emphasises participants or stakeholders communicating their own perspectives and priorities,¹⁸ and therefore provided an ideal platform from which to explore consumer perspectives about the HCH model.

Recruitment

Consumer patient participants were recruited from five purposively selected general practices (all non-HCH trial practices) to reflect the diversity of the geographic area of the South Eastern NSW PHN using the Australian Standard Geographical Classification – Remoteness Area (ASGC-RA).¹⁹ Recruitment targets were met with five focus groups (one from each of the five recruited practices) and 38 participants. Patients were invited to participate in the study by reception staff at the consenting general practices. The eligibility criteria required participants to be

over 18 years of age, to be receiving ongoing GP management for a chronic disease (one or more of diabetes, cardiovascular disease, arthritis or depression) and to be conversant in English. Participants who volunteered to take part in the study returned signed consent forms, in prepaid return envelopes, directly to the research team.

Data collection

Data were collected from focus groups and semi-structured interviews held with the participants between July and September 2017. Focus groups maximise interaction between participants and give priority to the participants' own language, concepts and understandings of the world. They also articulate the importance of exploring difference to avoid the artificial production of group consensus.²⁰ Two participants who were not able to attend a focus group were offered individual semi-structured interviews using the same focus group discussion (FGD) guide, and their data were analysed along with the data from the focus group participants.

A presentation based on material from the PHN was provided to give background information regarding the HCH model. A discussion guide (Table 1) was used to elicit and facilitate responses and interaction between participants and the researcher. An opening discussion was held before the presentation to elicit prior understanding of HCHs (Table 1, Discussion section 1). It was noted that only one participant had prior knowledge. The presentation included a definition and description of HCHs, the intended benefits and an illustration of what organisation of care would look like (Table 1, Presentation and discussion section 2). Focus groups and interviews were digitally recorded and transcribed verbatim. Transcripts were integrity checked, and identifiers were removed. Participants were allocated pseudonyms, differentiating whether they were male or female and from a focus group ('FG') or an individual interview ('Interview').

Analysis

A constant comparison approach²¹ was used to analyse the data, which enabled

the generation of a set of themes and subthemes. In this approach, transcripts of the FGDs are analysed by comparison and contrast of comments, phrases and concepts within each FGD to create codes, and then across FGDs to refine the codes and create categories of coded responses.²² Three members of the research team individually coded a subset of transcripts to identify coding categories within the data. The coding process involved discussion, decision making and refinement with the research team to agree on codes and overarching themes. The dataset was coded using NVivo (version 12), a software program that helps organise coded data.

The researchers engaged reflexively throughout the research process and were aware that their professional experience as researchers and personal subjectivities shaped their interpretation of the data.²³

The study was approved by the University of Wollongong and Illawarra Shoalhaven Local Health District Health and Medical Human Research Ethics Committee (number 2017/057).

Results

There were 38 participants: five focus groups (36 participants) and two individual interviews (one face-to-face and one telephone interview). The participant sample in Table 2 shows variation by sex, remoteness and socioeconomic status. There were nine males and 15 females from urban practices (RA1 major cities) and seven males and seven females from rural practices (RA2 inner regional areas). All participants were over 18 years of age, with the majority being aged 45 years or older.

Three overarching themes emerged from the data that reflect consumer perspectives about the HCH model: 'trying to interpret HCHs', 'uncovering the real agenda' and 'worrying about where things in general practice are headed'. Findings for each of these themes are presented below. The themes and subthemes are also listed in Table 3.

Trying to interpret HCHs

This first theme highlights the difficulty participants had in conceptually grasping

the tangible difference between the HCH model and their usual care.

Many consumers found the name of the model confusing. The use of the term ‘home’ in ‘Health Care Home’ (and also in Patient-Centred Medical Home) consistently created the expectation that the model was some type of care received in the home:

As soon as you mention ‘home’, automatically everyone thinks, ‘Oh okay, they come to your home, someone’s going to come there and look after you.’
[FG03 female]

The model was perceived to be ‘different’ from initial assumptions when it became clear that the model was ‘nothing about home health in a sense’ [Interview 1 male].

Overall, there was scepticism about the motivation for, and the effectiveness of, the initiative. For many consumers, it

was difficult to interpret the ways in which HCHs would actually benefit patients: ‘It seems it’s put forward, not at all to help patients, not even in the slightest’ [FG05 male].

It was suggested that the model might be ‘the best thing for them [GPs] and their practice, not for me’ [FG03 female].

Some consumers perceived little difference between their usual care and the HCH model and were ‘not sure whether anything will change’ [Interview 1 male]. Participants suggested that the existing GP Management Plan and Team Care Arrangements were ‘just exactly like the homecare [HCH] ... so what’s the difference?’ [FG01 male]. Others voiced concerns that the model might be inferior to the care they were currently receiving: ‘I think it sounds a bit like a dilution of what I’m already getting’ [FG04 male].

Most consumers agreed there was a need for a coordinated approach to care

and were supportive of this element of the HCH model that appeared to support networking and new ideas:

I’m excited about the changes that might come as far as having better networking and better access to new ideas.
[FG05 male]

Several consumers perceived benefits of having team-based care and shared health information as ‘thorough and better coverage of all aspects of health, which we should really be getting anyway’ [FG03 female].

Uncovering the real agenda

The second theme highlights the concerns the participants had about government control and financial cost-saving motivations.

Participants described a lack of faith in government agendas when it came

Table 1. Focus group and interview discussion guide

Discussion section 1	Presentation followed by discussion section 2	Discussion section 3
<ul style="list-style-type: none"> When we say Health Care Home (HCH), what do you think that might be? Have you ever heard anything about the HCH model? If yes, how did you come across that information? The Australian HCH model is based on an existing model called Patient Centred Medical Home – is that a term that anyone has heard? Any ideas about what that might be about? What do you think of when you imagine care that is ‘patient-centred’? 	<p>Definition and description of the HCH model</p> <ul style="list-style-type: none"> How do you think that sounds? Does it seem like something you would be interested in? Does it seem like something we need? <p>Description of organisation of care</p> <ul style="list-style-type: none"> How does this look to you? Does it seem like a good way to organise things? <p>Intended benefits of the model</p> <ul style="list-style-type: none"> Do these feel like important issues to you? What would better access look like to you? How would you feel about internet or telehealth services? What would improved self-management mean to you? Would you have concerns about the current funding model being changed? <p>What would you be looking for in an HCH?</p> <ul style="list-style-type: none"> If you had to choose an HCH, what would be important to you? What kinds of innovations do you think could be used to create more effective HCHs? 	<ul style="list-style-type: none"> Given what we have been discussing, do you think the idea of HCHs is a good one? Does an HCH model sound very different to the healthcare you currently receive? If your general practice chose to adopt the HCH model, what do you think would change for you? For other patients? What would you want to know before you were willing to enrol in the HCH? What would be the best way for you to receive that information? Would you choose to become part of the HCH model if it were available to you?

to their healthcare: ‘you hear the word government these days, you automatically think cutback’ [FG04 female]. Some perceived the HCH model was about making or saving money; that it was of benefit to the health system but not to patients: ‘that’s why we’ve got no faith in the government or the health system, is that the models are being set up to get the results that they want’ [FG02 male]. There were concerns about the ability of the HCH model to be sustained financially and logistically, particularly in rural areas or small general practices:

Where are they going to get all this money from? The government complains now that there’s no money, where are they going to get the money from for each patient? [FG03 female]

How do you even implement something like this in a one-doctor town? [FG02 female]

Participants also questioned how the HCH model would work. Questions were raised regarding the cost and financial

structure of the model, with some participants prepared to get involved as long as there were no cuts to current services: ‘I think as long as there’s no cut to service and as you know, we’ve got brilliant service now, then I don’t mind trying’ [FG02 male]. There was scepticism about the allocation of funds and the tier-based needs categorisation system. In particular, it was believed that the categorisation system lacked the flexibility to address individuals’ changing health circumstances:

If it was to go ahead, if we were allocated for example \$10,000 per year, if we only used \$4,000 of that would the \$6,000 roll back – would a bank occur for you personally? [FG04 male]

It scares me big time in the fact that we’re gonna be categorised and we probably won’t have much choice in what category we’re put in. [FG05 male]

Consumers were concerned that the initiative might prove to be more costly

than the current healthcare system. Several participants raised concerns about affordability, particularly for patients who are socially and economically disadvantaged and their ability to access healthcare:

I just feel so sorry for people who are pensioners ... it’s the haves and the have nots when it comes to money. [FG01 female]

Your quality of your healthcare shouldn’t be dependent on your ability to pay, particularly in your twilight years. [FG01 male]

Some participants also saw the potential for rorting of the system by selectively giving business to favoured colleagues:

There’s no policing, no one to keep an eye on whether doctors are being honest and whether they do need to see their patients or whether they’re just bringing them into make a quick buck. [FG05 male]

And would it end up jobs for the boys like, ‘He’s my favourite specialist, that’s where you’ll go’. [FG03 female]

Table 2. Participant sample

Focus group/ interview	Number and sex of participants	ASGC-RA remoteness of practice location	SEIFA decile of practice location
Focus group 1	5 5 males	RA1 major city	8
Focus group 2	9 6 females 3 males	RA2 inner regional	4
Focus group 3	7 6 females 1 male	RA1 major city	3
Focus group 4	5 1 female 4 males	RA2 inner regional	2
Focus group 5	10 7 females 3 males	RA1 major city	6
Interview 1	1 1 male	RA1 major city	8
Interview 2	1 1 female	RA1 major city	3
Totals	38 22 females 16 males		

Note: The SEIFA³⁰ decile is based on the Index of Relative Socio-economic Disadvantage and describes the decile ranking of the participating practices, with a decile of 8 and 6 indicating practices of least disadvantage and 2, 3 and 4 of most disadvantage. ASGC-RA, Australian Standard Geographical Classification – Remoteness Area; SEIFA, socio-economic indexes for areas

Worrying about where things in general practice are headed

The third theme illustrates how consumers were satisfied with their usual care and worried about the potential degradation of that care with the introduction of the HCH model.

Most participants were happy with the quality of care they currently received, perceiving it as ‘caring and supportive’ [FG03 female], ‘very high quality’ where they were ‘listened to’ and were involved in ‘shared decision making’ [FG04 female]. Some raised concerns that change to the system with the HCH model might pose a threat to their quality of care and decrease their access to eligible service and benefits:

The other thing I’d ask with this model is the allied health professionals, does that mean we’ll be able to see more of them or are we going to see less of them? [FG04 female]

Participants were concerned about whether they would be able to maintain

their choice of preferred GP and were sceptical about how the model could enable improved access to appointments. Many did not want anything to change regarding their current care: ‘I’m entirely satisfied with what I’m getting. I don’t need any improvements’ [FG04 male]. Some were openly opposed to the rollout of the HCH initiative:

I don’t like it, don’t roll it out. I’ve seen other government models where they allocate money to different people for different things and it just doesn’t get used correctly it’s wasted, it’s government bureaucracy, I’ve seen it not work in other areas. [FG04 female]

Others perceived that GPs were already overburdened and that the HCH model would pose an additional burden for them:

That’s not fair to the GPs. They’ve got enough to do. Their paperwork is extreme ... How can the doctors fit it in? They are overstretched now. [FG02 female]

Some participants wanted further information and evidence that the HCH model worked before they would be prepared to make a commitment to it, while others noted that they would trust in their GP’s opinion about whether they should enrol in the model or not:

Can you get out of it if you’re not happy? How much is it going to cost me? Is there a cooling-off period? [FG03 female]

I’d go there and I’d be trusting what Dr [name] thought about the set up and if she thought it was worth giving a go. I’d trust her integrity. [FG02 male]

Discussion

This research explored pre-implementation perspectives of consumers, who were patients of general practices not involved in HCH trials, about the acceptability and efficacy of the HCH model. Overall, consumers ranged from being ambivalent to openly opposed to the model. A high level of scepticism was reported about the motivation behind and the true intention of the HCH model. Even when encouraged to consider the success of the PCMH-type models in other locations, consumers remained dubious about the effects of HCH on choice, control and quality of their care.

This study contributes to the peer-reviewed literature concerning patient perspectives of the HCH model and is one of few studies examining pre-implementation consumer perspectives. There is evidence from systematic reviews that PCMH-type change in primary care can lead to

small-to-modest improvements in patient-reported experiences including overall patient satisfaction,²⁴ patient-reported care coordination,^{24,25} access²⁵ and measures of patient engagement.²⁵ However, the reality may be more nuanced than the aggregated data suggest. A mixed methods study from North America drew the conclusion that there was little or no correlation between the degree of self-assessed PCMH adoption within practices and patient experiences.¹⁵ Rather, Aysola et al noted that patients’ experiences of care were dictated by ‘overwhelmingly positive relationships with their providers’.¹⁵ Their findings are consistent with those of the present study regarding the primacy of the physician–patient relationship in patient experience and are important in patient-centred practice redesign.

The findings that the HCH model was poorly understood by consumers reflects previous research on PCMH-type models¹⁵ and should not be surprising given the novelty of the term and concept in Australia. The participants reported significant confusion with the terminology, stating it gave the impression of home-based care, rather than a home base for care within the general practice setting. However, more fundamentally than terminology, the participants struggled with differentiating the underlying concepts from the care they were already receiving. In addition, participants were concerned that the proposed HCH changes threatened the continuity of their current provider relationships, particularly with interpersonal continuity of care being highly important to people living with chronic conditions.^{26,27} Participants viewed decisions about enrolling in the model through the dual lenses of the need for hard outcome data and trust in the recommendation of their GPs.

The authors recommend that to help facilitate consumer uptake of the HCH model, there should be increased clarity regarding the name of the model, a clearer description of the additional benefits of the model in the context of existing multidisciplinary care arrangements, dissemination of a clear explanation of the financial arrangements associated with the tiered funding of the model, and the

Table 3. Themes and subthemes that identify key findings

Theme	Subtheme
Trying to interpret ‘Health Care Home’	<ul style="list-style-type: none"> • Confusion with using the term ‘home’ • Perceived concerns that it may not benefit patients • Sounds like usual care • Perceived benefits of the model
Uncovering the real agenda	<ul style="list-style-type: none"> • Concerns about the government’s agenda • Concerns about how funds are to be allocated • Concerns about affordability • Concerns about cheating the system
Worrying about where things in general practice are headed	<ul style="list-style-type: none"> • Concerns about quality, choice and control • Additional pressure on general practitioners • Need for evidence that the model works • Trust in general practitioners’ advice about enrolling in the model

ability for patients to maintain choice and control regarding practitioner selection and service utilisation.

Limitations

The findings of this study should be considered in the light of its limitations. Despite efforts to obtain a socially and geographically diverse sample, it is possible that invitations by general practice reception staff to patients with chronic disease and the self-selected nature of the participant groups could have led to bias in the views expressed. Although the researchers purposely selected patients with chronic conditions, as these are the target population for HCHs, this may also have influenced their responses, particularly as patients acknowledged that they were already receiving chronic disease care that met their expectations. A further limitation is that people not receiving care for chronic conditions or those who were not conversant in English were excluded. It is acknowledged that consumer perception of the HCH model was predicated on the presentation and questions answered at the commencement of the focus groups. Further information or experience may have altered those perceptions. While the research team applied reflexivity to the analyses, it is possible that their personal perspectives and their health professional backgrounds may have influenced the interpretation. Further research could include a community-based sample of people with chronic disease, irrespective of receiving chronic disease management, or a comparable study of patients who have enrolled in HCHs.

Conclusion

Even within the limitations of this study, the findings indicate consumers with chronic medical conditions may not readily embrace HCH practice redesign initiatives in Australia. In response, the authors make the following number of recommendations to aid consumer acceptance. There will need to be clarity in terminology and very clear communication regarding the concepts, need, expected outcomes and financial

implications of the HCH initiative. Most importantly, practice redesign will need to support interpersonal continuity of care with the consumer's preferred GP. Given the associations between provider interpersonal continuity of care, morbidity and mortality,^{28,29} the participants' concerns seem well founded. The authors recommend ongoing participatory research to inform practice redesign to reduce the risks of patient disengagement from primary care reform efforts.

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