

Educational models, participant experience and outcomes of a diploma course in practice management for Aboriginal Medical Services: a qualitative study

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ABSTRACT

Background. Practice managers and other administrative and management staff in Aboriginal Medical Services operate in a highly specialised cultural, social and administrative environment requiring a unique skill set. The TAFE NSW Diploma in Practice Management for Aboriginal Medical Services (DPMAMS) addresses the need for training in these skills. This study sought to explore DPMAMS graduates' experiences of having undertaken the diploma course, and the effects on their subsequent work practice and career. **Methods.** A qualitative study utilising individual, semi-structured interviews conducted via videoconference and employing a thematic analysis approach was performed. **Results.** Ten DPMAMS alumni participated. At the time of DPMAMS completion, two participants were Aboriginal Medical Services practice managers, two were reception staff, five were in non-practice manager administrative or management roles and one was in a clinical role. Principal themes in the study findings were related to (1) the rich and singular learning environment with emphasis on peer-to-peer learning (which also facilitated 'communities of practice' extending the collaborative learning model to post-DPMAMS peer learning and support); (2) knowledge and subsequent professional and personal confidence (leading to taking on increased workplace responsibility including post-DPMAMS mentoring roles); (3) translational effects on personal work and professional performance; (4) translational effects on work processes at the participants' Aboriginal Medical Services; and (5) the permeating influence of Aboriginal culture and commitment to Aboriginal communities. **Conclusions.** The DPMAMS is an education/training program of perceived high value and fitness for purpose. The findings of utility of education that is empowered by culture, values and peer support may be applicable in wider settings.

Keywords: continuing education, general practice, health care facilities, health facility administration, Indigenous health services, interprofessional education, manpower, services and medical receptionists, medical practice management, primary health care.

Introduction

The practice manager's (PM's) role in Australian general practices has expanded over the past several decades. PMs deal with increasing complexity of practice administration in response to regulatory, clinical and population health changes (Harris and Zwar 2014). The complexity of patient morbidity seen in these practices has increased markedly (Britt *et al.* 2016a). The proportion of participants in smaller practices of two to four general practitioners (GPs) decreased significantly, and the proportion working in practices of ≥ 10 individual GPs increased (15.8% in 2006–07 to 28.9% in 2015–16; Britt *et al.* 2016b), contributing further to administrative complexity.

With increasing administrative complexity, a general practice requires a team of professionals to provide the administrative support necessary to allow the practice

clinicians to deliver optimal health care (Laing *et al.* 1997). The Australian Association of Practice Managers (AAPM) (2022) identifies the core functions of a PM as encompassing a range of activities, including managing finance, human resources, marketing, information, risks, governance and organisational dynamics, business and clinical operations, and professional responsibility. Tertiary diploma courses are now available, at several training and academic institutions, providing specific training in the skill set demanded of PMs.

In addition to the wide range of practice management tasks within mainstream general practice, PMs and other administrative and management staff in Aboriginal Community-Controlled Health Services (ACCHS) and Aboriginal Medical Services (AMS) operate in a highly specialised cultural, social and administrative environment. This requires a unique further skill set.

As an element in closing the gap in health and life expectancy outcomes for non-Aboriginal people, there has been increasing emphasis on the delivery of culturally appropriate health care for Aboriginal and Torres Strait Islander peoples. ACCHSs are operated by, and accountable to, the local Aboriginal and Torres Strait Islander community, and are grounded in its local culture and values (Campbell *et al.* 2018). ACCHSs have been successful in improving healthcare for Aboriginal and Torres Strait Islander people (Panaretto *et al.* 2014).

The scope of clinical care offered within an ACCHS/AMS (hereafter 'AMS') constitutes a 'social model of health' differing somewhat from the 'disease-focus approach' prominent in mainstream primary care (Campbell *et al.* 2018). Incorporated in this social model of health is a need to address the heavy burden of multimorbidity in Aboriginal and Torres Strait Islander peoples (Broe and Radford 2018). Working within the social model entails a more diverse set of skills (and thus more diverse 'craft groups') within in the AMS – with a consequent imperative for co-ordination and teamwork – and engagement externally with dedicated Aboriginal and Torres Strait Islander services, as well as mainstream health services. The broad range of care offered to patients in AMSs, including prominent health promotion initiatives and screening programs, requires a high level of integration, co-ordination, training and upskilling within the AMS workforce (Nichols *et al.* 2018) through the creation of specific and culturally appropriate training schemes (King *et al.* 2012; Calabria *et al.* 2014). These training programs have focused on the medical and allied health staff working within the AMS (King *et al.* 2012), whereas training provisions for practice management and administrative staff have received less attention.

To support the development of AMS sector administrative staff, GP Synergy (the Regional Training Organisation responsible for delivery of specialist GP vocational training in NSW and ACT) collaborated with TAFE (Technical and Further Education) NSW to construct the nationally recognised Diploma in Practice Management for Aboriginal

Medical Services (DPMAMS; GP Synergy 2022). The course is run over 12 months, and covers a range of skills encompassing the core principles of practice management, together with ethical, cultural and legal issues specific to working in an AMS. Enrolment is open to staff currently employed in an AMS (including those in PM and non-PM roles). The course content has been constructed with extensive consultation with NSW AMSs, and with considerable input from Aboriginal educators, health professionals and community members into the design and delivery of the course. The course has been strongly supported by individual AMSs. Since the course's inception in 2015, there have been over 100 course graduates. The premise of this course is that increasing the skill base of AMS PMs and other staff will improve the management of AMS facilities, leading to better quality care for Aboriginal and Torres Strait Islander peoples.

We aimed to explore DPMAMS graduates' experiences of having undertaken the diploma course, and the effects on their subsequent work practice and career.

Methods

This was a qualitative study utilising individual, semi-structured interviews conducted via videoconference (Zoom) and employing a thematic analysis approach.

A study reference group comprised of Aboriginal members of the GP Synergy Aboriginal and Torres Strait Islander Health Committee provided advice on the conduct of the study, and advice on the context and interpretation of themes generated from the data as interviews were conducted and analysed.

Recruitment

Graduates of the DPMAM (2015–2019) were eligible to participate.

The sample frame was the list of graduates of the DPMAMS from 2015 to 2019 (87 graduates at the time of recruitment). Potential participants were sent a study invitation and information pack, along with a short demographic questionnaire, via both email and mailed hard copy (with a 3-week reminder email). Purposive sampling was planned to achieve a maximum variation sample, but eventually all respondents who expressed interest were interviewed.

Data collection

It was intended that interviews would be conducted face-to-face where practicable. However, due to the COVID-19 pandemic all interviews were conducted via videoconference. Interviews were conducted by an experienced non-Aboriginal qualitative researcher (PM) with the assistance of an Aboriginal research team member (AP or CO). This collaborative approach provided a cultural context to the interviews, allowing appreciation of, and exploration of, cultural issues

arising in the interviews, as well as the broader cultural context. It also contributed to the interviews being a culturally safe environment for interviewees to share their experiences.

An interview guide was constructed based on the extant literature, as well as the considerable knowledge of research team members of the AMS sector and the DPMAMS course. However, the interview guide did not limit topics for discussion, and interviews were, as far as possible, informant led. Data collection and initial analysis were iterative and concurrent, allowing the interview guide to be modified as needed to continually capture emerging perspectives and themes.

The interviews were transcribed verbatim, but with deidentification of individuals and AMSs.

Participants were invited to review the transcript generated from their interview and annotate it for any inconsistencies or for additional information they wanted to add.

Data analysis

Analysis of transcribed interviews employed an inductive thematic analysis approach (Braun and Clarke 2006) utilising a process of constant comparison. Analysis was led by the lead investigator (PM) assisted by another experienced non-Aboriginal qualitative researcher (LK) and two Aboriginal members of the research team with experience working in/with the AMS sector (AP and CO). The Aboriginal team members played an active role in thematic analysis, including providing an Aboriginal cultural lens to assist with identifying and interpreting emerging concepts and themes. The first six interview transcripts were independently coded by at least three researchers (PM, LK plus AP and/or CO), followed by discussion and agreement on an initial set of codes for the generation of a draft code book. Further collaborative analysis contributed to building the draft codebook to include emerging codes and themes. Summaries of current findings with indicative quotes were considered regularly in whole-team meetings and study reference group meetings to ensure richness of analysis and to gain further input on cultural issues.

The final four interviews were analysed by PM, who then applied the final codebook to all transcripts. In parallel with this coding process, emerging codes and themes were iteratively mapped to produce a schema of DPMAMS participant experiences, and the resultant effects on career and personal development.

Reflexivity throughout the analysis process involved constant consideration of the backgrounds of the researchers: non-Aboriginal GP researcher and educator (PM); non-Aboriginal psychologist researcher (LK); Aboriginal and Torres Strait Islander Cultural Education Unit Manager (AP); and Aboriginal Cultural Educator, former practice manager and DPMAMS alumnus (CO'B).

Ethics approval

Ethics approval was from Aboriginal Health and Medical Research Council Ethics Committee. HREC Reference number: 1573/19. The research was undertaken with the informed consent of the participants.

Results

Ten interviews were conducted. Rather than the planned maximum variation sample being recruited, all respondents were interviewed.

The demographic characteristics of participants were as follows: nine were women and seven self-identified as Aboriginal. At the time of the DPMAMS course, two were PMs, two were reception staff, five were non-PM administrative or management roles, and one was in a clinical role. At the time of the interviews, eight participants were employed at an AMS and two participants had moved on to non-AMS employment. Individual participant demographic characteristics will not be presented, to preserve anonymity given the restricted size of the sample frame.

Overall impressions of the course

These were almost entirely positive.

I can't think of anything that I thought, 'Oh, this doesn't really fit in this course or this is useless' or 'I'll never use that!' (Interview 9)

But knowing how valuable that course is, we've had... I think we've had... one, two, three, four, five, six after me go through... Everybody wants to do it. (Interview 10)

Negative impressions were infrequent and mostly around the amount of material covered.

I struggled to be able to compress that much information in the amount of time that it was allocated. (Interview 5)

For one participant, this was an impediment to a key teaching strategy (peer-to-peer learning, see below).

We were churning through the blocks... kind of just wanting to get things done to make sure that we're passing, but not really drawing on other people's experience. (Interview 6)

Themes

Principal themes were related to: (1) the rich and singular learning environment (which also facilitated 'communities of practice', which extended the collaborative learning

model to post-DMAMS peer learning and support); (2) the knowledge and subsequent professional and personal confidence produced by participation (which led to taking on increased workplace responsibility including post-DPMAMS mentoring roles); (3) the translational effects on personal work and professional performance; (4) the translational effects on work processes at the participants' AMSS; and (5) the permeating influence of Aboriginal culture and commitment to Aboriginal communities.

Other elements to emerge from the analysis were the effects on career advancement and motivation/preparedness for further education. Fig. 1 shows the overall schema. Overarching themes, relevant across the whole schema, were the support of AMSS and the motivation of participants to undertake the course and implement the learning. The perceived overall result (meeting the objective of the DPMAMS) was improved delivery of care and services in individual AMSS.

Theme (I) the learning environment

This was the most prominent set of findings. Within the overall theme were a number of subthemes: the relaxed and flexible teaching and learning structure; the culturally and socially 'safe' environment; extensive collaborative peer-to-peer learning; and the varied 'craft backgrounds' of the participants.

The relaxed and flexible teaching and learning structure

This related to the attitude and manner of the lecturers/teachers, and to the course structure (with much learning done in small groups).

... it was like you were learning all the time, but it was not just so textbook-driven ... it was more of a relaxed sort of adult style, if you'd like ... [Other courses I've done] I found more like you were going back to school. (Interview 9)

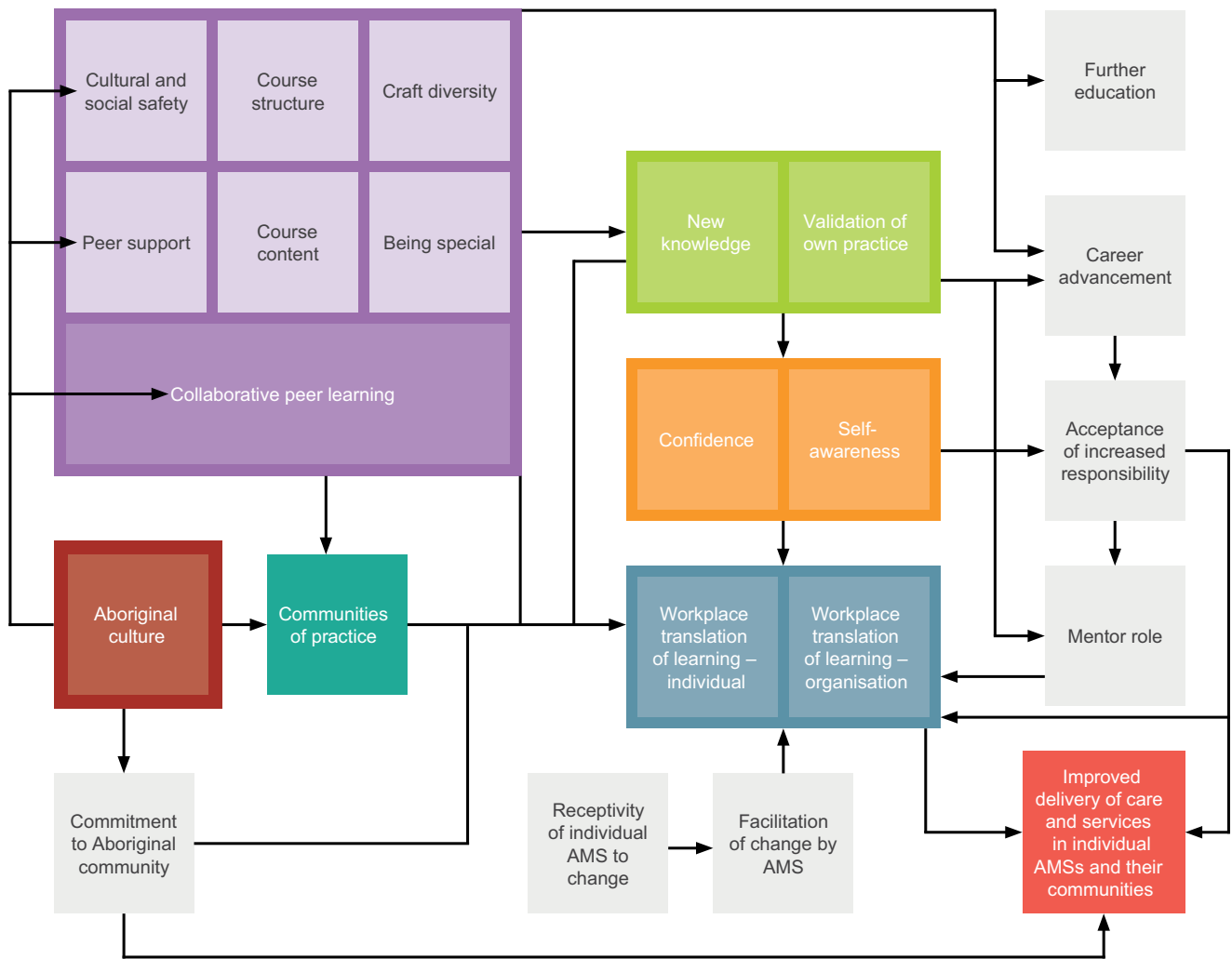


Fig. 1. Schema of relationship of themes operating in the experiences of Diploma in Practice Management in Aboriginal Medical Services participants.

As soon as the presenters walked in, you just felt comfortable. (Interview 10)

The relaxed and flexible approach was thought by participants to be culturally appropriate, and was facilitated by small group learning, organisation of extra-curricular activities (especially team dinners) and by having the participants feel 'special'.

The motels where we had the meals, we didn't want for nothing ... It was perfectly put together. (Interview 3)

The culturally appropriate, and culturally and socially 'safe', environment

Participants reported their learning environment to be a 'safe space'. This related to mutual respect for the individual participants.

And you had to be respectful and let people have their say. So, respect, confidence. (Interview 10)

I loved that. Having the confidence to ask stupid questions. (Interview 5)

There was no reason to be scared. It was beautiful. It really was great. (Interview 3)

And it also related to ensuring cultural governance and integrity.

[the course was made as] culturally safe and as interactive as possible. I don't think I would have finished it if I didn't have the supports that were there. (Interview 5)

Some Aboriginal people, they get quite embarrassed to even say anything or do anything in front of people, but everyone was very comfortable, they could ask whatever they wanted. (Interview 8)

There was also recognition that Aboriginal cultural sensitivity and respect was facilitative of an environment encouraging of cultural sensitivity more generally.

with GP Registrars, recognising the needs of their own cultural beliefs, if they're from a different country and allowing them...if they are Muslim, I think Muslims pray at a certain time and a number of times each day, and allowing that and not being discriminative against that. (Interview 1)

The provision for extensive collaborative peer-to-peer learning

The various elements of the learning environment (the course structure and content, peer support, craft diversity, 'being special', and the culturally and socially safe

environment) came together in peer-to-peer learning. Interaction of participants both inside and outside of class was explicitly and implicitly encouraged and facilitated. There was much small group work and, within these groups, a great deal of shared learning through problem-solving. There was also peer-to-peer learning, whereby DPMAMS participants shared their experiences and, when appropriate, their expertise.

there was structured learning, but then there was also self-taught [i.e. peer-to-peer] learning ... I think there was a lot of cross-learning. (Interview 4)

it was bouncing off each other and I think the teachers led it that way. (Interview 9)

You get to sit down and have a conversation with others about problem-solving and ideas and all that sort of stuff... because when you start hearing what they're doing and how they feel and what happens in their daily [work], you're sharing that... It makes you reflect on yourself and the way you practise and learn, because you just see some people there that are so good at what they do. (Interview 7)

The utility of the varied 'craft backgrounds' of the participants in facilitating peer-to-peer learning

The content of peer-to-peer learning went beyond different practices and procedures in different AMSs and different levels of experience. The heterogeneity of 'craft groups' (PMs, clinical people, finance people, receptionists, administrators etc.) were vital elements in this peer-to-peer learning. This could bring a different perspective to problem-solving.

there was admin, there was RNs, there was a funeral worker... We had a vast range of participants in that class... We had a CEO! (Interview 10)

you know, other people have ideas. Even though they may be a receptionist or an RN. (Interview 5)

it fed in different ideas and a different way of looking at and working as a group together. (Interview 9)

But it could also be in explaining concepts in the course curriculum relevant to their particular 'craft group' expertise.

It was good having a broad range of people... so, the finance part... we had someone that worked in accounts... and she explained and helped break things down for me... When it comes to medical, it was good that there was... an RN or Aboriginal Health Practitioner... They helped me through those parts where I felt like I might otherwise [have] drowned. (Interview 2)

Although this educational ‘value-adding’ was the general experience, in one instance, processing the information from expert peers could be challenging.

I wasn’t intimidated, because they were lovely people. I was just getting frustrated with myself, because I wasn’t understanding it [aspects of financial management in AMSs], as they were just like, ‘Oh, that’s that! That’s that!’ (Interview 1)

Theme (2) the knowledge, and subsequent professional and personal confidence produced by participation

The principal immediate outcome of course participation was increased skills and knowledge, and with this came marked increases in professional and personal confidence.

I definitely think it has increased my confidence...like, increase in my knowledge and my confidence built, and having the support system of the cohort as well. (Interview 3)

This confidence was predicated on increased course-acquired knowledge, but also on confirmation of existing skills and knowledge, and ‘validation’ of participants as competent practitioners in their work roles.

[I already] probably did on the job, just gaining some skills and knowledge on the job, but actually seeing it there in the content within the course, and being able to incorporate that into my daily tasks and duties, I think that’s now given me the confidence and being able to set higher goals rather than trying to coast along where I was. (Interview 2)

Career progression and confidence to undertake further education were further outcomes of the DPMAMS.

that Diploma has started where I am today. That was the base of my education now. It opened the door. (Interview 8)

Theme (3) the translational effects on personal work and professional performance

Subsequent outcomes were application of acquired skills and capability to individuals’ own work performance.

I can do this, and I’m trained in this. I can do it properly and I know what it means to do this role. (Interview 6)

I think it’s helped me heaps in my role. ... So, it’s really opened my eyes and given me the knowledge I needed to step up into this role [practice manager]. (Interview 8)

DMMAMS participation led to taking on of increased workplace responsibility, including post-DPMAMS mentoring roles.

learning so much just whets your appetite to think, ‘Oh, I want to learn more. I want to be better at this, have more knowledge [and] be able to pass on more knowledge. (Interview 9)

it’s just given me that background on how to support people that are in the roles. (Interview 6)

A consequence of the collaborative peer-learning course structure, and the resulting professional and personal confidence was the formation of enduring informal ‘communities of practice’ of alumni of several DPMAMS cohorts (maintained mainly by email and telephone contact). These communities of practice facilitated practical advice and assistance between alumni long after course completion, and directly and practically supported the work and professional performance of the community of practice members.

And it’s still happening now! That’s the thing!... Oh, absolutely! I can just ring up... well [name] is a wealth of knowledge, and other people that I actually attended the course with ... sharing the knowledge. (Interview 10)

We still are all linked up together with our business emails, and especially during what’s been recently happening with the pandemic and everything. (Interview 2)

Theme (4) the translational effects on work processes at the participants’ AMSs

Course participation, for many alumni, translated not only to effects on their own work performance, but to procedural and structural changes in their AMS.

It [DMAMS participation] makes you look and you go, ‘That’s not right! That’s out of date!’ or ‘We haven’t done that or something’s missing.’ (Interview 7)

Again, this was predicated on both DPMAMS-acquired knowledge and confidence.

I knew I had the skills and knowledge to then be able to put it in my workplace and didn’t feel like I was speaking out of turn or anything. I knew that what I was saying made sense and it was backed up by the learning that I had. (Interview 2)

... the wanting to learn and wanting to become more of a leader in it, not being hesitant in learning something and being able to implement that into your organisation. I think that takes confidence as well. (Interview 9)

In some cases, these were considerable or basic changes in AMS functioning. These required a matching of an alumnus' capacity and confidence with a particular AMSs' receptivity to change and facilitation of that change.

I did keep pushing and pushing [management] and, as I said, six or seven months down the track, we finally did get that, but I wouldn't have had the confidence at all [pre-DPMAMS] to have continued to push that through. (Interview 5)

Theme (5) the permeating influence of Aboriginal culture and commitment to Aboriginal communities.

A strong overarching theme was that a desire to contribute to their community and to the health of Aboriginal people was a strong motivation (for non-Aboriginal, as well as Aboriginal participants) for both DPMAMS participation and for implementation of DPMAMS learnings in their work practice.

Being here for my community, supporting my mob and doing all I can for them, going above and beyond. That's my main objective in my role. (Interview 8)

My commitment to [AMS] and working in Aboriginal Health, it gets into your bones! (Interview 10)

There was a 'fit' of course structure, content and learning methods to the AMS context (including the cultural context). Although there was marked 'craft group' diversity, all course participants were working in AMSs, and the course content was very AMS-focused and cognisant of AMSs being part of the communities they served.

Every module that we looked at, there was that Aboriginal context in it. (Interview 4)

The net effect of this focus, plus the structure of the learning – relaxed and flexible teaching, cultural and social safety, and small group learning with peer-to-peer learning – was that the sum of the course content, structure and learning approaches was an optimal fit for the needs (including the cultural needs) of the participants as workers in the AMS sector.

An important point, though, was that although sharply focused on the specifics of AMS practice, and while felt to be of high practical utility, many participants appreciated the 'theoretical' aspects of the course, especially the teaching around the 'lenses', introduced in the course content, through which AMS practice could be viewed.

The lenses as well. That was really interesting! Learning the lenses, the structural, humanistic, politics and the symbolic. (Interview 3)

Because it opened my eyes with the four lenses ... it opened my eyes up heaps and what values we actually have here at AMS through those. (Interview 8)

Discussion

Summary of the main findings

Our findings are of a complex relationship of DPMAMS course content and learning environment (informed by Aboriginal culture and values and by the cultural and social determinants of Aboriginal and Torres Strait Islander health), leading to far-reaching effects on the professional work practice of alumni and on the AMSs in which they work.

The central findings were around the course learning environment, which encompassed cultural and social safety, peer support, and craft diversity in fostering collaborative peer learning. This collaborative peer learning was singularly appropriate for transfer of learning to the ACCHS environment, where teamwork and collaboration are paramount. Practical outcomes were increased individual professional capacity and work performance of alumni, and translation of skills and knowledge to the structure and function of their workplaces. These outcomes were mediated by DPMAMS-related increases in confidence, alumni commitment to their communities and to wider Aboriginal health, communities of practice, which evolve from individual DPMAMS cohorts' course experience, and by individual AMS receptivity to DPMAMS alumni-led change.

Strengths and limitations

A strength of the study was the collaboration of investigators with a deep knowledge of the AMS health sector, and of the DPMAMS program and its cultural underpinnings. It is also, to our knowledge, the only study of education/training for Aboriginal and Torres Strait Islander practice management.

Limitations of the study included the less-than-anticipated responses to invitations to participate, which meant that intended purposive sampling was not possible. The likely cause of the difficulty with recruitment (AMSs and staff being pre-occupied with the effects of the COVID-19 pandemic) was unavoidable. Despite these limitations, we achieved a study sample of a broad range of craft groups and geographic workplace locations. We also had a broad and rich range of themes and issues covered in our interviews, although we were not able to establish thematic saturation. At the practical level of the DPMAMS course itself, the relative lack of negative experiences reported by the participants also limits identification of possible areas where the course content or conduct could be iterated.

Implications for practice and policy

It is apparent that the educational model entailing principles of peer support, peer-to-peer learning, craft diversity, and cultural and social safety was singularly well suited to education/training in Aboriginal medical practice management. Peer-to-peer learning, in particular, was perceived to be central to the model's function in this study, and has been demonstrated to improve performance in medical education settings (Brierley et al. 2022). The model would be appropriate for adoption beyond NSW/ACT. However, the DPMAMS is practicable for only a limited proportion of AMS staff. A further application of these principles might be in wider contexts than the diploma-level education of the DPMAMS. For example, for AMS staff continuing professional education/upskilling activities briefer and less intense than the DPMAMS. The model may also have applicability in contexts beyond Aboriginal and Torres Strait Islander health care. Having been found in this study to be singularly well received by the Aboriginal participants and perceived to be culturally appropriate, the model could be employed in other educational programs focusing on Aboriginal and Torres Strait Islander people, including in non-general practice or non-health settings. Aspects of the model may also be applicable in non-Aboriginal learning environments.

One striking finding was the post-DPMAMS communities of practice, which developed spontaneously in some DPMAMS alumni cohorts. These could be formally facilitated and supported (while remaining voluntary) in the DPMAMS course, and serve as a model for other professional education.

Implications for further research

Future research should investigate the NSW and ACT DPMAMS educational model in other settings. In particular, peer-to-peer learning in groups with disparate craft-group backgrounds is worthy of trial in other settings.

Conclusion

We found evidence for an education/training program of perceived high value and fitness for purpose. The findings of utility of education that is empowered by culture, values and peer support might be applicable in wider settings.

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Data availability. Data (interview transcripts) will not be available. Although de-identified by name and place, the transcripts contain contextual information that would enable identification of individual participants.

Conflicts of interest. The authors, except MvD, are employees of GP Synergy, the Regional Training Organisation responsible for delivering GP vocational training in NSW/ACT. GP Synergy has had a major role in the development and delivery of the DPMAMS. CO'B is an alumnus of the DPMAMS and the coordinator of the delivery of subsequent DPMAMS courses.

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