Appendix 1

Process Mapping Framework

Process Mapping Framework – Stage 1: Site visit

B ORGANISATIONAL PROCESSES				
Inputs	**Process - "How & why?"**	**Narrative**	**Evidence**	**Ref or N/A**
B100 Health Service System				
People ▪ Who are the key individuals in this process – identify the appropriate people for the 'key informant interviews' ▪ Who reviews /monitors the process, when and how? **Technology** ▪ Is there technology to support the process (refer to 'Process' column)? ▪ How does it support the process (refer to 'Process' column)? **Infrastructure** ▪ Are there policies, procedures and protocols in place to support the process? ▪ How do they support the process?	**Infrastructure development** Cover: ❖ Project services (incl. Staff and type of services) ❖ Infrastructure (incl. Offices, transport etc) ❖ IT infrastructure/support services ▪ How do the processes work? Consider: ▪ What services are in place? ▪ What development has occurred in these services since the inception of the Project? ▪ Do participant HSPs have IT links to the Project?		*e.g. policies and procedures, guidelines, walk-through, observation, organisation charts, key informant interviews*	
	Governance and management framework ▪ How does the process work? Consider "development of" ▪ What governance and management processes are in place? ▪ How is the project organised and controlled? Consider: – Delegations of authority – Decision making structure – Communication networks within the Project – Review, monitoring and feedback protocols			

B ORGANISATIONAL PROCESSES				
Inputs	**Process - "How & why?"**	**Narrative**	**Evidence**	**Ref or N/A**
B100 Health Service System				
People ▪ Who are the key individuals in this process – identify the appropriate people for the 'key informant interviews' ▪ Who reviews /monitors the process, when and how? **Technology** ▪ Is there technology to support the process? ▪ How does it support the process? **Infrastructure** ▪ Are there policies, procedures and protocols in place to support the process? ▪ How do they support the process?	**Integration** Successful *Project* level integration with external groups/bodies has three elements: ❖ Communication strategy ❖ Information flow based on the strategy; and ❖ Action occurring on information received. ▪ How does the process work? Consider: ▪ What are the Project's goals in relation to integration? ▪ Which external groups (e.g. key stakeholders such as Area Health Service, Division of GPs, Community groups, other peak bodies) is the Project seeking to integrate with? ▪ Who does the Project liaise with from the external groups and how often? ▪ What integration processes are in place between the Project and these groups? Consider for e.g.: – Communication strategy and implementation – Policy development and implementation ▪ Are there any multi-disciplinary teams (i.e. teams which include both Project members and people from external groups) involved in the Project? ▪ What is the structure and membership of the multi-disciplinary teams involved in the Project?			
B200 Capacity Building				
People ▪ Who are the key individuals in this process – identify the appropriate people for the 'key informant interviews' ▪ Who reviews /monitors the process, when and how? **Technology** ▪ Is there technology to support the process? ▪ How does it support the process? **Infrastructure** ▪ Are there policies, procedures and protocols in place to support the process? How do they support the process?	**Identification of Community needs** ▪ Who is the Project identifying as its Community? ▪ Is the Project actively seeking to build the capacity of this Community? If so, what steps have been taken to build capacity?			
	Organisational development ▪ How does the process work? Consider: ▪ What organisational processes are in place at baseline? ▪ What development has occurred in these processes since the inception of the Project?			
	Workforce development ▪ How does the process work? Consider: ▪ What workforce strategies are in place at baseline? ▪ What development has occurred in these strategies since the inception of the Project (e.g. community needs identification process)?			

B ORGANISATIONAL PROCESSES				
Inputs	**Process - "How & why?"**	**Narrative**	**Evidence**	**Ref or N/A**
B100 Health Service System				
	Resource allocation ▪ How does the process work? Consider: ▪ What resource allocation processes are in place at baseline? ▪ What development has occurred in these processes since the inception of the Project?			

C CARE-RELATED PROCESSES				
Inputs	**Process - "How & why?"**	**Narrative**	**Evidence**	**Ref or N/A**
C100 Client				
People ▪ Who carries out the process?	**Marketing/reach** ▪ How does the process work? Consider: ▪ How is the target group identified? ▪ What steps are taken to attract the target group (e.g. pamphlet distribution, local TV and radio advertisements)? ▪ When did the marketing begin?			
Technology ▪ Is there technology to support the process? ▪ How does it support the process?	**Recruitment** ▪ How does the process work? Consider: ▪ Which recruitment strategies are used in recruiting clients/groups of clients? e.g. telephone, face to face, mail ▪ Which appear to be the most successful and why? ▪ Which clients/groups of clients participate and why? ▪ What factors appear to influence participation rates and in which direction? ▪ What are the reason(s) for drop-outs			
	SM orientation[1] ▪ How does the process work? Consider: ▪ What is the form and structure of SM planning? ▪ What are the reason(s) for drop-outs?			
	AND/OR			
	Enrolment ▪ How does the process work? Consider: ▪ How are enrolment rates influenced?			
Infrastructure	**Education and training** ▪ How does the process work? Consider: ▪ How was the course developed ▪ What is the form and structure of the self-management education? ▪ What are the reason(s) for drop-outs from the course? ▪ What are the reason(s) for the difference between scheduled and completed courses?			

C CARE-RELATED PROCESSES				
Inputs	**Process - "How & why?"**	**Narrative**	**Evidence**	**Ref or N/A**
C100 Client				
▪ Are there policies, procedures and protocols in place to support the process? ▪ How do they support the process?	***AND/OR***			
	Disease specific education and training ▪ How does the process work? Consider: ▪ What is the form and structure of the disease specific self-education?			
People ▪ Who carries out the process? **Technology** ▪ Is there technology to support the process? ▪ How does it support the process? **Infrastructure** ▪ Are there policies, procedures and protocols in place to support the process? ▪ How do they support the process?	**Education and training of SM Program personnel** ▪ How does the process work? Consider: ▪ How was the course developed ▪ What is the form and structure of the self-management education? ▪ What are the reason(s) for drop-outs from the course? ▪ What are the reason(s) for the difference between scheduled and completed courses?			
People ▪ Who carries out the process? **Technology** ▪ Is there technology to support the process? ▪ How does it support the process? **Infrastructure** ▪ Are there policies, procedures and protocols in place to support the process? ▪ How do they support the process?	**Care/SM planning** Cover: ❖ Client assessment ❖ Care planning ❖ Implementing care plan ❖ Monitor & review ❖ How does the process work? How do the processes work? Consider: ▪ How does assessment work? ▪ How are care/SM plans developed? ▪ When are care/SM plans developed? ▪ Who documents the care plan? ▪ Are there designated tools ▪ What are the components of a care/SM plan? ▪ Are care plans multi-disciplinary? ▪ How are care plans implemented? ▪ What training and education has occurred for HSPs/project staff implementing the care planning process ▪ What's the client's role in the process? ▪ How are the information requirements defined ▪ How is the care plan process (including design, delivery, outcome) communicated to all those involved? Include client, HSP, SM coach (or equivalent) and third parties referred to in the plan e.g. dietician ▪ How is the care plan monitored and followed up?			

C CARE-RELATED PROCESSES				
Inputs	**Process - "How & why?"**	**Narrative**	**Evidence**	**Ref or N/A**
C100 Client				
	Support from SM Program personnel ▪ How does the process work? Consider: ▪ What support processes are available to clients from the Project? – Type, intensity, frequency – Follow-up (visits, calls) ▪ How are support processes organised? ▪ How do clients access support (routinely and in emergencies)? Consider also structured and non structured support. ▪ Does the type of support and by whom it is delivered differ depending upon client requirements			

C CARE-RELATED PROCESSES				
Inputs	**Process - "How & why?"**	**Narrative**	**Evidence**	**Ref/NA**
C200 Carer/family/Significant Other				
People ▪ Who carries out the process? **Technology** ▪ Is there technology to support the process? ▪ How does it support the process? **Infrastructure** ▪ Are there policies, procedures and protocols in place to support the process? ▪ How do they support the process?	**Marketing/reach** ▪ How does the process work? Consider: ▪ What role (intended and actual) does the Carer/family/significant other have in the Project? ▪ What is the target group and how is it identified, and by whom? ▪ What steps are taken to attract the target group (e.g. pamphlet distribution, local TV and radio advertisements)?			
	Recruitment ▪ How does the process work? Consider: ▪ Which recruitment strategies are used in recruiting care/family/SO? e.g. telephone, face to face, mail ▪ Which appear to be the most successful and why? ▪ Which care/family/SO participate and why? ▪ What factors appear to influence participation rates, and in which direction? ▪ What are the reason(s) for drop-outs			
	SM orientation ▪ How does the process work? Consider: ▪ What is the form and structure of SM orientation? ▪ What are the reason(s) for drop-outs?			
	Education and training ▪ How does the process work? Consider: ▪ How was the course developed ▪ What is the form and structure of the self-management education? ▪ What are the reason(s) for drop-outs from the course? ▪ What are the reason(s) for the difference between scheduled and completed courses?			
People ▪ Who provides support/follow-up to carer/family/SO from the Project **Technology** ▪ Is there technology to support the process? ▪ How does it support the process? **Infrastructure** ▪ Are there policies, procedures and protocols in place to support the process? ▪ How do they support the process?	**Support from SM Program personnel** ▪ How does the process work? Consider: ▪ What support processes are available to carer/family/SO from the Project? Consider: – Type, intensity, frequency – Follow-up (visits, calls) ▪ How are support processes organised? ▪ How do carer/family/SO access support (routinely and in emergencies)? Consider also structured and non structured support. ▪ Does the type of support and by whom it is delivered differ depending upon client requirements			

C CARE-RELATED PROCESSES				
Inputs	**Process - "How & why?"**	**Narrative**	**Evidence**	**Ref or N/A**
C300 Community				
People ▪ Who carries out the process? **Technology** ▪ Is there technology to support the process? ▪ How does it support the process? **Infrastructure** ▪ Are there policies, procedures and protocols in place to support the process? ▪ How do they support the process?	**Reach** ▪ How does the process work? Consider: ▪ What role (intended and actual) does the Community have in the Project? ▪ Which groups of clients in the community participate? ▪ Which recruitment strategies are used in recruiting at the community level? ▪ How are participation rates influenced?			
	Health promotion ▪ How does the process work? Consider: ▪ How is Health Promotion model developed & by whom? ▪ How is the SM Program involved?			
	Health planning ▪ How does the process work? Consider: ▪ How is the community health plan developed? ▪ Who is involved in community health planning? ▪ When is the community health plan developed? ▪ What are the components of a community health plan?			
	Support from Project ▪ How does the process work? Consider: ▪ What support processes are available to the community from the Project? Consider: - Type, intensity, frequency - Follow-up (visits, calls) ▪ How are support processes organised? ▪ How does the community access support?			

C CARE-RELATED PROCESSES				
Inputs	**Process - "How & why?"**	**Narrative**	**Evidence**	**Ref or N/A**
C400Health Service Providers				
People ▪ Who carries out the process?	**Marketing/reach** ▪ How does the process work? Consider: ▪ What role does the HSP have in the Project? E.g. does the HSP refer/recruit clients to SM Project or do they play a more active role as service coordinator/care planner role? ▪ How are potential HSPs identified? ▪ What steps are taken to attract HSPs e.g. pamphlet distribution, local TV and radio advertisements?			

C CARE-RELATED PROCESSES				
Inputs	**Process - "How & why?"**	**Narrative**	**Evidence**	**Ref or N/A**
C400Health Service Providers				
Technology ▪ Is there technology to support the process? ▪ How does it support the process? **Infrastructure** ▪ Are there policies, procedures and protocols in place to support the process? ▪ How do they support the process?	**Recruitment** ▪ How does the process work? Consider: ▪ Which health professionals participate and why? ▪ Which recruitment strategies are used in recruiting HSPs? e.g. telephone, face to face, mail ▪ How are participation rates influenced?			
	Education and training ▪ How does the process work? Consider: – GP's – Allied health professionals – Other ▪ How is the course developed? ▪ What is the form and structure of the course? ▪ What are the reason(s) for drop-outs ▪ What are the reason(s) for the difference between scheduled and completed courses?			
	Support from Project ▪ How does the process work? Consider: ▪ What support processes are available to HSPs post training from the Project? Consider, type, intensity and frequency ▪ How are these processes organised? ▪ How do HSPs access support? ▪ Does this differ depending upon what support is required?			

Appendix 2

Process mapping thematic analysis

Client: Marketing

Level	Theme	1	2	3	4	DP Classifications
1	**Purpose**	No range				
2	**Nature (focus):** ▪ **Direct/Indirect**	Project to clients[1]	⟷		Project to HSPs to clients	
	▪ **Targeted/ Opportunistic**	Searching actively for potential clients	⟷		Approaching clients on a more impromptu basis	
3	**Conducted by**	Project staff	⟷		HSPs, Community groups	
4	**Marketing approach:** ▪ **Strategy**	Dedicated external	⟷		Internal Project based	
	▪ **Implementation**	Dedicated external	⟷		Internal Project based	

Nature

Level 2 – Direct/Indirect - reflects the nature of marketing to clients by the Project

1. All of the Project's marketing focus is on marketing directly to clients
2. The majority of the Project's marketing focus is on marketing directly to clients WITH some direct marketing to Health Service Providers (HSPs) who in turn will market the benefits of the Program to clients
3. The majority of the Project's marketing focus is on marketing directly to HSPs who in turn will market the benefits of the Program to clients WITH some direct marketing to clients
4. All of the Project's marketing focus is on marketing directly to HSPs who in turn will market the benefits of the Program to clients

Level 2 - Targeted / Opportunistic - reflects how the Project is approaching the marketing to individual clients

1. Targeted – Project staff/HSPs only identify specific clients for marketing the benefits of (Self Management) SM and the Program in a targeted way, for e.g. through the review of case lists, existing directories of people with diabetes, other databases
2. The majority of clients are marketed to in a targeted way WITH some being marketed to in an opportunistic manner
3. The majority of clients are marketed to in an opportunistic manner WITH some being marketed to in a targeted way

[1] This may lead to Project to clients to GPs

4. Opportunistic – Project staff/HSPs only identify clients for marketing the benefits of SM and the Program in an unplanned way during the course of their normal working day e.g. when client present themselves in a GP surgery, or when HSP/Project staff come into contact with eligible clients in other ways

Level 3 - *Conducted by* – who conducts the marketing to clients

1. All of the marketing to clients is conducted by Project staff
2. The majority of marketing is undertaken by Project staff, with some being undertaken by HSPs or community groups
3. The majority of marketing is undertaken by HSPs or community groups, with some being undertaken by Project staff
4. All of the marketing to clients is conducted by HSPs or community groups

Marketing approach

- **Level 3 - Strategy**
  1. Dedicated marketing resource (outside of the project team) or use of external consultants to develop the marketing strategy
  2. Dedicated marketing resource (outside of the project team)or use of external consultants to develop the marketing strategy WITH some input from project staff
  3. Internal project-based marketing approach drawing upon the internal expertise of the group to develop the marketing strategy WITH some input from a dedicated marketing resource (outside of the project team)or use of external consultants
  4. Internal project-based marketing approach drawing upon the internal expertise of the group to develop the marketing strategy

- **Level 3 - Implementation – includes the design of marketing material and actual marketing activities**
  1. Dedicated marketing resource (outside of the project team) or use of external consultants to implement the marketing strategy
  2. Dedicated marketing resource (outside of the project team) or use of external consultants to implement the marketing strategy WITH some input from project staff
  3. Internal project-based marketing approach drawing upon the internal expertise of the group to implement the marketing strategy WITH some input from a dedicated marketing resource (outside of the project team) or use of external consultants
  4. Internal project-based marketing approach drawing upon the internal expertise of the group to implement the marketing strategy

Client: Recruitment

Level	Theme	1	2	3	4	DP classifications
2	**Referral**	Self	◄——►		**All avenues**	
2	**Recruitment**	No range				
2	**Role of project staff**	Dedicated to the recruitment role	◄——►		Ongoing role	

Level 2 - *Referral* - how are people first introduced to the project

1. Self-referral only
2. GP referral only/Aboriginal Health worker
3. GP and other HSP's
4. All avenues – or at least 2 of the 3 (i.e. self, GP's and/or HSPs)

Level 2 - *Role of project staff in the recruitment of clients*

1. Role of Project staff relates to the process of recruitment (including marketing)- only
2. Role of Project staff extends somewhat beyond the process of client recruitment – e.g. to include 1-2 of the additional processes 1) client enrolment 2) care planning 3) education and training and 4) client support
3. Role of Project staff mostly extends beyond the process of client recruitment – e.g. to include 2-3 of the additional processes 1) client enrolment 2) care planning 3) education and training and 4) client support
4. Project staff who are involved in client recruitment (including marketing) also have an ongoing role with all aspects of the Project i.e.1) client enrolment 2) care planning 3) education and training and 4) client support

Client: Education and training of Self Management (SM) Personnel[2]

Level	Theme	1	2	3	4	DP classifications
2	**Timing**	Pre-recruitment	⟷		Ongoing	
2	**Basis**	Project based and pre-defined	⟷		Broadly based and choice	
2	**Training type**	Core (Lorig, Flinders, RACGP guidelines)	⟷		Purpose specific e.g. disease specific training	
3	**Extent**	Limited (one occasion)	⟷		Ongoing (refresher)	

Level 2 - ***Timing of initial training of SM personnel (excluding refresher courses)***

1. All training of SM personnel occurred before the recruitment of any clients to the Project
2. The majority of the training of SM personnel occurred before the recruitment of clients to the Project WITH some occurring on an ongoing basis
3. The majority of the training of SM personnel occurs on an ongoing basis (post the recruitment of clients) WITH some occurring pre-client recruitment
4. All training of SM personnel occurs on an ongoing basis with none provided before the recruitment of SM personnel

Level 2 - ***Basis of training of SM personnel***

1. All of the training provided is project based i.e. training which is project specific (being project initiated and adopted)
2. The majority of the training is project based with some more broad based training being provided
3. The majority of the training is broad based with some project specific training being provided

[2] Includes the education and training of HSPs who are directly related to the Project e.g. Leaders (Qld) and coaches (Vic)

4. All of the training on offer is broadly based as indicated by the degree of choice available and is somewhat driven by what is available to SM personnel that is not necessarily offered specifically by the project, being a reflection of what is available in the immediate community in which the project operates

Level 2 - ***Type of training being offered to SM personnel***

1. Only elements, or all of the core education and training is being offered to SM personnel (i.e. Lorig, Flinders, RACGP)
2. The core education and training is being offered to SM personnel (Lorig, Flinders, RACGP) together with a limited range of purpose specific training being offered
3. The core education and training is being offered to SM personnel (Lorig, Flinders, RACGP) together with a greater range of purpose specific training being offered
4. A complete suite of purpose specific SM education and training in addition to the core training is provided to SM personnel e.g. training on a disease type e.g. diabetes

Level 3 – ***Extent of training offered to SM personnel***

1. Education and training is offered to SM personnel on a limited basis i.e. on one occasion only
2. Education and training is offered to SM personnel on a limited basis, but more than once
3. Education and training is offered on a repeated (but limited and not ongoing) basis
4. Education and training is offered on a regular and ongoing basis (e.g. there are compulsory refresher courses for which there is a given timetable)

Client: Care Planning

Level	Theme	1	2	3	4	DP classifications
1	**Role**	The vehicle for introducing interventions	⟷		One of many interventions	
2	**Driver**	GPs/Practice Nurse	⟷		Project Officers	
2	**Timing**	Immediately at the time of recruitment	⟷		Over the course of Project	
2	**Tools**	No range				
3	**Formality**	Formal	⟷		Informal	
3	**Follow – Up**	Formal	⟷		Informal	

Level 1 - *Role* - importance of CP planning within the overall care related process.

1. Care Planning (CP) is an intrinsic part of the Project being - "The *only* vehicle for intervention". Indicator: all clients in the Project will have a care plan.CP is the *primary* vehicle for intervention. Indicator: the majority (but not necessarily all) of clients in the Project will have a care plan.
3. CP is *a* vehicle for intervention. Indicator: a minority of clients in the Project will have a care plan.
4. CP is not an intrinsic part of the Project - "One of a suite interventions". Indicator: clients will not necessarily have a care plan.

Level 2 - *Driver* – how the care plan gets linked into the project.

1. GPs/Practice Nurse[3]/other HSP are the originator of the care plan, alerting clients to the benefits of SM and referring them to the Project
2. GP/Practice Nurse/other HSP with assistance from Project officers originate the care plan. Project officers provide some assistance e.g. they may provide assistance with the administration of the Partners in Health (PIH) etc.
3. Project officers originate the care plan with GP/Practice nurse/other HSP providing assistance and/or sign-off.
4. Project Officers originate and complete the care plan without assistance/sign-off from GP/Practice nurse/other HSP

Level 2 - *Timing* – when is care planning undertaken

1. All of the care plan is completed immediately at the time of recruitment
2. The majority of the care plan is completed at the time of recruitment, the remainder being over the course of the Project
3. Elements of the care plan are completed at the time of recruitment, with remainder being developed and refined over the course of the Project
4. Care plan is developed over the course of Project

Level 3 - *Formality* - this is the formality of the care planning PROCESS, typified through Medical Benefits Scheme (MBS) recognition

1. Formal – set framework, and qualification for MBS, followed for each client
2. Quite formal – set framework, no qualification for MBS, followed for each client
3. Quite informal – recommended framework only provided by the Project that may be followed for each client
4. Informal – no framework

Level 3 - *Follow-up* - of Care planning

1. Formal – set follow-up procedure intrinsic to care plan procedure. *No* contact with client occurs outside of the follow-up timetable
2. Quite formal – set follow-up procedure built into care plan procedure. *Some* contact with client can occur outside of the follow-up timetable
3. Quite informal – recommended follow-up procedure in place, not necessarily documented in care plan. Follow-up contact (be it regular or irregular) with the client can occur outside of the recommended contact procedure
4. Informal – no recommended procedure in place, follow-up may or may not be documented in the care plan. Regular/irregular contact with the client occurs.

[3] Some Practice nurses may also have a role in the Project – distinction to be made is whether they are employed by the GP or employed by the Project.

Client: SM Planning

Level	Theme	1	2	3	4	DP classifications
1	**Role**	The vehicle for introducing interventions	⟷		One of many interventions	
2	**Driver**	GPs/Practice Nurse	⟷		Project Officers	
2	**Timing**	Immediately at the time of recruitment	⟷		Over the course of Project	
2	**Tools**	No range				
3	**Formality**	Formal	⟷		Informal	
3	**Follow – Up**	Formal	⟷		Informal	

Level 1 - *Role* - importance of SM planning within the overall care related process.

1. Self Management (SM) planning is an intrinsic part of the Project being - "The *only* vehicle for intervention". Indicator: all clients in the Project will have a SM plan.SM is the *primary* vehicle for intervention. Indicator: the majority (but not necessarily all) of clients in the Project will have a SM plan.
3. SM is *a* vehicle for intervention. Indicator: a minority of clients in the Project will have a SM.
4. SM is not an intrinsic part of the Project - "One of a suite interventions". Indicator: clients will not necessarily have a SM Plan.

Level 2 - *Driver* – how the SM plan gets linked into the project.

1. GPs/Practice Nurse[4]/other HSP are the originator of the SM plan, alerting clients to the benefits of SM and referring them to the Project
2. GP/Practice Nurse/other HSP with assistance from Project officers originate the SM plan. Project officers provide some assistance e.g. they may provide assistance with the administration of the Partners in Health (PIH) etc.
3. Project officers originate the SM plan with GP/Practice nurse/other HSP providing assistance and/or sign-off.
4. Project Officers originate and complete the SM plan without assistance/sign-off from GP/Practice nurse/other HSP

Level 2 - *Timing* – when is SM planning undertaken

1. All of the SM plan is completed immediately at the time of recruitment
2. The majority of the SM Plan is completed at the time of recruitment, the remainder being over the course of the Project
3. Elements of the SM Plan are completed at the time of recruitment, with remainder being developed and refined over the course of the Project
4. SM plan is developed over the course of Project

Level 3 - *Formality* - this is the formality of the SM planning PROCESS, typified through Medical Benefits Scheme (MBS) recognition

1. Formal – set framework, and qualification for MBS, followed for each client
2. Quite formal – set framework, no qualification for MBS, followed for each client
3. Quite informal – recommended framework only provided by the Project that may be followed for each client
4. Informal – no framework

Level 3 - *Follow-up* - of SM planning

1. Formal – set follow-up procedure intrinsic to SM plan procedure. *No* contact with client occurs outside of the follow-up timetable
2. Quite formal – set follow-up procedure built into SM plan procedure. *Some* contact with client can occur outside of the follow-up timetable
3. Quite informal – recommended follow-up procedure in place, not necessarily documented in SM Plan. Follow-up contact (be it regular or irregular) with the client can occur outside of the recommended contact procedure
4. Informal – no recommended procedure in place, follow-up may or may not be documented in the SM Plan. Regular/irregular contact with the client occurs.

[4] Some Practice nurses may also have a role in the Project – distinction to be made is whether they are employed by the GP or employed by the Project.

Client: Enrolment

Level	Theme	1	2	3	4	DP classifications
2	**Course scheduling**	Pre scheduled	↔		Not scheduled	

Level 2 - Course scheduling

1. All of the project's courses are pre scheduled (i.e. the times for the courses are pre-set, the project then needs to recruit the numbers to meet the scheduled times)
2. The majority of the project's courses are pre-scheduled with some courses not being pre-booked
3. The majority of the project's courses not pre-booked with some courses being pre-scheduled
4. All of the courses are not scheduled i.e. the courses are run when there is sufficient demand to run one.

Client: Education and training of clients

Level	Theme	1	2	3	4	DP classifications
2	**Determinants of client training**	Fundamental, Intrinsic, standardised	⟷		Based on client need (with a range of options)	
3	**Nature of training:** ▪ **Driver**	Project staff	⟷		Community	
	▪ **Type**	**Lorig**	⟷		Disease specific / other	
	▪ **Basis**	One-on-one	⟷		Group	

Level 2 - ***Determinants of client training***

1. Education and training of clients is a fundamental, intrinsic and standardised activity within that project which all clients receive
2. The majority of education and training of clients is fundamental, intrinsic and standardised to the project which all clients receive with some components being based on client need
3. The majority of Education and training provided is based upon client need with a range of training options available and education options available, with there being some fundamental/intrinsic/standardised components which all clients receive
4. Education and training of clients being based upon client need with a range of training and education options available.

Nature of training

- **Level 3 - Driver - who drives the education and training**
  1. The Project drives the content, timing and administration of the education and training of clients
  2. The Project drives the content, timing and administration of the education and training given to clients for the majority of the time, with some input from the Community being provided

3. The Community drives the content, timing and administration of the education and training given to clients for the majority of the time, with some input from the Project being provided
4. The Community drives the content, timing and administration of the education and training of clients

- **Level 3 - Type – type of education being offered to clients**
  1. The only sort of training and education being offered to clients is the standard Lorig course
  2. The majority of the training and education being offered to clients is the standard Lorig course with some disease specific / “other” non standard courses being made available
  3. The majority of the training and education being offered to clients is disease specific / “other” non standard courses with some standard Lorig training being made available
  4. The only sort of training and education being offered to clients is disease specific / “other” non standard courses

- **Level 3 - Basis – basis of the education and training of clients i.e. how clients are taught**
  1. All of the clients are taught/trained on a one-on-one basis
  2. The majority of clients are taught/trained on a one-on-one basis, with some courses being offered on a group basis
  3. The majority of courses being offered to clients are on a group basis, with some one-on-one courses being offered
  4. All of the education and training being offered to clients is taught on a group basis

Client: Support from SM Personnel

Level	Theme	1	2	3	4	DP classifcations
3	**Nature of support**	Formal	⟷		Informal	
3	**Initiated**	Project staff	⟷		Client	
3	**Support availability**	**Limited**	⟷		Unlimited	

Level 3 - *Nature of Support* - the structure and regularity(or otherwise) of the type of support being offered to clients

1. Formal – regular and structured support is offered to <u>all</u> clients, based on a set policy/framework. This is evidenced by a plan being in place for the type and timing of support activities being provided to clients, which has been documented and communicated to clients
2. Quite formal – while a framework is in place for support, it is not set, and may not always be followed.
3. Quite informal – a loose structure exists for the type and timing of support being offered to clients, may only be used for a minority of clients
4. Informal – no structure exists for the type or regularity of support being offered to clients, support occurs on an ad hoc basis

Level 3 – *Initiated* – who initiates support activities

1. All support is initiated by project staff
2. The majority of support is Project initiated, with some being initiated from client requests
3. The majority of support is client initiated, with some being initiated from the Project
4. All support is initiated from client requests

Level 3 - *Support availability*

1. Clear and defined limits are formally placed on the availability of support and these are communicated to all clients. Support cannot be initiated or sought outside of the set times
2. Clear limits are informally/formally placed on the availability of support. In the majority of cases support is never provided outside of the set times

3. Some limits are informally placed on the availability of support but in the majority of cases support can be initiated or sought outside of these times
4. Unlimited – Project staff/clients initiate contact at non prescribed times

Health Service Provider: Marketing

Level	Theme	1	2	3	4	DP classifications
1	**Purpose**	Recruitment of GPs – (recruitment of clients)	⟷		Increase awareness	
2	**Focus**	GPs	⟷		"Whole of Service/ Community"	
2	**Mechanism**	More strategic	⟷		Less strategic	
3	**Marketing approach:** ▪ **Strategy**	Dedicated/ external	⟷		Internal/ project -based	
	▪ **Implementation**	Dedicated/ external	⟷		Internal/ project -based	

Level 1 – *Purpose of marketing to HSPs*

1. Aim of marketing is for the recruitment of GPs only, with GPs being the only source of client referrals
2. Aim of marketing is for the recruitment of GPs, with GPs being the only source of client referrals **AND** to increase awareness amongst the wider HSP community about the benefits of SM
3. Aim of marketing is to increase awareness amongst the HSP community of the benefits of SM **AND** to encourage client referrals to the Project from the HSP community
4. Aim of marketing is *only* to increase awareness amongst the HSP community of the benefits of SM, no recruitment purpose

Level 2 – *Focus of marketing to HSPs*

1. Focus of the marketing effort was to a select group of individual GPs *only*
2. Focus of the marketing effort was to a select group of individual GPs **AND** to some extent to reach a broader range of other HSPs
3. Focus of the marketing effort was to reach a broad range of HSPs *only* (i.e. no targeting for recruitment)

4. Focus of the marketing was a Whole of Service/ Community approach *only* (i.e. no targeting for recruitment)

Level 2 – *Mechanism* – overarching approach to marketing the Project to HSPs

1. Strategic – a *fully* formed structured strategic approach to marketing implementation, which includes *all four* of the following indicators:
    - Existence of a marketing strategy which systematically considers the most effective/appropriate/efficient way to implement the strategy e.g. identifies a process for the identification and establishment of relationships with a comprehensive range of existing collectives or other bodies to promote the Program to a particular group
    - Evidence of a marketing roll-out/implementation which is consistent with the strategy
    - Evidence of the marketing strategy being monitored, reviewed and updated in the light of experience
    - Full documentation of the process
2. Quite strategic – structured approach to marketing implementation which is represented by the Project undertaking two or more (but not all) of the above indicators
3. Somewhat strategic – a less formal approach to marketing implementation which is represented by the Project undertaking one of the above indicators
4. Unstructured – an informal and unstructured approach to marketing implementation, as indicated by:
    - A non-systematic/unstructured marketing strategy
    - Informal methods of marketing in place and may vary from site to site
    - Methods of marketing depend on informal relationships between Project and HSPs

***Marketing approach* – specifically, how is marketing to HSPs undertaken**

- **Level 3 - Strategy**
    1. Dedicated marketing resource (outside of the project team) or use of external consultants to develop the marketing strategy
    2. Dedicated marketing resource (outside of the project team)or use of external consultants to develop the marketing strategy WITH some input from project staff
    3. Internal project-based marketing approach drawing upon the internal expertise of the group to develop the marketing strategy WITH some input from a dedicated marketing resource (outside of the project team) or use of external consultants
    4. Internal project-based marketing approach drawing upon the internal expertise of the group to develop the marketing strategy
- **Level 3 - Implementation – includes the design of marketing material and actual marketing activities**
    1. Dedicated marketing resource (outside of the project team) or use of external consultants to implement the marketing strategy
    2. Dedicated marketing resource (outside of the project team) or use of external consultants to implement the marketing strategy WITH some input from project staff

3. Internal project-based marketing approach drawing upon the internal expertise of the group to implement the marketing strategy WITH some input from a dedicated marketing resource (outside of the project team) or use of external consultants
4. Internal project-based marketing approach drawing upon the internal expertise of the group to implement the marketing strategy

Health Service Provider: Recruitment of GPs

Level	Theme	1	2	3	4	DP classifcations
2	**Approach**	Formal network building	⟷		Existing formal /informal networks	
3	**Recruitment protocol**	Formal - Contract	⟷		Informal - Verbal agreements	

Level 2 - ***Approach taken by Projects to develop relationships with GPs for recruitment processes***

1. To recruit GPs, the Project has undertaken a new formal network building process 'from scratch' i.e. potential GP partnerships were identified in objective and structured format
2. To recruit the Project has mainly undertaken a new formal network building process with SOME utilisation of existing formal and informal networks
3. To recruit the Project has mainly utilisation of existing formal and informal networks with SOME new formal network occurring
4. To recruit GPs, the Project has utilised existing formal and informal networks only

Level 3 - ***Recruitment protocol*** **-** In the recruitment of GPs – there is in all cases some form of agreement to participate in the project and in the recruitment of clients, with a **range** in the formality of recruitment protocols involving GPs.

1. Formal – Contract between Project and GP(s)
2. Quite formal - Memorandums of Understanding between Project and GP(s)
3. Quite informal - Letters of commitment exchanged between Project and GP(s)
4. Informal - Verbal agreements between Project and GP(s)

Health Service Provider: Education and training

Level	Theme	1	2	3	4	DP classifcations
1	**Aim**	Use techniques within their daily practice as active and integral members of a SHC project	↔		Raise awareness of Self management	
2	**Timing**	Pre – client recruitment	↔		Ongoing	
3	**Nature of training:** ▪ **Type**	Core	↔		Suite of education and training	
	▪ **Participation GP's**	Compulsory	↔		Voluntary	
	▪ **Participation other HSPs**	Compulsory	↔		Voluntary	
	▪ **Extent GP's**	Comprehensive	↔		Not comprehensive	
	▪ **Extent other HSPs**	Comprehensive	↔		Not comprehensive	

Level 1 – ***Aim of HSP education & training***

1. Use of the techniques associated with SM by a practitioner within their daily work practice as active and integral members of a SHC project.
2. Practitioners adopting to a greater degree the techniques of SM within their daily practices
3. Practitioners adopting to a lesser degree the techniques of SM within their daily practices
4. Raising awareness only, without expectation of adoption of practices.

Level 2 – *Timing of HSP education & training*

1. All training of HSPs occurred before the recruitment of any clients to the Project
2. The majority of the training of HSPs occurred before the recruitment of clients to the Project WITH some training occurring on an ongoing basis
3. The majority of the training of HSPs occurs on an ongoing basis (post recruitment of clients) WITH some occurring pre-client recruitment
4. All training of HSPs occurs on an ongoing basis with none provided before the recruitment of clients.

Nature of training and education offered to HSPs

- **Level 3 - Type**
  1. Only the core education and training is being offered to HSPs e.g. Lorig, Flinders, RACGP
  2. The core education and training is being offered to HSPs e.g. Lorig, Flinders, RACGP together with a limited range of Project developed training
  3. The core education and training is being offered to HSPs e.g. Lorig, Flinders, RACGP together with a greater range of Project developed and other training
  4. A complete suite of SM education (Project developed and/or other) and training in addition to the core training is provided to HSPs

- **Level 3 - Participation – recruited GPs**
  1. All the training and education offered to GPs is compulsory
  2. The majority of training and education on offer to GPs in compulsory, with some optional courses
  3. The majority of training and education on offer to GPs in voluntary, with some compulsory courses
  4. All the training and education offered to GPs is voluntary

- **Level 3 - Participation – other HSPs**
  1. All the training and education offered to HSPs is compulsory
  2. The majority of training and education on offer to HSPs in compulsory, with some optional courses
  3. The majority of training and education on offer to HSPs in voluntary, with some compulsory courses
  4. All the training and education offered to HSPs is voluntary

- **Level 3 - Extent – recruited GPs: comprehensiveness of the education and training being provided (indicated for instance by the length of the training and level of its detail).**
  1. Comprehensive - for example, Flinders 2 day workshop.
  2. More comprehensive - for example, Flinders 1 day workshop.
  3. Less comprehensive - for example, Flinders ½ day workshop.
  4. Not comprehensive – for example, Flinders 3 hour overview.

- **Level 3 - Extent – other HSPs: comprehensiveness of the education and training being provided (indicated for instance by the length of the training and level of its detail).**
  1. Comprehensive - for example, Flinders 2 day workshop.
  2. More comprehensive - for example, Flinders 1 day workshop.
  3. Less comprehensive - for example, Flinders ½ day workshop.
  4. Not comprehensive – for example, Flinders 3 hour overview.

Health Service Provider: Support from SM Personnel

Level	Theme	1	2	3	4	
2	**Type** ▪ **Lorig**	Formal	⟷		Informal	
	▪ **Other**	Formal	⟷		Informal	
2	**Initiated**	Project personnel	⟷		HSP	
2	**Infrastructure**	Formal needs analysis	⟷		Responsive to request	

Level 2 - *Type* – formality of the support from the Project to the HSPs

1. Formal – structured, planned, regular contact
2. Quite formal – some structure, but can be less planned and regular
3. Quite informal support – some regularity, but can also be impromptu
4. Informal support - usually occurs with less regularity on a more impromptu bases – stems more around demand (for instance)

Level 2 – *Initiated* – who initiates support from Project personnel to HSPs

1. Project personnel – all support is initiated by project staff
2. Combination - initiated by project staff in most cases, but sometimes initiated by HSPs
3. Combination - initiated by HSPs in most cases, but sometimes initiated by Project personnel
4. HSP - all requests for support are initiated by the HSPs

Level 2 - *Infrastructure support* – from Project for HSPs

1. Infrastructure support is the result of a formal needs assessment

2. Informal assessment of needs undertaken and support stems from this
3. Support driven by a combination of informal assessment of needs and ad hoc requests
4. Infrastructure Support is the result of individual request only.

Community: Definition of Community

Level	Theme	1	2	3	4	DP classifcations
NA	**Scope**	Current or potential clients/ consumers who could benefit from self management	⟷		Whole of the community	

Scope of Projects definition of community

1. Current/potential clients/consumers who could benefit from SM – ***client/individual*** driven
2. Current/potential clients and groups of clients who could benefit (i.e. collectives of potential clients) and client GPs – client and client GP driven
3. Primarily potential/current client/client GP definition, but definition acknowledges the broader community context
4. Project has a whole of the community approach

Community: Marketing Strategy

Level	Theme	1	2	3	4	DP classifcations
NA	**Project goals**	Community is an active focus of the Project	⟷		Community is a less active focus of the Project	
NA	**Client vs. community focus (Broad focus vs. client focus)**	Larger than Project, a broad public health focus	⟷		Client identification/ recruitment driven community marketing	

Project Goals **- the degree to which the Project is actively focusing on reaching the community.**

1. The concept of "reaching the community" is a central focus of the Project's strategy
2. "Reaching the community" is a prominent but not central focus of the Project's strategy
3. "Reaching the community" is a peripheral focus of the Project's strategy
4. "Reaching the community" is a background feature of the Project's goals only, and not a focus of its strategy

Broad focus vs Client focus in marketing

1. Broad public health focus – Project's strategy has a wider focus than clients or client groups (recruitment). Community engagement is a major focus
2. Combination – with emphasis on community engagement being prominent but not major driver
3. Combination – emphasis on community engagement is peripheral, with primary emphasis on client and client groups
4. Client focus – client and client groups are the major focus, community engagement has been a by-product of client recruitment needs

Community: Implementation Strategy

Level	Theme	1	2	3	4	DP classifications
NA	**Approach/ Methods:** ▪ **Nature**	Bring the community **into** the Project	⟷		Project seeks the community **out**	
	▪ **Structure**	**Strategic**	⟷		Progressive	

Approach/ Methods

Approach – nature of the relationship being developed with the Project's defined

1. "Bring the community <u>into</u> the Project" – the Project is actively trying to <u>integrate</u> the community into the project. Indicators for this include:
    - Evidence that the community has an active and key role in decision making
    - Evidence that other community consultation occurs and is ongoing
2. Project is actively trying to involve the community, meeting one of the above criteria – some engagement
3. Project is trying to raise community awareness about the Program – contact, but little engagement
4. "Project seeks the community out" – the Project only goes out and makes contact with the community for certain purposes e.g. client recruitment, where community engagement is a by-product of client recruitment – no community engagement as an end in itself

Approach – structure of the approach to reaching the community

1. Strategic – clearly identified definition of community, its role (be that a lesser or greater role), and how to achieve that role in the project
2. Quite strategic – Clear identification of community and its role, less clarity about how to achieve the role
3. Quite progressive – definition of community and its role attempted but not yet clarified
4. Progressive - the process of identification of community and its role is evolving across the life of the project.

Community: Indicators of Implementation

Level	Theme	1	2	3	4	
NA	**Participation**	Low level of involvement	⟷		High level of involvement	
NA	**Representation**	Client focused	⟷		Community focused	
NA	**Consultation**	Extensive	⟷		Less extensive	

Participation **-** the level of **integration** of the community into the Project

1. The community isn't involved in any decision making and there is no community consultation
2. The community plays a role in decision making **OR** there is some of community consultation (e.g. community focus groups)
3. The community plays a role in decision making **AND** there is some community consultation
4. The community has a key and active role in decision making and there is continual community consultation

Representation **–** the **nature** of the representation of the community

1. The nature of the community representation in the Project has been mainly client focused (e.g. consumer group representation on committees)
2. The nature of the community representation in the Project is mainly client focused, WITH some community input
3. The nature of the community representation in the Project is mainly community focused, WITH some client focus
4. The nature of the community representation in the Project is more community focused (e.g. community group representation on committees)

Consultation **–** the **extent** of the Projects consultation with the community.

1. The extent of the Projects consultation with the community has been very extensive. Indicators for this include:
   - Ongoing and regular consultation

- A range of community groups are consulted
- Many avenues of consultation are used [e.g. focus groups, awareness sessions, community mapping, education & training,]; and
- A wide focus of discussion

2. Project consultation with the community has been reasonably extensive, e.g.:
   - Consultation is on a repeated [but limited and not ongoing] basis
   - Quite a number of community groups are consulted
   - Quite a few avenues of consultation are used (say three); and
   - A rather wide focus of discussion
3. Project consultation with the community has been quite extensive e.g.:
   - Consultation is limited but occurs more than once
   - A rather more limited number of community groups are consulted
   - More than one (say two) avenue is used to consult the community; and
   - There is quite a narrow focus of discussion
4. Project consultation with the community has been less extensive, e.g.:
   - One off consultation occurs
   - A Limited number of community groups are consulted
   - A very limited number of avenues of consultation are used [e.g. one avenue]; and
   - There is a narrow focus of discussion

Appendix 3

Project Report Template

Project Report

Purpose of this document

The purpose of this document is to outline the topics and items of information – qualitative and quantitative, that the National Evaluator needs as a data source from project records and Local Evaluator reports for the National Evaluation. This document should be used as the guide for the collection and reporting of qualitative information (with every attempt made to answer the questions raised, since they link directly back to the Evaluation Questions and Hypotheses) and as a template for the quantitative information required. It is anticipated that at any given data collection point there will be no more than 5% missing data.

It is anticipated that the type of information described in the tables will be available through Project records and the Local Evaluator reports to the Projects. Indeed, it may be decided at Demonstration Site level that the Local Evaluator completes the attached.

The information obtained in the Project Report will be lifted out and put into the Minimum Data Set by the National Evaluator.

Layout of document

- *The document is laid out in accordance with the Process, Impact and Outcome evaluation of the National Evaluation Framework.*
- *The space shown against prompt for comment is in no way indicative of the quantity of information required by the National Evaluator. Projects should determine for themselves the space required for an adequate response.*
- *Room has also been provided to note the source of the observation or data enclosed to allow for verification if necessary.*

Project Report

PROCESS	PROCESS DESCRIPTORS (Qualitative)	Comment	PROCESS INDICATORS (Quantitative)	Comment	Source of Information
Client					
Marketing/reach	Description of marketing process to clients: ▪ How is the target[1] group identified? ▪ What steps are taken to attract the target group (e.g. pamphlet distribution, local TV and radio advertisements)? ▪ What changes to the process have occurred since the last Project Report to the National Evaluator and why? Include, problems encountered and improvements made. Record effect of change, if known.		No. of items of information distributed compared to planned		*e.g. Project Records*
			No. of potential clients contacting the Project following marketing campaign compared to expected		
			Proportion of total Project budget devoted to marketing/reach		
Recruitment of clients	Description of client recruitment process be it directly via the Project or via the GP: ▪ Which recruitment strategies are used in recruiting clients/groups of clients? e.g. telephone, face to face, mail ▪ Which appear to be the most successful and why? ▪ Which clients/groups of clients participate and why? ▪ What factors appear to influence participation rates and in which direction? ▪ What are the reason(s) for drop-outs ▪ What changes to the process have occurred since the last Project Report to the National Evaluator and why? Include, problems encountered and improvements made. Record effect of change, if known.		No. and % of people in the target population[1] participating[2] in the Project		
			No. of drop-outs from the Project out of total clients recruited		
			No. and type of Project contacts: ▪ Project to client; ▪ Client to Project		
			Proportion of total Project budget devoted to client recruitment		

[1] Definition of population: Total population – overall population of area covered by Project; Population with Chronic Conditions (PCC) – proportion of total population with specified chronic conditions; Target population – proportion of PCC, Project is aiming to recruit

[2] Participation in the Project is deemed to occur when the consent form is signed.

PROCESS	PROCESS DESCRIPTORS (Qualitative)	Comment	PROCESS INDICATORS (Quantitative)	Comment	Source of Information
Client					
SM orientation[3]	Description of the suite of interventions identified for SM orientation: ▪ What is the form and structure of SM planning? ▪ What are the reason(s) for drop-outs? ▪ What changes to the process have occurred since the last Project Report to the National Evaluator and why? Include, problems encountered and improvements made. Record effect of change, if known.		% of clients who commenced SM orientation and completed the process.		
			Proportion of total Project budget devoted to SM orientation		
Enrolment[4]	Description of client enrolment process to Project: ▪ Is enrolment process organised through the Project or GP/facilitator? ▪ How are enrolment rates influenced? ▪ What changes to the process have occurred since the last Project Report to the National Evaluator and why? Include, problems encountered and improvements made. Record effect of change, if known.		No. of clients enrolled in the SM course		
			Proportion of total Project budget devoted to client enrolment		
Education and training of clients	Description of education and training received by clients: ▪ How was the course developed ▪ What is the form and structure of the self-management education? ▪ What are the reason(s) for		% of clients enrolled who also completed the course		
			% courses scheduled that are completed		

[3] Relates specifically to Projects which are not undertaking formal SM education and training courses
[4] Enrolment relates specifically to enrolment onto a SM training course (e.g. Lorig-style).

PROCESS	PROCESS DESCRIPTORS (Qualitative)	Comment	PROCESS INDICATORS (Quantitative)	Comment	Source of Information
Client					
	drop-outs from the course? ▪ What are the reason(s) for the difference between scheduled and completed courses? ▪ What changes to the process have occurred since the last Project Report to the National Evaluator and why? Include, problems encountered and improvements made. Record effect of change, if known.		Proportion of total Project budget devoted to the provision of education and training for clients		
Education and training of SM Program personnel [*insert appropriate Project term*]	Description of education and training received by SM Program personnel: ▪ How was the course developed ▪ What is the form and structure of the self-management education? ▪ What are the reason(s) for drop-outs from the course? ▪ What are the reason(s) for the difference between scheduled and completed courses? ▪ What changes to the process have occurred since the last Project Report to the National Evaluator and why? Include, problems encountered and improvements made. Record effect of change, if known.		% of "lay leaders" who were originally clients		
			% of courses scheduled that are completed		
			% of staff enrolled who completed training		
			Proportion of total Project budget devoted to the provision of education and training for SM Program personnel		
Disease specific education and training	Description of disease specific education delivered as developed by the Projects to clients: ▪ What is the form and structure of the disease specific self-education?		Proportion of total Project budget devoted to the provision of disease specific education for clients		

PROCESS	PROCESS DESCRIPTORS (Qualitative)	Comment	PROCESS INDICATORS (Quantitative)	Comment	Source of Information
Client					
Care/SM planning	Description of care/SM plan development process: ▪ How are care/SM plans developed? ▪ Who is involved in care/SM planning? E.g. SM coach, Practice nurse, GP ▪ When are care/SM plans developed? ▪ What are the components of a care/SM plan? ▪ What changes to the process have occurred since the last Project Report to the National Evaluator and why? Include, problems encountered and improvements made. Record effect of change, if known.		% of clients in the SM Program who have care/SM plans. Of those clients with a care/SM plan, state who is the care/SM planner involved		
Support from SM Program personnel [*insert appropriate Project term*] to carer/family/SO	Description of support processes made available to the clients from the Project: ▪ What support processes are available to clients from the Project? Consider: – Type, intensity, frequency – Follow-up (visits, calls) ▪ How are support processes organised? ▪ How do clients access support? ▪ What changes to the process have occurred since the last Project Report to the National Evaluator and why? Include, problems encountered and improvements made. Record effect of change, if known.		No. of contacts by SM Program personnel post-orientation/training with client		
			No. of calls received to the Project from clients post-orientation/training		
			% of clients recruited involved in follow-up Project support groups and activities		
			Proportion of total Project budget devoted to the provision of client support services		

PROCESS	PROCESS DESCRIPTORS (Qualitative)	Comment	PROCESS INDICATORS (Quantitative)	Comment	Source of Information
Carer/family/Significant Other					
Marketing/reach	Description of marketing process to care/family/SO: ▪ How is the target[1] group identified? ▪ What steps are taken to attract the target group (e.g. pamphlet distribution, local TV and radio advertisements)? ▪ What changes to the process have occurred since the last Project Report to the National Evaluator and why? Include, problems encountered and improvements made. Record effect of change, if known.		No. of potential carer/family/SO contacting the Project following marketing campaign compared to expected	*e.g. Project Records*	
			Proportion of total Project budget devoted to marketing carer/family/ SO		
Recruitment of carer/family/SO	Description of client recruitment process be it directly via the Project or via the GP: ▪ Which recruitment strategies are used in recruiting care/family/SO? e.g. telephone, face to face, mail ▪ Which appear to be the most successful and why? ▪ Which care/family/SO participate and why? ▪ What factors appear to influence participation rates and in which direction? ▪ What are the reason(s) for drop-outs ▪ What changes to the process have occurred since the last Project Report to the National Evaluator and why? Include, problems encountered and improvements made. Record effect of change, if known.		Proportion of client/family /SO recruited to total clients recruited		
			No. and % of carer/family/SO recruited compared to expected		
			Proportion of total Project budget devoted to recruiting carer/family/ SO		
SM orientation[5]	Description of the suite of interventions identified for SM orientation: ▪ What is the form and structure of SM planning? ▪ What are the reason(s) for drop-outs? ▪ What changes to the process have		No. of carer/family/ SO enrolled in the SM course.		

[5] Relates specifically to Projects which are not undertaking formal SM education and training courses

PROCESS	PROCESS DESCRIPTORS (Qualitative)	Comment	PROCESS INDICATORS (Quantitative)	Comment	Source of Information
Carer/family/Significant Other					
	occurred since the last Project Report to the National Evaluator and why? Include, problems encountered and improvements made. Record effect of change, if known.		Proportion of total Project budget devoted to SM orientation		
Education and training of carer/family/SO	Description of education and training received by carer/family/SO: ▪ How was the course developed ▪ What is the form and structure of the self-management education? ▪ What are the reason(s) for drop-outs from the course? ▪ What are the reason(s) for the difference between scheduled and completed courses? ▪ What changes to the process have occurred since the last Project Report to the National Evaluator and why? Include, problems encountered and improvements made. Record effect of change, if known.		% of carer/family/SO enrolled who also completed the course.		
			Proportion of total Project budget devoted to the provision of education and training for carer/family/ SO		
Support from SM Program personnel [*insert appropriate Project term*] to carer/family/SO	Description of support processes made available to care/family/SO from the Project: ▪ What support processes are available to carer/family/SO from the Project? Consider: – Type, intensity, frequency – Follow-up (visits, calls) ▪ How are support processes organised? ▪ How do carer/family/SO access support? ▪ What changes to the process have occurred since the last Project Report to the National Evaluator and why? Include, problems encountered and improvements made. Record effect of change, if known.		No. of contacts (e.g. follow-up calls) by SM Program personnel with care/family/SO		
			No. of calls received to the Project from carer/family/SO post-orientation/ training		
			% of carer family/SO recruited involved in follow-up Project support groups and activities		
			Proportion of total Project budget devoted to the provision of carer/family/SO support services		

PROCESS	PROCESS DESCRIPTORS (Qualitative)	Comment	PROCESS INDICATORS (Quantitative)	Comment	Source of Information
Community					
Reach	Description of the reach process ▪ Which groups of clients in the community participate? ▪ Which recruitment strategies are used in recruiting at the community level? ▪ How are participation rates influenced? ▪ What changes to the process have occurred since the last Project Report to the National Evaluator and why? Include, problems encountered and improvements made. Record effect of change, if known.		No. of meetings with Community groups/leaders, as proportion of those planned.		*e.g. Project Records*
			No. of items of information distributed into Community settings (e.g. pamphlets) compared to planned		
			Proportion of total Project budget devoted to Community reach activities		
Health promotion	Description of development and implementation of the Health Promotion model: ▪ How is Health Promotion model developed? ▪ How is the SM Program involved? ▪ What changes to the process have occurred since the last Project Report to the National Evaluator and why? Include, problems encountered and improvements made. Record effect of change, if known.		No. of community-based health strategies developed with the Community		
			Proportion of total Project budget devoted to Community health promotion		
Health planning	Description of Community health plan development process: ▪ How is the community health plan developed? ▪ Who is involved in community health planning? ▪ When is the community health plan developed? ▪ What are the components of a community health plan? ▪ What changes to the process have occurred since the last Project Report to the National Evaluator and why? Include, problems encountered and improvements made. Record effect of change, if known.		No. of individual clinical audits that assess whether the objectives of the Community health plan have been met		
			Proportion of total Project budget devoted to Community health planning		

PROCESS	PROCESS DESCRIPTORS (Qualitative)	Comment	PROCESS INDICATORS (Quantitative)	Comment	Source of Information
Community					
Community support processes	Description of support services available to the Community from the Project: ▪ What support processes are available to the community from the Project? Consider: – Type, intensity, frequency – Follow-up (visits, calls) ▪ How are support processes organised? ▪ How does the community access support? ▪ What changes to the process have occurred since the last Project Report to the National Evaluator and why? Include, problems encountered and improvements made. Record effect of change, if known.		Proportion of total Project budget devoted to Community support services		
Organisational development	Description of the organisational processes to support and the development of capacity building of the Community: ▪ What organisational processes are in place at baseline? ▪ What organisational processes have been developed to support the project since the last Project Report to the National Evaluator and why? Include, problems encountered and improvements made. Record effect of change, if known.				
Workforce development	Description of the workforce strategies to support and the development of capacity building of the Community: ▪ What workforce strategies are in place at baseline? ▪ What workforce strategies have been developed to support the project since the last Project Report to the National Evaluator and why? Include, problems encountered and improvements made. Record effect of change, if known.				

PROCESS	PROCESS DESCRIPTORS (Qualitative)	Comment	PROCESS INDICATORS (Quantitative)	Comment	Source of Information
Community					
Resource allocation	Description of the resource allocation to support and the development of capacity building of the Community: ▪ What resource allocation processes are in place at baseline? ▪ What resource allocation processes have been developed to support the project since the last Project Report to the National Evaluator and why? Include, problems encountered and improvements made. Record effect of change, if known.		No. of Project staff employed to support the capacity building of the Community		
			Proportion of total Project budget devoted to support the capacity building of the Community		

PROCESS	PROCESS DESCRIPTORS (Qualitative)	Comment	PROCESS INDICATORS (Quantitative)	Comment	Source of Information
Health Service Providers					
Marketing/reach	Description of marketing/reach process for HSPs. ▪ What role does the HSP have in the Project? E.g. does the HSP refer/recruit clients to SM Project or do they play a more active role as service coordinator/care planner role? ▪ How are potential HSPs identified? ▪ What steps are taken to attract HSPs e.g. pamphlet distribution, local TV and radio advertisements? ▪ What changes to the process have occurred since the last Project Report to the National Evaluator and why? Include, problems encountered and improvements made. Record effect of change, if known.		No. of information kits on SM Program sent to HSPs compared to expected.		*e.g. Project Records*
			No. of HSPs contacts to the Project following marketing campaign compared to planned		
			Proportion of total Project budget devoted to marketing/reach of HSPs		
Recruitment of HSPs	Description HSP recruitment process: ▪ Which health professionals participate and why? ▪ Which recruitment strategies are used in recruiting HSPs? e.g. telephone, face to face, mail ▪ How are participation rates influenced? ▪ What changes to the process have occurred since the last Project Report to the National Evaluator and why? Include, problems encountered and improvements made. Record effect of change, if known.		No. of HSPs recruited into the Project compared to planned		
			Proportion of total Project budget devoted to the recruitment of HSPs		
Education and training of HSPs	Description of education and training received by GP's, Allied health professionals and other HSPs: ▪ How is the course developed? ▪ What is the form and structure of the course? ▪ What are the reason(s) for drop-outs ▪ What are the reason(s) for the difference between scheduled and completed courses? ▪ What changes to the process have occurred since the last Project Report to the National Evaluator and why? Include, problems encountered and improvements made. Record effect of change, if known.		% of recruited HSPs who also completed training.		
			% courses scheduled that are completed		
			Proportion of total Project budget devoted to educating/training HSPs		

PROCESS	PROCESS DESCRIPTORS (Qualitative)	Comment	PROCESS INDICATORS (Quantitative)	Comment	Source of Information
Health Service Providers					
Support of HSPs	Description of support processes available to HSPs (e.g. Telephone support post education) from the Project: ▪ What support processes are available to HSPs post training from the Project? Consider, type, intensity and frequency ▪ How are these processes organised? ▪ How do HSPs access support? ▪ What changes to the process have occurred since the last Project Report to the National Evaluator and why? Include, problems encountered and improvements made. Record effect of change, if known.		No. of contacts by SM Program personnel with HSPs		
			No. of calls received to the Project to HSPs		

PROCESS	PROCESS DESCRIPTORS (Qualitative)	Comment	PROCESS INDICATORS (Quantitative)	Comment	Source of Information
Health Service System					
Infrastructure development	Description of (including development of) services to support Project: ▪ What services are in place at baseline? ▪ What services have been developed to support the project since the last Project Report to the National Evaluator and why? Include, problems encountered and improvements made. Record effect of change, if known.		No. of staff and services established		*e.g. Project Records*
	Description of infrastructure (including development of) to support Project: ▪ What infrastructure is in place at baseline? ▪ What infrastructure and services have been developed to support the project since the last Project Report to the National Evaluator and why? Include, problems encountered and improvements made. Record effect of change, if known.		N/A		
	Description of IT support (and development of) of Project including participant HSPs: ▪ What IT infrastructure and support services are in place at baseline? ▪ What IT infrastructure and support services have been developed to support the Project since the last Project Report to the National Evaluator and why? Include, problems encountered and improvements made. Record effect of change, if known.		N/A		

PROCESS	PROCESS DESCRIPTORS (Qualitative)	Comment	PROCESS INDICATORS (Quantitative)	Comment	Source of Information
Health Service System					
Governance and management framework	Description of governance and management (and development of) procedures and structures to support Project: ▪ governance and management processes are in place at baseline? ▪ What governance and management processes have been developed since the last Project Report to the National Evaluator and why? Include, problems encountered and improvements made. Record effect of change, if known. ▪ How is the project organised?		N/A		
Integration	Description of the integration processes (e.g. communication strategy, policy development) between Project and key stakeholders (e.g. Area Health Service, Division of GPs, Community groups, other peak bodies): ▪ What communication processes are in place between the Project and key stakeholders? ▪ What is the structure and membership of multi-disciplinary teams involved in the Project? ▪ What changes to the process have occurred since the last Project Report to the National Evaluator and why? Include, problems encountered and improvements made. Record effect of change, if known.		No. of multi-disciplinary teams involved in the Project.		

IMPACT	IMPACT DESCRIPTORS (Qualitative)	Comment	IMPACT INDICATORS (Quantitative)	Comment	Source of Information
Community					
Capacity building ▪ Infrastructure ▪ Sustainability ▪ Problem solving strategies	Comment, based on your observations of the Project, on the: ▪ Quality of organisational structures in place ▪ Availability and quality of resources ▪ No. of networks and partnerships with other agencies ▪ Quality of the problem solving mechanisms in place	*These questions should be considered at the same time as responding to the Process elements re: Sustainability*			*e.g. Project Records*
Health Service Provider					
Perceptions/experiences/ satisfaction with SM Program	What are the reasons for HSPs dropping out of the SM Program? *(refer to Process evaluation)*		% HSP dropping-out from SM program *(refer to Process evaluation)* No. of referrals to SM Program from HSPs		
Health Service System					
Sustainability	Comment, based on your observations of the Project, on the: ▪ Quality of Organisational structure ▪ Quality of Governance procedures/structure ▪ Degree of success in integrating SM program: - internally within the "organisation's core business"; and - externally with other bodies e.g. an Area Health Service or a professional body ▪ The availability of recurrent funding for the Program (e.g. on IT and other equipment, staff training, recruitment) ▪ The success with the Project has attracted and retained staff ▪ The amount of forward planning which has occurred	*These questions should be considered at the same time as responding to the Process elements re: Sustainability*	N/A		

OUTCOME	OUTCOME DESCRIPTORS (Qualitative)	Comment	OUTCOME INDICATORS (Quantitative)	Comment	Source of Information
Client					
Mortality	N/A	N/A	Mortality rate among participants		*e.g. Project Records*

Appendix 4

Data Collection and Management Guide

Department of Public Health & Community Medicine,
University of Sydney at Westmead

Sharing Health Care Initiative

National Evaluation Framework

Data Collection and Management Guide

Preface

The document presented is the **Data Collection and Management Guide**, as referred to in the Proforma Memorandum of Understanding, dated 22 May 2002, and represents a formal element of the National Evaluation Framework.

The aim of the Guide is to provide practical and generic data collection and management assistance to the Demonstration Projects and Local Evaluators.

The Guide has been developed through extensive consultation with the Demonstration Projects, Local Evaluators and the Commonwealth Department of Health Ageing and we would like to take this opportunity to thank them for their invaluable contribution towards the development of this document.

Table of Contents

1 Introduction

The aim of the Data Collection and Management Guide (the 'Guide') is to provide assistance to the Sharing Health Care Demonstration Projects and Local Evaluators (known collectively as the 'Projects') with the data collection and management requirements of the National Evaluation.

A key input to the success of the National Evaluation will be the quality of the data received from the Projects. Therefore, Projects must ensure that the data submitted to the National Evaluator is complete, accurate and timely.

Whilst the knowledge and experience in this area of the participating Projects is acknowledged, it is necessary for the National Evaluator to have such a Guide in place to ensure that there is a consistent approach across the Projects with respect to data collection and management.

The Guide is not Project specific but has been designed to complement the individual Project's Memoranda of Understanding (MOU), which will state the basis upon which their data will be collected and managed.

The Guide has been prepared on the basis that all Projects will be entering data locally and has been designed to accompany the National Evaluation data dictionary and data management databases. These 'tools' will assist Projects with the local data entry requirements of the National Evaluation Framework. For example, the data management databases will have pre-formatted cells to help prevent illegal entries.

This Guide covers all aspects of the data collection and management requirements of the National Evaluation:

- Questionnaires: Client Information, Client Health and Client Service Use (Chapter 2)
- Project Report (Chapter 3)
- Focus Groups: Transcripts and Report (Chapter 4)

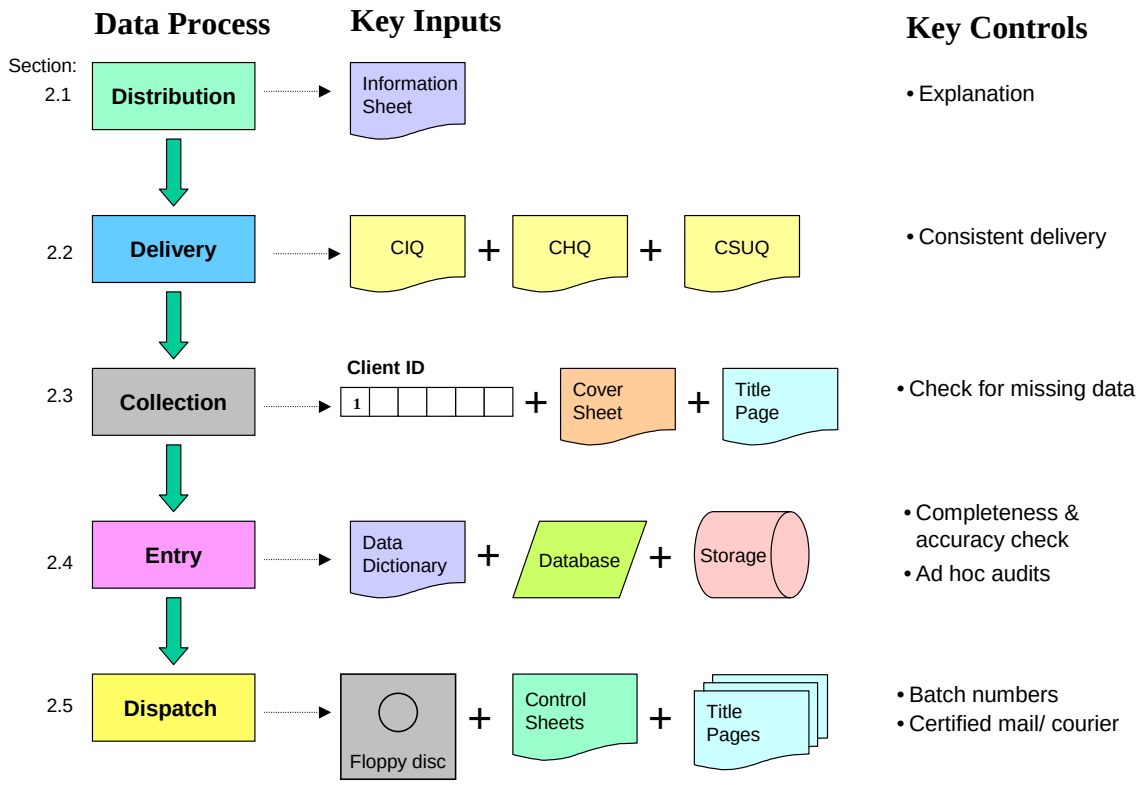
However, the primary focus of this Guide is the data collection and management requirements surrounding the questionnaires, since being at individual client level makes it a complex area with a greater risk of error. Such errors are also more difficult to retrieve.

The Guide is organised so that under each heading there is a series of dots points explaining the National Evaluator's requirements.

2 Questionnaires

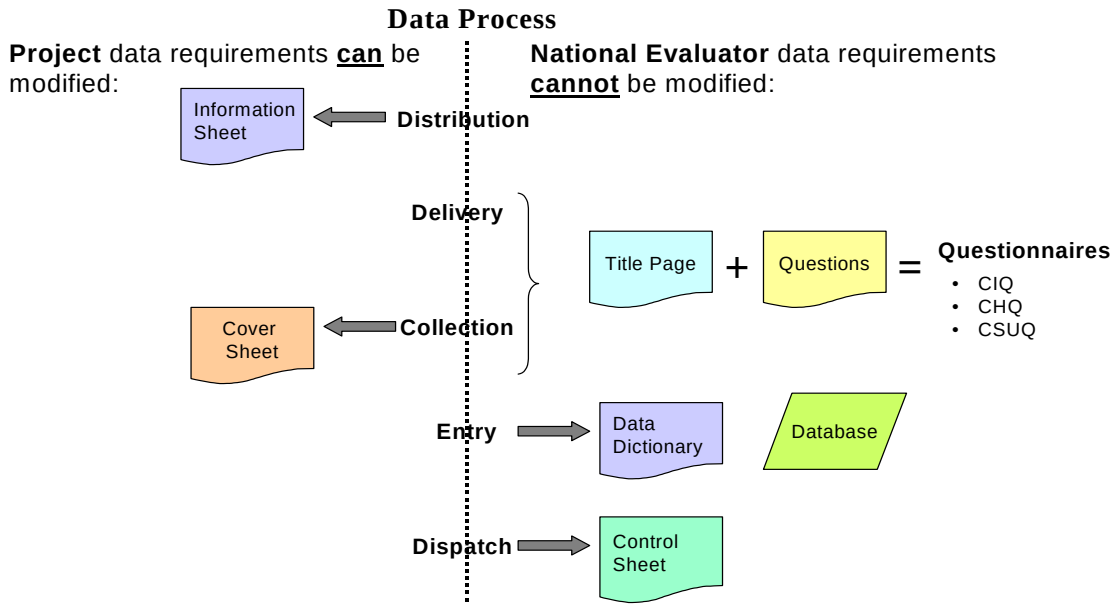
- There are three questionnaires that need to be completed by clients:
  - The Client Information Questionnaire (CIQ);
  - The Client Health Questionnaire (CHQ); and
  - The Client Service Use Questionnaire (CSUQ) – being Questions 64 to 72 of the CHQ
- The following diagram highlights the key themes of this Chapter (Sections 2.0 to 2.6) and how it is structured.

Figure 1: Client Data Collection and Management Methodology Overview for Questionnaires



- As can be seen by the above diagram the following Sections refer to various data management tools (for example, the client Information Sheet and client questionnaires), some of which can be modified to meet the Projects' specific needs and others which cannot.
- The following diagram below illustrates how these data management tools are organised i.e. where in the data collection and management process they come and whether or not they can be modified by Projects.

Figure 2: Client Data Collection and Management Tools



2.1 Distribution

- Prior to the administration of the questionnaires (CIQ and CHQ) at **Baseline**, it will be necessary to explain to clients the purpose of the questionnaires and their role in the National Evaluation.
- To assist in this process, a *sample* **Information Sheet** has been provided by the National Evaluator in Appendix P of the MOU. This Sheet gives background information regarding the Sharing Health Care Initiative (SHCI), the Local and National Evaluators, the adopted approach towards the evaluation and information regarding the confidentiality surrounding a client's participation in the evaluation of the SHCI. The final page of the Information Sheet is a *sample* consent form, which needs to be *signed* and *dated* by *all* clients.
- Many Projects have designed their own consent forms and processes to meet their Project's local needs. All that the National Evaluator requires is that the Information Sheet includes the above information and that the following procedure is followed:
  - administration of the Information Sheet and the collection of the consent form must occur prior to the administration of the Baseline CIQ and CHQ; and
  - clients should keep the information content of the consent process whilst the Projects should keep the consent form itself.

2.2 Delivery

- The mode of delivery (face to face, telephone or postal) and conditions of collection must be **consistent**[1] throughout the Project. The method of delivery will be recorded in Appendix H of the MOU.
- If the questionnaires are administered face-to-face or by telephone:
  - adequate explanation regarding the purpose of the questionnaires must be provided prior to their completion;
  - assistance with the process in general or with particular items in the questionnaires must be given to clients throughout the administration of the questionnaires.
- For postal surveys, to ensure that a high response rate and good quality data are returned, careful provision (before, during and after questionnaire delivery) will need to be made for:
  - adequate explanation to clients as to the process;
  - answering client queries; and
  - how the clients complete and return the questionnaires.
- It is the expectation of the National Evaluator that delivery of the questionnaires at Baseline will occur prior to any client intervention. If rare exceptions do occur, then this must be recorded by the Project and communicated to the National Evaluator when the data is dispatched to the National Evaluator.

2.3 Collection

2.3.1 Client Identification Number

- Each client will be allocated an unique identification (ID) number by the Projects.
- Whilst a Project may have their own basis for allocating IDs, the following requirements apply for National Evaluation purposes:
  - a client's ID must have **six** digits and can include both alpha and numeric characters; and
  - the first digit must represent the State or Territory from which the Project comes. This prefix digit has been allocated to each Project as follows:

Prefix	State or Territory
1	ACT
2	NSW
3	NT
4	QLD
5	SA
6	TAS
7	VIC
8	WA
9	Pika Wiya

[1] An exception is only allowable for the CSUQ at 12 months: e.g. questionnaires can be mailed out where for other measurement occasions the questionnaires were delivered face-to-face. Again this needs to be specified in the MOU.

- A six digit number was chosen assuming that no project would recruit in excess of 9,999 clients.
- Pika Wiya, which is an Indigenous project within the South Australia Demonstration Project, has also been allocated a separate prefix for analysis purposes.
- If required, the National Evaluator can supply a list of possible client identifiers.
- The client ID must to be written on each of the pages of all the questionnaires by Project staff. To assist in this, the final versions of the questionnaires for each State or Territory will have the relevant prefix included on the questionnaire itself.
- Where client ID is not placed on each of the pages, the project will take full responsibility for the loss or miss allocation of any pages, re-contacting clients where necessary, to capture lost data.

2.3.2 Completing the Questionnaire

2.3.2.1 Cover Sheet

- It is expected that on the front of each questionnaire there will be a **Cover Sheet** which will be designed by the individual Projects to meet their own requirements (as for the Information Sheet).
- The purpose of the Cover Sheet is to inform clients about:
  - why the information is being collected
  - client confidentiality procedures
  - Project contact information.
- Another purpose of the Cover Sheet is to give Projects a way of recording all the clients who have completed the questionnaires. As such the Cover Sheet should also include the following information:
  - client name
  - client gender
  - client date of birth
  - client ID
- At the completion of each questionnaire, the Cover Sheet should be removed from the questionnaire and given to the client, with the client information removed. It is noted that this procedure may need to be adapted to meet the needs of postal surveys.
- Ultimately, it is the Projects' responsibility to be the custodian of complete, accurate and secure client information. Therefore, as long as appropriate procedures are in place to ensure this, the detail of the control procedures will be Project specific and recorded in the MOU.
- An example of a customisable Cover Sheet is given in Appendix A of this Guide.

2.3.2.2 Title Page

- The **Title Page** is the *first page* of each questionnaire and must be completed by the Project at the commencement or completion of the interview for face-to-face/telephone delivery or immediately on its return if administered through mail-out delivery.

- The Title Page of each questionnaire contains the following information:
  - questionnaire title
  - identification number
  - gender[2]
  - date of birth[2]
  - date of recruitment
  - date of questionnaire completion[3]
  - administration point (e.g. Baseline, 6 months, 12 months and 18 months or end of Project)
  - client residential postcode
  - region[4]
- With face-to-face/telephone delivery, prior to closing the interview, the questionnaire should be reviewed to ensure it has been completed correctly. For example, no missing data or multiple responses to one question. A checklist may assist this process.
- If the questionnaire has been mailed out, responses must be reviewed for completeness within 3 working days of receipt. If a client has not fully answered the questionnaire, reasonable efforts should be made to contact the client immediately, to complete the questionnaire. If the attempt(s) are unsuccessful, then the incomplete data will need to be recorded as 'missing.'
- At the conclusion of each questionnaire administration, the Title Page should be photocopied and retained by the Project until the dispatch of data (together with the Title Pages) to the National Evaluator.
- For client confidentiality purposes, the National Evaluator does not require the client's personal details (i.e. name and address).
- Project Records will need to be updated accordingly to reflect the completion of the questionnaire by the client.

2.4 Entry

- The method of data entry and the controls in place for specific Projects will be recorded in Appendix H of the MOU.
- The controls in place must be designed to ensure completeness and accuracy of data input. Examples of such controls include:
  - double entry of data
  - the employment of an experienced data entry professional or equivalent
- Projects must also ensure that they have adequate back-up arrangements in place. For each floppy disc containing data that is sent to the National Evaluator, Projects will need to:

---

[2] For the CIQ only, the 'Date of Birth' and 'Gender' data requirements form part of the questionnaire itself.
[3] For postal delivery – the 'date of questionnaire completion' will be the date the questionnaire is received back at the Project.
[4] Projects must define the number of regions covered by their Project, and allocate identifiers to them..

- retain two copies of the floppy disc;
- store the files on the Project's IT system
- keep the originating data i.e. the questionnaires.

- To reassure the Projects, DoHA and the National Evaluator as to the quality of data input, ad hoc audits of Project data will be undertaken by the National Evaluator.

2.4.1 Data Dictionary

- A data dictionary has been prepared to assist the Projects in:
  - coding data;
  - entering data; and
  - interpreting data.
- The data dictionary is a reference manual which supports the data management databases.

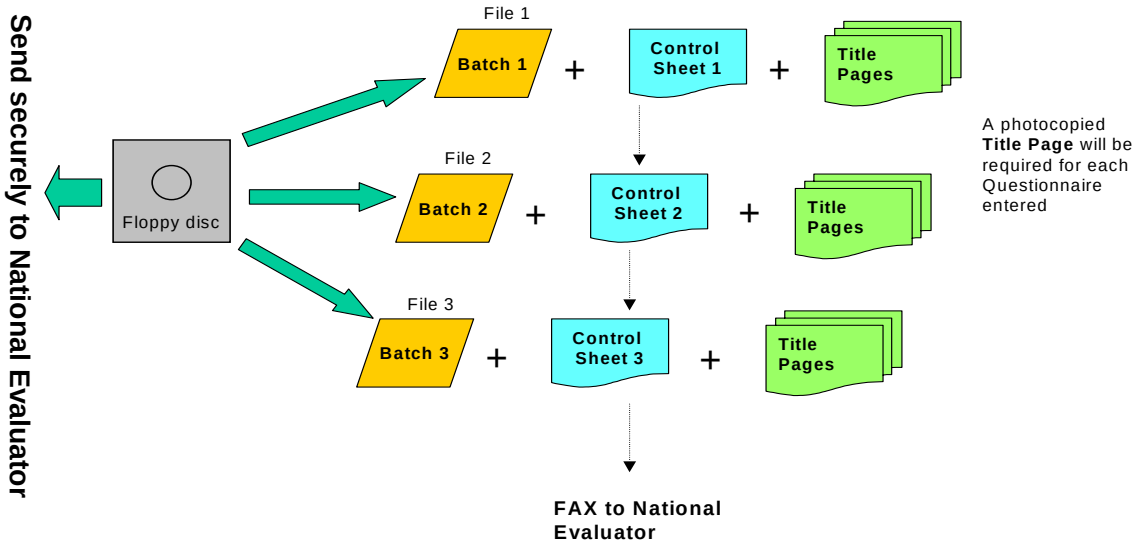
2.4.2 Data Management Database Proforma

- The National Evaluator is currently preparing the data management databases to assist Projects with their data input.
- The key features of the databases include:
  - Access 2000 format
  - Nine different databases to reflect the number of Projects (including Pika Wiya)
  - Pre-formatted cells that reject illegal values
- The National Evaluator will accept data in the other formats (e.g. Excel, SSPS) as long as the data received are correctly labelled and the data variables match. The National Evaluator will then translate the data into an Access format for analysis.
- The National Evaluator will expect data to be entered in this format and will require only this data. It will be the responsibility of the Projects to 'clean'/filter their data to meet this format prior to dispatch to the National Evaluator.

2.5 Dispatch

- The timing of data transfer to the National Evaluator will be documented in the individual Project's MOUs, however, it is expected that Projects will send their data on an approximate three monthly basis.
- When a Project is ready to dispatch data to the National Evaluator, the following steps should be taken:
  - fax the data Control Sheet(s) which list(s) the data being sent to the National Evaluator
  - send the floppy disc(s) containing the data via certified mail or secure courier to the National Evaluator with the relevant data Control Sheets and Title Pages attached
- The following diagram summarises the dispatch process, after which the data Control Sheet and Batch Numbering processes are considered in more detail.

Figure 2: Client Data Dispatch



2.5.1 Control Sheet and Batch Numbering

- A data **Control Sheet** must be completed together with assigning it with a **Batch Number** as entered by the Project in the relevant database prior to the dispatch of client data to the National Evaluator.
- An amended "Appendix J" of the MOU shows the expected format of the data control sheet, in Appendix B of this Guide.
- The data dictionary explains how the batch number will be determined and entered, but the batch number will vary depending upon:
  - the type of data being collected (e.g. CIQ, CHQ or CSUQ)
  - the number of times this sort of batch has been sent
  - the administration point of the data being sent
- Batches cannot comprise of mixed questionnaires or of differing administration points, but it is possible for one floppy disc to include a number of batches with the appropriate controls sheets attached.
- For the National Evaluator to undertake its own consistency, accuracy and completeness checks, Projects must attach photocopies of the Title Pages for each Control Sheet sent.
- It is the Projects' responsibility to ensure that the information sent is complete and accurate and to adhere to the above controls. This will be evidenced by the signature of a nominated responsible officer on the data control sheet.

2.6 Data Management

- For completeness purposes:
  - Projects should retain copies of the original questionnaires.
  - Project are required to keep a record of all clients completing the questionnaires. The Project must ensure that this information is secure at all times.

3 Project Report

- The Project Report provides key information for the Process evaluation (and to a lesser extent the Impact and Outcome evaluations) component of the National Evaluation Framework.
- The Project Report has been incorporated into the six monthly reporting process to the Department of Health and Ageing (DoHA) as an appendix to the main report. When Projects send the full report to DoHA, it will also be necessary for the Projects to send the appendix to the National Evaluator.
- The format, including instructions for completion, for the Project Report is shown in Appendix M of the MOU.
- Key considerations when completing the Project Report:
  - all the prompts must be covered to ensure standardisation with other Projects.
  - where an item is not at all applicable, Projects will still need to include the item in the report, but state that it is 'not applicable.' Non applicable items will have been agreed with the National Evaluator and specified as in the MOU.
  - there will also be instances where there has been no change or movement in a process or indicator since the previous reporting period. In such cases, 'no change' should be written against the appropriate headings in the Project Report, and where it is considered necessary by the Projects give any relevant commentary against this comment.
- The National Evaluator will require an electronic (email) and paper version of the Project Report. The paper documentation should be sent by certified mail.

4 Focus Groups

- Focus groups are required for the Impact Evaluation (and to a lesser extent the Outcome Evaluation) of the client, care/family/ significant other, community and health service provider domains of the National Evaluation.
- Two sorts of data are required from the focus groups for the National Evaluation:
  - Transcripts
  - Focus Group Report
- During the focus group process, adequate care must be taken during the recruitment of people to ensure:
  - they represent a fair cross-section of the Program's participants, whilst still having had a certain level of involvement in the SM Program to enable them to speak knowledgeably about it; and
  - all of the participants have been involved in the Program for approximately the same length of time dating from the Program's commencement.
- It is also expected that an experienced focus group facilitator is employed by the Project to ensure that focus groups are run effectively.
- The nominated facilitator will be agreed with the National Evaluator and recorded in the MOU.

- All focus group participants must complete a **Record Sheet** (Appendix N of the MOU), which will be returned with the Focus Group Report and transcripts.
- The National Evaluator will require an electronic (email) and paper version of the Focus Group Report and of the transcript. The paper documentation should be sent by certified mail.
- Copies of the transcripts and Focus Group Reports sent to the National Evaluator must be kept by the Projects.

4.1.1 Transcript

- To obtain raw data from the focus groups, Projects will need to produce a transcript of the discussions held. The transcript will be returned along with the Focus Group Report (see next Section) to the National Evaluator in accordance with the timeframe outlined in the MOU.
- The National Evaluator would recommend the use of a stenographer (or equivalent) to record the proceedings of the focus group.
- The method of transcription will be agreed with individual Projects and recorded in the MOU.
- The transcripts are required to support the outcomes of the Focus Group Report.

4.1.2 Focus Group Report

- One Focus Group Report will be required from each Project at each measurement interval (as set out in the MOU) for each domain (client, carer/family/significant other).
- The format, including instructions for completion, for the Focus Group Report is shown in Appendix O of the MOU.
- The Focus Group Report will be written-up by the facilitator based on their interpretation of the key themes arising from the discussions in the focus groups held. As such, the facilitator will need to bring together their impressions of the focus groups' outcomes and the transcripts to synthesise the major points for the reporting purposes.

5 Contact Details

When any of the above data is ready to be sent to the National Evaluator, please send it to the relevant Project contact at PricewaterhouseCoopers:

Project:	**ACT, NSW, TAS and VIC**	**NT, QLD, SA and WA**
Contact:	Ray Quigley	Caitlin Francis
Telephone:	(02) 8266 5642	(02) 8266 1648
Email:	ray.quigley@au.pwcglobal.com	caitlin.f.francis@au.pwcglobal.com
Fax:	(02) 8286 5642	(02) 8286 1648
Address:	PricewaterhouseCoopers, 201 Sussex Street, Sydney, NSW, 1171	

Appendix 5

Client Focus Group Report

Client Focus Group Report

Purpose of this document

The purpose of this document is to outline the topics of information, that the National Evaluator requires as a data source from the outcomes of the Client Focus Groups. This document should be used as the guide for the reporting of information collected from the Client Focus Groups. The guide is a reflection of all the prompts that were asked of the Client Focus Group attendees.

The information obtained in the Client Focus Group Report will be lifted out and placed into the Minimum Data Set by the National Evaluator.

General comments:

- **A minimum of two client focus groups are undertaken at three points in time over the course of the National Evaluation of the Sharing Health Care Initiative.**
- **The attached report is a culmination of the minimum of two client focus groups undertaken at one of these three points in time.**
- **The space given against each prompt is in no way indicative of the quantity of information required by the National Evaluator. Projects should determine for themselves the space required for adequate responses.**

Items to accompany the Client Focus Group Report are:

- **This cover sheet;**
- **A transcript of each of the Client focus groups; and**
- **The Client Record sheets.**

PLEASE PROVIDE THE FOLLOWING:

1) The name of the demonstration project:

_____

2) This Client Focus Group Report is for:
Please tick ONE box.

Beginning [ ]

Middle [ ]

End [ ]

3) The total number of INVITEES for the Client Focus Groups was _____ [*insert appropriate number].*

4) The total number of ATTENDEES for the Client Focus Groups was _____ *[insert appropriate number].*

5) Today's date: _____/_____/_____

6) Please describe how Clients were recruited to attend these focus groups:

_____

_____

Client Focus Group

Impact assessed	Dimensions	Prompts	Comment
Overall satisfaction with SM Program	• Overall satisfaction with the SM Program and its impact on life	Overall, how satisfied are you with the SM Program? What has been the impact (if any) of the SM Program on your life?	
Perceptions and experiences with SM orientation/education and training including relationship of SM Program personnel (including follow-up)	• SM Program recruitment and orientation/education and training process (including follow-up)	How well do you think you were informed about the Sharing Health Care initiative when you first joined? Overall, how satisfied have you been with the training/orientation you have received? Consider: • The time between joining the program and undertaking your training? • Was the venue a good one? • Was the information understandable, relevant and useful? • Was the leader organised, friendly and helpful? Overall, how satisfied have you been with the post-orientation/training follow-up?	

Impact assessed	Dimensions	Prompts	Comment
Perceptions and experiences with SM orientation/education and training including relationship of SM Program personnel (including follow-up) **(Continued …)**	• Impact of the SM orientation/education and training on lifestyle and condition management	Do you think that the SM education and training/orientation has had an impact: • The way you manage your condition/s? • Your lifestyle in general?	
	• Relationship with the SM Program personnel *[insert appropriate project term]*[1] - Access	With regards to your relationship with the SM Program personnel *[insert appropriate project term]:* Have you been able to see and/or speak with the SM Program personnel *[insert appropriate project term]* when you needed to? Consider: • Their physical location? • The hours that they operate or are contactable?	
	- Care/self management plan	Did you feel you were *listened* to by the SM Program personnel *[insert appropriate project term]* at the time of the development of your care plan or equivalent?	
		To what extent has the SM Program personnel *[insert appropriate project term]* involved you in making decisions about your care?	
	- Communication and information	When you meet or speak with the SM Program personnel *[insert appropriate project term]*, to what extent are your questions answered? To what extent do you feel that the SM Program personnel *[insert appropriate project term]*, you adequate information about your condition/s?	
	- Quality of the relationship	Overall, how would you describe the quality of your relationship with the SM Program personnel *[insert appropriate project term]*.	

[1] 'Appropriate title' refers to the projects adopted name for the personnel who are the main point of contact/focus for clients e.g. coaches

Impact assessed	Dimensions	Prompts	Comment
Perceptions and experiences of care and relationships (including follow-up) with HSPs **Thinking about you MAIN health service provider.**	• Access	To what extent do you feel that getting or accessing heath services has been restricted or hindered? Consider: • Waiting lists? • Location of services? • Opening times (hours of operation)? • Financial cost? • Emergency situation?	
	• Care/self management plan	Did you feel you were *listened* to by your HSPs during the development of your care/self management plan? To what extent have health service providers *involved you* in making decisions about your immediate and future care?	
	• Communication and information	When you meet or speak with your HSPs, to what extent are you questions answered? To what extent do you feel that your HSPs give your adequate information about your condition/s?	
	• Quality of relationship	Overall, how would you describe the quality of your relationship with your main HSPs?	

Appendix 6

Carer Focus Group Report

Carer Focus Group Report

Purpose of this document

The purpose of this document is to outline the topics of information, that the National Evaluator requires as a data source from the outcomes of the Carer Focus Groups. This document should be used as the guide for the reporting of information collected from the Carer Focus Groups. The guide is a reflection of all the prompts that were asked of the Carer Focus Group attendees.

The information obtained in the Carer Focus Group Report will be lifted out and placed into the Minimum Data Set by the National Evaluator.

General comments:

- **A minimum of two carer focus groups are undertaken at three points in time over the course of the National Evaluation of the Sharing Health Care Initiative.**
- **The attached report is a culmination of the minimum of two carer focus groups undertaken at one of these three point in time.**
- **The space given against each prompt is in no way indicative of the quantity of information required by the National Evaluator. Projects should determine for themselves the space required for adequate responses.**

Items to accompany the Carer Focus Group report are:

- **This cover sheet;**
- **A transcript of each of the carer focus groups; and**
- **The Carer Focus Group Record sheets.**

PLEASE PROVIDE THE FOLLOWING:

1) The name of the demonstration project:

_____

2) This Carer Focus Group Report is for:
Please tick ONE box.

Beginning [ ]

Middle [ ]

End [ ]

3) The total number of INVITEES for the Carer Focus Groups was _____ [*insert appropriate number].*

4) The total number of ATTENDEES for the Carer Focus Groups was _____ *[insert appropriate number].*

5) Today's date: _____/_____/_____

6) Please describe how carers were recruited to attend these focus groups:

_____

_____

Carer Focus Group Report

Impact/Outcome assessed	Dimensions	Prompts	Comment
Overall satisfaction with SM Program	• Overall satisfaction with the SM Program and its impact on the client's and carer/family/SO's life	Overall, how satisfied are you with the SM Program? What has been the impact on the life of the person you are caring for? What has been the impact (if any) of the SM Program on your life?	
Perceptions and experiences of SM orientation/education and training including relationship with SM Program personnel (including follow-up)	• SM Program recruitment and orientation/education and training process	Were you fully informed about the Sharing Health Care Program when the person you are 'caring' for first joined? As a carer, overall, how satisfied have you been with the training/orientation you have received? Consider: • The time between joining the program and undertaking your training/orientation? • Was the venue a good one? • Was the information understandable, relevant and useful? • Was the leader organised, friendly and helpful? Overall, how satisfied have you been with the post-training/orientation follow-up?	
Perceptions and experiences of SM orientation/education and training including relationship with SM Program personnel (including follow-up)	• Impact of the SM orientation/education and training on lifestyle and condition management	As a consequence of your participation in the SM Program, has the program impacted at all, upon: • Your role as a Carer? • Your lifestyle in general?	

Impact/Outcome assessed	Dimensions	Prompts	Comment
Perceptions and experiences with SM education and orientation/training (including follow-up) **(Continued)**	• Relationship with the SM Program [*insert appropriate project term]*[1]*:* - Access	With regards to your relationship with the SM Program [*insert appropriate project term]:* Have you been able to see and/or speak with the SM Program [*insert appropriate project term]* when you needed to? Consider: • Their physical location? • The hours that they operate or are contactable?	
	- Care/self management plan	Did you feel you were listened to by the SM Program [*insert appropriate project term]* at the time of the development of the care plan or equivalent?	
		By being a part of the program and/or self management care plan, do you feel that your needs, as a carer, were accurately and clearly identified?	
		To what extent has the SM Program [*insert appropriate project term]*, involved you in making decisions about your role as a carer?	
	- Communication and information	When you meet or speak with the SM Program [*insert appropriate project term], spea*king as a carer, to what extent are your questions answered?	
		To what extent do you feel that the SM Program [*insert appropriate project term]*, gives you enough advice about how to look after yourself (as a 'carer')?	
		To what extent do you feel that the SM Program [*insert appropriate project term]*, gives you enough advice about how to care for the person you are caring for?	
	- Quality of the relationship	Overall, how would you describe the quality of your relationship with [*insert appropriate title*]?	

[1] 'Appropriate title' refers to the projects adopted name for the personnel who are the main point of contact/focus for carers e.g. coaches

Impact/Outcome assessed	Dimensions	Prompts	Comment
Perceptions and experiences of care and relationships (including follow-up) with HSPs **Thinking about the MAIN health service provider who attend to the person you care for…**	- Access	To what extent do you feel that getting or accessing heath services for the person you care, have been restricted or hindered? Consider: • Waiting lists? • Location of services? • Opening times (hours of operation)? • Financial cost? • Emergency situation?	
	- Care/self management plan	Did you feel you were *listened* to by the HSPs during the development of the care/self management plan of the person you care for?	
		To what extent have health service providers *involved you* in making decisions about: • The help you receive as a carer?; • The help for the person you are 'caring' for?	
	- Communication and information	When you meet or speak with a HSP, to what extent are your questions answered? Did you get enough advice about how to look after yourself as a 'carer'?	
	- Quality of relationship	Overall, how would you describe the quality of your relationship with your main HSP?	

Outcome	Dimensions	Prompts	Comments
Burden, perceptions of stress	• Inconvenience (e.g. time, impact on work/personal plans/other activities) • Financial strain • Physical strain • Emotional strain (e.g. arguments, disruption to family) • Sleep disturbance • Feelings of being overwhelmed • Impact on the relationship with client	As a 'carer', please tell me how this role has impacted upon you. Consider whether it is: • An inconvenience (e.g. takes too much time, or restricts your free time)? • A financial strain? • A physical strain (e.g. lifting)? • Disturbs your sleep?	
		As a carer, have you had to make emotional adjustments? Have there been for example: • instances of family adjustments? • other personal adjustments? e.g. turning down employment opportunities, • arguments and other upsets? e.g. watching changes in the person you care for?	
		Are there times when you feel overwhelmed by the role of a carer?	
		Has being a part of the SM Program helped in any way in coping with any or all of these 'carer impacts'?	

Appendix 7

Health Service Provider Focus Group Report

Health Service Providers

Purpose of this document

The purpose of this document is to outline the topics of information, that the National Evaluator requires as a data source from the outcomes of the Health Service Providers Focus Groups. This document should be used as the guide for the reporting of information collected from the Health Service Providers Focus Groups. The guide is a reflection of all the prompts that were asked of the Health Service Providers Focus Group attendees.

The information obtained in the Health Service Providers Focus Group Report will be lifted out and placed into the Minimum Data Set by the National Evaluator.

General comments:

- **A minimum of two Health Service Providers Focus Groups are undertaken at three points in time over the course of the National Evaluation of the Sharing Health Care Initiative.**
- **The attached report is a culmination of the minimum of two Health Service Providers Focus Groups undertaken at one of these three point in time.**
- **The space given against each prompt is in no way indicative of the quantity of information required by the National Evaluator. Projects should determine for themselves the space required for adequate responses.**

Items to accompany the Health Service Providers Focus Group report are:

- **This cover sheet;**
- **A transcript of each of the Health Service Providers Focus Groups; and**
- **The Health Service Providers Focus Group Record sheets.**

PLEASE PROVIDE THE FOLLOWING:

1) The name of the demonstration project:

_____

2) This Health Service Providers Focus Group Report is for:
Please tick ONE box.

Beginning [ ]

Middle [ ]

End [ ]

3) The total number of INVITEES for the Health Service Providers Focus Groups was _____ [*insert appropriate number].*

4) The total number of ATTENDEES for the Health Service Providers Focus Groups was _____ *[insert appropriate number].*

5) Today's date: _____/_____/_____

6) Please describe how Health Service Providers were recruited to attend these focus groups:

_____

_____

Health Service Providers Focus Group

Impact	Dimensions	Prompts	Comments
Perceptions/experiences/ **satisfaction with SM Program**	• Overall job satisfaction in the context of SM	What are your impressions (positive and negative) of the SM Program and its impact on your overall job satisfaction?	
		Does the SM Program fit with your preferred way of working?	
		Overall, how useful is the SM Program, to: • you;? • to your clients?	
	• Care/self management plan process (review, follow-up, usefulness)	In your experience, what are you overall impressions (positive and negative) of: • the care and self management approach adopted – consider time spent with client, burden, remuneration, usefulness for you and the client.	
		• level of care coordination as a consequence of this program?	
	• Roles	Do you feel that your role in the care of your clients has changed as consequence of SM?	
		How satisfied are you with the roles the following are taking in the SM Program: • Yourself?	
		• Clients?	
		• Project office including management, and providers of the program?	
		• Other Health Service Providers?	

Impact	Dimensions	Prompts	Comments
Perceptions/experiences/ satisfaction with SM Program (Continued …)	• Communication networks (including IT)	Has being apart of the SM Program affected in any way your communication networks? Consider communication: • With other health service providers – within and across settings; • With clients involved in the program • With the program office (the people from whom you may receive referrals).	
		Overall, are you satisfied with the level and quality of this communication?	
	• Quality of relationships with clients	To what extent has the SM Program changed your relationship with your clients? Consider whether it is better, worse or unaffected.	
Impact of SM program (including training and education received) on working life including	• Changing behaviours, • Barriers to change and • Suggested improvements to the SM Program	Can you give examples or case studies of when the SM Program has impacted on your work life: • Positively?	
		• Negatively?	
		What is the impact of the SM Program with respect to changing your behaviour – or the way you practice?	

Appendix 8

Community Focus Group Report

Community Focus Group Report

Purpose of this document

The purpose of this document is to outline the topics of information that the National Evaluator requires as a data source from the outcomes of the Community Focus Groups. This document should be used as the guide for the reporting of information collected from the Community Focus Groups. The guide is a reflection of all the prompts that were asked of the Community Focus Group attendees.

The information obtained in the Community Focus Group Report will be lifted out and placed into the Minimum Data Set by the National Evaluator.

General comments:

- **A minimum of one Community Focus Group is undertaken at three points in time over the course of the National Evaluation of the Sharing Health Care Initiative.**
- **The attached report is a culmination of the minimum of one Community Focus Group undertaken at one of these three point in time.**
- **The space given against each prompt is in no way indicative of the quantity of information required by the National Evaluator. Projects should determine for themselves the space required for adequate responses.**

Items to accompany the Community Focus Group report are:

- **This cover sheet;**
- **A transcript of the Community Focus Group; and**
- **The Community Focus Group/s Record sheets.**

PLEASE PROVIDE THE FOLLOWING:

1) The name of the demonstration project:

_____

2) This Community Focus Group Report is for:
Please tick ONE box.

Beginning [ ]

Middle [ ]

End [ ]

3) The total number of INVITEES for the Community Focus Group/s was _____ [*insert appropriate number].*

4) The total number of ATTENDEES for the Community Focus Group/s was _____ *[insert appropriate number].*

5) Today's date: _____/_____/_____

6) Please describe how Community representatives were recruited to attend this focus group:

_____

_____

Community Focus Group

Impact	Dimensions	Prompts	Comment
Perceptions and experiences of the SM Program in the context of the wider community (e.g. key groups or stakeholders which represent the view of a defined community).	• Knowledge and awareness of the SM Program within the Community	As a member of your Community, how well informed have you been about the SM Program?	
		How well informed do you feel that the appropriate members of the community are about the SM Program?	
		Do you feel that you, as a member of your Community, were adequately involved in the design, development and implementation of the SM Program?	
	• Information (quality, quantity, dissemination and reach/penetration into the Community)	Do you feel that the information was of good quality and appropriate?	
		Do you feel that this information reached the majority of those it needed to reach?	
	• Overall perception of the benefit derived by the Community from the SM Program (e.g. 'a good thing', expected future demand)	Do you think there is any benefit to be derived by the Community from this program?	
		Do you feel that SM Programs of this sort, should be maintained or extended?	

Impact	Dimensions	Prompts	Comment
Perceptions and experiences of the SM Program in the context of the wider community (e.g. key groups or stakeholders which represent the view of a defined community). **(Continued …)**	• Suggested improvement to the SM Program	As a member of your Community how could the SM Program be improved, if at all? Consider: • The marketing and reach of the program? • The quality of the SM training (if known)? • The quality of the program in general? • The ease or otherwise of accessing the program? • The support offered to clients? • The governance/management structure of the program?	

Appendix 9

Key Informants Interviewed

SHCI Key informants interviewed at each time point

State	Title / Organisation	Number of interviews		
		Baseline	Middle	Last
ACT	Chief Executive Officer, ACT Division of General Practice	√	√	√
	Program Manager, ACT Community Care	√	√	
	Health Consumer Association ACT	√	√	
	Community Health			√
	Health Care Consumers Association of the ACT (HCCA) and Self-Help Organisations United Together (SHOUT)			√
	Education Program Coordinator, Arthritis ACT		√	√
NSW	Director, Allied Health, Primary Health Support Team	√		
	Senior Nurse Manager		√	√
	Co-Director, Division of Critical Care, Liverpool Health Services	√	√	√
	Senior Nurse Manager			√
	Senior Nurse Manager			√
	Area Director of Medical and Clinical Services, South Western Sydney Area Health Service		√	
	Senior Nurse Manager			√
	Director, Planning Division South Western Sydney Area Health Service	√		
	South Western Sydney Area Health Service GP Unit, UNSW Medical School	√	√	
NT	Medical Director, Katherine West Health Board	n/a	√	√
	GP from Lajamanu	n/a	√	
	Chief Executive Officer, Katherine West Health Board	n/a	√	√
QLD	St Luke's Nursing Service			√
	Clinical Team Leader, Brisbane North Division of General Practice	√		
	St Vincent's Community Health Service	√		
	Manager, Clinical Program, Brisbane Division of General Practice		√	
	Site Manager, Community Health		√	√
	Chief Executive Officer, Arthritis Foundation	√	√	√
SA	Pharmacist, Monarch Pharmacy	√	√	√
	Deputy Chief Executive Officer, Pika Wiya Health Service	√		
	Medical Director, Pika Wiya Health Service	√		
	Director, South Australian Centre for Rural and Remote Health and Spencer Golf Rural Health School	√	√	√
	Chief Executive Officer, Pika Wiya Health Service		√	√
	GP Practice Head, Jenkins Avenue Surgery		√	√
TAS	Physiotherapist at Royal, Department of Health & Human Services		√	√
	Community Development Officer, Community Development Department, Glenorchy City Council	√		
	Diabetes cooking class instructor, Diabetes TAS			√

State	Title / Organisation	Number of interviews		
		Baseline	Middle	Last
	Welfare Programs Coordinator, Polish Welfare Office	√		
	Physiotherapist State Manager, Department of Health & Human Services		√	
	Project Officer, Arthritis Foundation, North West Region		√	
	Chief Executive Officer, Arthritis Foundation	√		
	Director, Department of Rural Health, University of Tasmania	√		
VIC	Chief Executive Officer, Whitehorse Community Health Service	√	√	√
	Manager, Chronic Disease Strategy Unit, Department of Human Services	√		
	Manager Health Promotions / Acting Manager Health Services, Inner East Community Health			√
	Primary Care Partnership		√	√
	Executive Manager, Whitehorse Division of General Practice	√	√	√
	Manager Chinese Health Foundation	√	√	
WA	GP, Victoria Group Medical Centre		√	√
	Rehabilitation Advisor, Heart Foundation			√
	Director, Eastern Perth Public and Community Health	√	√	
	Manager, Health Services Division, Diabetes Australia	√	√	
	Director, WA AIDS Council		√	√
	Chief Executive Officer, Canning Division of General Practice	√	√	√
	GP, Practice Head	√		

Appendix 10

An Explanation Of The Rating System For The Key Informant Interviews

Network Partnerships 'The relationships between groups and organisations within a community network'		
Indicator	**Rating**	**Definition**
The network has capacity to **identify** the organisations and groups with **resources** to implement/sustain the Program	1 Not at all / very limited	Nothing has been done to identify such organisations. There is limited or no clear understanding of what type of network is required.
	2 Somewhat	Some work has been done to identify organisations, but it has not necessarily been underpinned by a formal strategy. There is an understanding of which organisations would be useful for the network. *<u>Example responses to achieve this rating:</u>* • *For several of the projects, there is no approach in how to build the network beyond the steering committee.* • *A number of groups have been engaged to run activities as part of the project but no work has been conducted to sustain the program.* • *Some work re implementation and sustainability but not substantial. Train key people to implement the program and sustainability limited to awareness raising. Waiting for evaluation before undertake any serious planning re sustainability.*
	3 Substantial	Substantial work has been done in identifying suitable organisations to be part of the network. There is a real understanding in how a network can benefit the program and what each of the partners will contribute to the program. *<u>Example responses to achieve this rating:</u>* • *One project has, besides the key parties who are part of the consortium, approached specific organisations to form strategic alliances and develop mechanisms that strongly support the program.* • *Strong capacity to identify resources and groups to implement the program, but limited awareness of the availability of resources to sustain the program. NGOs in the program intend to sustain it.* • *Strong commitment to SM approach. Funds set aside to look at sustainability. Project is linked to other key programs looking at SM. These programs have the potential to provide ongoing funding to the project.*
	4 Almost entirely / entirely	A suitable network has been established and it has the resources to implement and sustain the program. This rating is only likely to be given once the project has been going for some time i.e. there is evidence of maturity and longevity for this indicator. *<u>Example response to achieve this rating:</u>* • *Network has strong capacity to identify organisations with resources to implement / sustain the program. Sustainability was considered from the beginning and has been on many meeting agendas. Budget surplus has been identified and requested to use this for sustainability. Called for EOI for ways in which elements of the project can be made sustainable. Working with a range of orgs re sustaining the program.*

Network Partnerships (continued) 'The relationships between groups and organisations within a community network'		
Indicator	**Rating**	**Definition**
The network has capacity to **deliver** a Program	1 Not at all / very limited	There is no clear understanding of roles within the project.
	2 Somewhat	There appears to be an understanding of who is responsible for what and how the different parties should co-operate to deliver the program, but nothing is formalised. *<u>Example responses to achieve this rating:</u>* • *For one project, some of the partners have not been active in the project for part of the time. There appeared to be no clear agreement about what each of the partners should contribute.* • *One project was being delivered and there was good feedback from participants.*
	3 Substantial	There are clear roles and responsibilities for the parties involved in the program. A steering committee (or similar) exists and the expertise they bring to the project is relevant. *<u>Example responses to achieve this rating:</u>* • *One project has developed memorandums of understanding between the steering committee members to clarify what each one of them will contribute to the program.* • *Staff from a range of organisations have been trained to run courses and other organisations are responsible for different mechanisms to support the program, such as ongoing workshops.* • *Scheduled CDSM activities into weekly program of the clinic. Project runs health promotion activities. Involved elders and Board member. Visit people at home if need to.*
	4 Almost entirely / entirely	There is evidence that the parties nominated for the different roles are the appropriate ones and there is evidence that the network can deliver a program. This rating is only likely to be given once the project has been going for some time i.e. there is evidence of maturity and longevity for this indicator. *<u>Example response to achieve this rating:</u>* • *NGO support groups are already well established. Other groups involved include women's health, men's health, housing group, community nurses, diabetes, asthma, cancer support, heart foundation, Commonwealth care link etc. These groups work together to present sessions. Venue hire and marketing have been funded.*

Network Partnerships (continued) 'The relationships between groups and organisations within a community network'		
Indicator	**Rating**	**Definition**
There is a sustainable network established to **maintain** and resource a program	1 Not at all / very limited	No or limited work has been done to ensure the network can be maintained. *<u>Example responses to achieve this rating:</u>* • *The project was established and running but key groups are yet to determine if they will be involved in sustaining the program.* • *Unsure of whether a network has been established outside the Steering Group to maintain and resource the program.*
	2 Somewhat	Some or parts of the networks formed are likely to continue to exist beyond the current project due to the perceived benefits of the network. The reason could be that some of these networks existed before the commencement of the current project. *<u>Example responses to achieve this rating:</u>* • *For one project, the sponsor of the project sees it as their role to reach out to the community and that the commitment of that party is likely to go beyond the life of the project.* • *Although there is a strong network currently involved in the program, consideration of sustainability has only recently commenced. There is also some lack of communication between key organisations.*
	3 Substantial	There are indications that the networks likely to exist (as per 2) will also be able to provide suitable resources for a program. *<u>Example responses to achieve this rating:</u>* • *Program has been established and is running well. Steering group has begun to look at ways in which the program can be sustained through each of the partners - looking to lock the program into core Division activities (e.g. through Commonwealth Chronic Disease programs). They have good working relationships that are expected to continue.* • *Strong commitment to SM approach. Funds set aside to look at sustainability. Project is linked to other key programs looking at SM. These programs have the potential to provide ongoing funding to the project. Model for sustaining the program to be determined.*
	4 Almost entirely / entirely	There is evidence that the network will continue to exist and will be able to maintain a program beyond the life of the current program i.e. there is evidence of maturity and longevity for this indicator. *<u>Example responses to achieve this rating:</u>* • *Network has strong capacity to identify organisations with resources to implement / sustain the program. Sustainability was considered from the beginning and has been on many meeting agendas. Budget surplus has been identified and requested to use this for sustainability. Called for EOI for ways in which elements of the project can be made sustainable. Working with a range of orgs re sustaining the program.*

Knowledge Transfer 'The development, exchange and use of information within and between the groups and organisations within a network or community'		
Indicator	**Rating**	**Definition**
The network has capacity to **develop** a Program that meets **local needs**	1 Not at all / very limited	No or limited effort has been done in trying to understand the local needs.
	2 Somewhat	Some action has been taken to try to understand the local needs such as obtaining views from different groups via workshops or surveys. *<u>Example responses to achieve this rating:</u>* • *One project held focus groups with different groups of people.* • *Program is meeting some local needs as Nurses, the Arabic community and chronic pain groups are involved. Less successful with GPs and broader Area Health Service. Not much done initially in terms of context mapping.*
	3 Substantial	It appears that suitable information has been collated and that this information has been used to develop a program. *<u>Example responses to achieve this rating:</u>* • *One project holds regular weekly meetings in each sector for self management coordination. This is to ensure that the services are coordinated, not duplicated.* • *One project surveyed the needs of clients, ran a pilot course, worked with orgs to recruit participants and ascertained their ongoing individual needs through an interview.* • *Looked at demographics, costing, and resources available, where services were located and identified issues and barriers. Project involved a wide range of organisations. Early results that project has built capacity of participants too.* • *Literature review was conducted to develop the project, including identification of need. Community needs also addressed through ongoing consolation of the consortium.* • *Diversity is a big issue in the area so included a strategy to target the Arabic community. Successful engagement of local GPs and Arabic medical practitioners. Developed a methodology that meets the needs of GPs.*
	4 Almost entirely / entirely	There is evidence that the network has capacity to develop a program that meets local needs. This rating is only likely to be given once the project has been going for some time and some examples can be provided i.e. there is evidence of maturity and longevity for this indicator. *<u>Example response to achieve this rating:</u>* • *Established local community health committee, engaged elders and other community members, flexible with ideas to make them suit the community e.g. walking groups and changed food policy of local shops.*

Knowledge Transfer (continued) **‘**The development, exchange and use of information within and between the groups and organisations within a network or community’		
Indicator	**Rating**	**Definition**
The network has capacity to **transfe**r knowledge in order to achieve the desired outcomes/implement a program within network	1 Not at all / very limited	No or limited actions have been done to transfer knowledge.
	2 Somewhat	Some attempts have been made to transfer knowledge such as issuing newsletters, but there is no structured plan for which knowledge should be transferred and how. *<u>Example responses to achieve this rating:</u>* • *One project sees that knowledge transfer can be done via train-the-trainer, but there are no clear plans at this stage.* • *Successfully trained Nurses, reps of the Arabic community and chronic pain group, but no GPs have participated in training. Knowledge transfer needs a driver to co-ordinate it.*
	3 Substantial	Several methods of knowledge transfer have been used. *<u>Example responses to achieve this rating:</u>* • *Several of the projects used visits by project staff, publications of newsletters, inclusion of information in partners different newsletters, media coverage etc.* • *Knowledge transferred through the steering group, reference group, focus groups, biannual coach debriefing, circulation of project reports, quarterly newsletter. Knowledge is also transferred back to agencies although there is no formal process for this.* • *Newsletters, website, consortium meetings, coaches transfer knowledge in their agencies. Transfer knowledge to GPs but could be improved to educate GPs further about SM.*
	4 Almost entirely / entirely	There is an agreement of which knowledge should be transferred over the life of the program to which parties, together with the methods of transfer. There is evidence that the network has been able to transfer suitable knowledge in a suitable manner which is aimed at the outcomes of the program i.e. there is evidence of maturity and longevity for this indicator. *<u>Example responses to achieve this rating:</u>* • *Participants have transferred their knowledge / skills / experience to other areas and projects. Modelling of good project management has been transferred to the health system. Coaches have extensive training and receive ongoing debriefing. Looking to train others. Taken the CDSM message to other organisations and as well as set up a website.*

Knowledge Transfer (continued) 'The development, exchange and use of information within and between the groups and organisations within a network or community'		
Indicator	**Rating**	**Definition**
There is has capacity to **integrate** a program into the mainstream practices of the network partners **Note:** this is separate to the transfer of knowledge to individual clients through education and training.	1 Not at all / very limited	No or limited work has been done in trying to integrate the knowledge into the network partners' practices. <u>*Example responses to achieve this rating:*</u> • *While one program had been established and was running well, there was little involvement from key organisations and no consideration had been given to integrating the program.* • *Little or no planning to integrate the program into mainstream practices of the network partners. Not sure the program will be maintained.*
	2 Somewhat	It has been raised how the practices can be integrated by the networks partners, and some plans have been put together. <u>*Example responses to achieve this rating:*</u> • *Nurses will continue with the project but unsure how this will occur in relation to decision making. Discussions have been at the awareness raising level and they'll wait to see evaluation results before making any decisions re sustainability.* • *While the project is likely to lead to closer working relationships between participants, no definite plans to integrate the project into mainstream practices of network partners.*
	3 Substantial	It is clear how it is intended that the network partners will integrate the practices into their own program, but it has not been carried out as yet. <u>*Example responses to achieve this rating:*</u> • *Steering group has begun to look at ways in which the program can be sustained and integrated into the work of the partners e.g. into the work of the Division of GPs.* • *Strong emphasis integrating project into mainstream practices of network partners. Funds set aside to look at integrating project into normal business of community health centres. Project linked to other key SM programs.*
	4 Almost entirely / entirely	There is evidence that the network partners have integrated the knowledge obtained in the program into their own practices i.e. there is evidence of maturity and longevity for this indicator. <u>*Example response to achieve this rating:*</u> • *Services all run by same organisation, network is already there. It's already an integrated service.*

Problem Solving **'**The ability to use well-recognised methods to identify and solve problems arising in the development and implementation of an activity or program'		
Indicator	**Rating**	**Definition**
There is capacity within the network to **work together** to solve problems	1 Not at all / very limited	There are no examples of any problems that have been solved within the network.
	2 Somewhat	There are some examples of problems that have been solved. *<u>Example responses to achieve this rating:</u>* • *One project mentioned that recruitment from GPs has been an issue that has been discussed and appropriate actions taken by recruiting through another organisation.* • *Not aware of any formal problem solving structures in place other than network meetings, but there is capacity to overcome any problems that have arisen e.g. additional administrative resources were provided to the project to reduce project officers workload.*
	3 Substantial	There are several examples of different types of issues that have been solved. *<u>Example responses to achieve this rating:</u>* • *Different projects provided different types of problems that have been solved from more complex strategic issues to day-to-day operational issue.* • *Consortium members have worked together for a long time and have good ability to resolve problems. Infrastructure in place to address problems. Problem solving mechanisms are at 4 levels.*
	4 Almost entirely / entirely	There are several examples of major issues that the project has solved during the life of the project. It has not resulted in changes in the persons involved i.e. there is evidence of maturity and longevity for this indicator. *<u>Example response to achieve this rating:</u>* • *Any problems have been dealt with in open discussion in Steering Group, all problems have been solvable. Detailed proposal was developed before the project began to identify problems and mechanisms to resolve them.*

Problem Solving (continued) **'**The ability to use well-recognised methods to identify and solve problems arising in the development and implementation of an activity or program'		
Indicator	**Rating**	**Definition**
There is the capacity to **identify** and **overcome** problems encountered in achieving the desired outcomes	1 Not at all / very limited	There is no evidence of any formalised procedures in place.
	2 Somewhat	There appear to be mechanisms in place to overcome problems. <u>*Example responses to achieve this rating:*</u> • *For one project, the project structure is used to overcome problems i.e. depending on the issue; either of the following fora will be used: Project Director and immediate supervisor, sector committee or steering committee.* • *For one project, small problems were solved by the steering committee and there are different governance groups. When issues arise they write letters or set up meetings. There is a willingness to solve problems and most have been resolved.*
	3 Substantial	There appears to be structures or mechanisms in place both to identify and to overcome problems. <u>*Example responses to achieve this rating:*</u> • *One project has used role plays to try to understand the implications of the interaction between the GP and the patient. This has been used both to identify and to overcome problems.* • *Review in monthly practitioner meetings, identify barriers and overcome them. Look at how things are done in each organisation. Coach debriefing assist coaches to learn and resolve problems. Focus groups look at why model is working etc. Yet to determine how and what aspects of the program will be integrated into mainstream services.*
	4 Almost entirely / entirely	There is evidence of structures or mechanisms in place to identify and overcome problems i.e. there is evidence of maturity and longevity for this indicator. <u>*Example response to achieve this rating:*</u> • *Procedures and mechanisms to solve problems were set up at the beginning of the project through a consultative process. Consortium members had a history of working together. Problems addressed at a variety of levels. System works well.*

Problem Solving (continued) **'**The ability to use well-recognised methods to identify and solve problems arising in the development and implementation of an activity or program'		
Indicator	**Rating**	**Definition**
There is capacity to **sustain** flexible problem solving	1 Not at all / very limited	There is no evidence of any capacity that can be sustained. *<u>Example response to achieve this rating:</u>* • *Doubts if problem solving capacity will be sustained. Thinks it will become volunteer run.*
	2 Somewhat	Some effort has been put into ensuring that the mechanisms used can be sustained. *<u>Example responses to achieve this rating:</u>* • *Not aware of any formal problem solving structures, but the members of the network will continue to work together and will be able to resolve any problems as they have in the past.* • *Consortia have worked together for a long time and have good ability to resolve issues. Still determining how this will be integrated into mainstream practice, may impact on ability to sustain flexible problem solving.* • *Infrastructure in place to resolve problems and usually overcome through communication and negotiation. Difficult to sustain a problem solving capacity and either the health service or a GP division needs to take up the project as its driver.*
	3 Substantial	Substantial effort has been put into ensuring that the mechanisms used can be sustained. *<u>Example responses to achieve this rating:</u>* • *Problem solving will be sustained through the strong relationships that have been built. There's a proposal outlining problems and mechanisms for solutions that was developed prior to the project – it is part of the underlying infrastructure of the project.*
	4 Almost entirely / entirely	There is evidence of a problem solving capacity that can be sustained beyond the life of the project i.e. there is evidence of maturity and longevity for this indicator. *<u>Example responses to achieve this rating:</u>* • *Team approach where everyone contributes shut down clinic and everyone's invited. As problems are solved through a number of community mechanisms it would seem that it is sustainable.*

Infrastructure – Policy Capital 'The level of investment in a network by the groups and organisations that make up the network'		
Indicator	**Rating**	**Definition**
The network has capacity to develop program related **policy capital**	1 Not at all / very limited	No action has been taken to date to try to build policy capital. *<u>Example response to achieve this rating:</u>* • *No ownership or responsibility for policy capital.*
	2 Somewhat	Some effort has been made to approach or include local health politicians to make it possible to influence future policy direction. *<u>Example responses to achieve this rating:</u>* • *One project has made a conscious decision to involve senior management of State Health. Another project has very good working relationships with local politicians in town and they are happy to talk to the Minister on behalf of the project.* • *Consortium has established good infrastructure and governance procedures.*
	3 Substantial	A structured approach has been taken to ensure that future policy direction can be influenced by the project. *<u>Example responses to achieve this rating:</u>* • *Formal agreements with partners have outlined expectations and reporting requirements. These have held things together and provided clarity regarding relationships and a framework and structure within which to deal with uncertainties. These agreements have broader application within the division.* • *Policies and protocols have been developed and include a manual for risk management, quality improvement, record keeping and communication about clients. These skills will be transferred to other projects.* • *Working on protocols and a framework for introducing the program into different areas. Looking at policy issues related to bringing peer leaders into the organisation.*
	4 Almost entirely / entirely	There is evidence that the project has been able to influence the direction of health policy.

Infrastructure – Financial Capital 'The level of investment in a network by the groups and organisations that make up the network'		
Indicator	**Rating**	**Definition**
The network has capacity to develop **financial capital**	1 Not at all / very limited	No action has been taken to date to try to build financial capital. *<u>Example response to achieve this rating:</u>* • *Not aware of any investments that are in place to fund initiatives that maintain the network.*
	2 Somewhat	Some effort has been done to investigate where further or additional funding could be obtained from. *<u>Example responses to achieve this rating:</u>* • *One project funded staff at a higher level in an attempt to attract the right people.* • *The issue of financial capacity is only just being considered. It seems that each group is looking at sustainability separately.* • *Funds set aside to look at sustainability. Project is linked to other key SM programs that have potential to provide ongoing funding to the project.*
	3 Substantial	Some additional or further funding has been obtained. *<u>Example responses to achieve this rating:</u>* • *Financial capital is being considered in line with sustainability. Easing some staff back to other organisations to allow for some funding to be left to provide additional training for leaders from other organisations.* • *Financial capacity being looked at as part of sustainability. Consortium members examining how they will sustain the model. Have funding from the Dept of Veteran Affairs. Participating in other projects that may provide funding.*
	4 Almost entirely / entirely	There is evidence that the project has developed a long term plan for how further funding can be obtained. This plan is likely to succeed.

Infrastructure – Human / Intellectual Capital 'The level of investment in a network by the groups and organisations that make up the network'		
Indicator	**Rating**	**Definition**
The network has capacity to develop **human / intellectual capital**	1 Not at all / very limited	No action has been taken to date to try to build human or intellectual capital.
	2 Somewhat	Some activities have been done in trying to develop human or intellectual capital. *<u>Example responses to achieve this rating:</u>* • *One project has provided training for consumer representatives in committee skills.* • *One project had all workers attend advance Lorig training and other activities but unsure of ongoing investment as it depends on which direction they decide to go.* • *Training set up for nurses and they'll try to educate many consumers, engaging GPs in training has been less successful. Want to pull all work together to determine which model to use.*
	3 Substantial	There are clear plans of how human and intellectual capital will be built as part of the project. *<u>Example responses to achieve this rating:</u>* • *Leader and peer training, ongoing workshops, participation in community groups there is strong capacity to develop human capital.* • *All coaches received training in CDSM, motivational interviewing skills and coaching. Participation of coaches in training has benefits across the organisation. Looking to roll out training in CDSM.*
	4 Almost entirely / entirely	There is evidence that the project has developed human and intellectual capital that will be of benefit to the wider community. *<u>Example responses to achieve this rating:</u>* • *Training and supporting coaches across the consortium members' organisations. Involve wide range of community groups in providing program activities. Have a website and conduct other promotional / awareness activities.* • *Training has been conducted for remote health staff and this will be ongoing, its part of the agenda of service management meetings.*

Infrastructure – Social Capital 'The level of investment in a network by the groups and organisations that make up the network'		
Indicator	**Rating**	**Definition**
The network has capacity to develop **social capital**	1 Not at all / very limited	No action has been taken to date to try to build social capital. *<u>Example response to achieve this rating:</u>* • *"Given the Steering Group issues, don't go there".*
	2 Somewhat	Social capital has been built as a result of the interaction of the project. *<u>Example responses to achieve this rating:</u>* • *For most of the projects, the key organisations have worked together before, but not necessarily in the same way. As a result of the work to date, the relationships have deepened and knowledge about the organisations increased.* • *Social capital built through meetings but no activities outside of this.* • *Consortium members have worked together over a long period and have established good working relationships which are key to the success of the project to date.*
	3 Substantial	There are clear plans of how social capital will be built as part of the project. *<u>Example responses to achieve this rating:</u>* • *One project has included this as an outcome of developing the memorandum of understanding.* • *A lot of interface – meetings, emails, phone conversations, drop in to organisation. Relationships described as productive, respectful, and harmonious.* • *Working together has added trust between network members and relationships have been built with community and peer leaders. Including peer leaders form the community has been important in increasing the flow of information and understanding.* • *Project staff invested time in community development and developing social capital. Aim to get the community to see the clinic as a positive, trusting environment. Staff fostering communication between services to increase trust.*
	4 Almost entirely / entirely	There is evidence that the project has developed social capital that will be of benefit to the wider community. *<u>Example response to achieve this rating:</u>* • *Process of developing social capital begun in 1995 with CCT as they met with many people to sign off on project. Built governance structures (health committees), have a community development officer, have developed videos that are broadcast on the community television (features Board members).*

Appendix 11

Development of Client Information Questionnaire data sources

Client Information Questionnaire – questions and data sources

Item	Question	Source	Modified/not modified	Comment
Sex	Are you male of female Not 'What is your sex?'	National health data dictionary ABS 1269.0 1998	Modified	Different phasing of question. Response types same
DOB	What is your date of birth	National health data dictionary ABS 1269.0 1998		
COB	In which country were your born	Census 2001 National health data dictionary ABS 1269.0 1998		
Language	Do you speak a language other than English at home?	Census 2001 ABS 1267.0 1997		
ATSI	Are you Aboriginal or Torres Strait Islander Origin?	Census 2001		
Marital status	What is your present marital status	Census 2001		
Number of babies	If you are female, how many babies have you had?	National Health Survey – Women's supplementary Health Form 2001		
Schooling	What is your highest level of primary or secondary school you have completed?	Census 2001		

Item	Question	Source	Modified/not modified	Comment
Qualification	What is your highest level of qualification that you have completed?	Census 2001		
Employment	How would you describe your current employment status	NSW health survey 1997/1998		
Occupation	It you are employed full or part time, what is your occupation	National evaluator Coded using ABS 122.0 1997)		Different phasing of question. Response types same
Retired occupation	If you are retired, what was your main occupation? Than is the main occupation that you previously spent most time doing.	National evaluator Coded using ABS 122.0 1997)		Different phasing of question. Response types same
Income sources	Do you receive income from any of these sources?	National Health data dictionary		
Pension types	Do you currently receive any of these pensions, allowances or benefits?	National Health Survey 2001		
Living arrangements	What are your current living arrangements?	HACC minimum data set 1998		
Accommodation setting	Which of the following best describes the setting in which you live?	HACC minimum data set 1998	Modified	Question same Response types grouped

Item	Question	Source	Modified/not modified	Comment
Carer availability	A carer is a person who may be a family member, friend, relative or other who regularly helps you formally or informally with managing your life.	HACC minimum data set 1998	Modified	Different phasing of question. Response types same
Carer residence	If you have a carer, which of the following best describes them?	HACC minimum data set 1998	Modified	Different phasing of question. Response types same
Smoking	Which of the following best describes your smoking status?	NSW health survey 1997/1998		
Alcohol consumption	How often do you have an alcoholic drink of any kind?	NSW health survey 1997/1998		
Amount of alcohol consumption	On a day that you have alcoholic drinks, how many standard drinks do you have>	NSW health survey 1997/1998	Modified	To ensure example of a ‘standard drink’ is equivalent to State/Territory terminology

The primary data sources for the Client Information Questionnaire were:

• Census 2001	See ABS publication 2901.0 *Census dictionary* www.abs.gov.au
• National Health Survey 2001 • National Health Survey – Women's supplementary Health Form 2001	See ABS publication 4364.0 *National Health Survey: Users' Guide* for detailed information about the survey www.abs.gov.au
• NSW health survey 1997/1998	See the New South Wales Health web site for further details on this survey (www.health.nsw.gov.au)
• HACC minimum data set 1998 •	See the guidelines to the HACC MDS and HACC Data Dictionary v 1.0 1998 for further details concerning this data set http://www.health.gov.au/internet/wcms/publishing.nsf/Content/hacc-pub_mds_gdd.htm-copy2
• National Health Data Dictionary	See Australian Institute of Health and Welfare publication AIHW Catalogue Number HWI 30 *National Health Data Dictionary Version 10* for more details

Appendix 12

Non-Indigenous Client Information Questionnaire

CLIENT INFORMATION QUESTIONNAIRE

Office Use Only

1. Are you male or female?
   *Please tick **one** box.*

   Male ……..……...…….... ☐ — 1

   Female ……..…..…..... ☐ — 2

2. What is your date of birth?

D	***D***	***M***	***M***				
Y	***Y***	***Y***	***Y***				

Office Use only:

Identification number: | | | | | | |

Date of recruitment: | | | | | | | | |
D D M M Y Y Y Y

Date of questionnaire completion: | | | | | | | | |
D D M M Y Y Y Y

Administration point:
(tick appropriate box)

Baseline ……. ☐

Six months ….……..... ☐

Eighteen months or end of project ……..… ☐

Client Residential Postcode: | | | | |

Region: | |

3. In which country were you born?

*Please tick **one** box.*

		Office Use Only
Australia …….	☐	1101
England ……..	☐	2102
Scotland …….	☐	2105
New Zealand ……..	☐	1201
Italy …….	☐	3104
Greece …….	☐	3207
Croatia ……	☐	3204
Lebanon ……..	☐	4206
Saudi Arabia ……...	☐	4209
China……...	☐	6101
Viet Nam ……	☐	5105
Other ……...…	☐	####

Specify:

_____

4. Do you speak a language other than English *at home*?

*Please tick **one** box.*

No, English Only ……..……..….	☐	1201
Yes, Italian ……..	☐	2401
Yes, Greek ……..	☐	2201
Yes, Cantonese ……...	☐	7101
Yes, Mandarin ……	☐	7104
Yes, Arabic …….	☐	4202
Yes, Lebanese …….	☐	4202
Yes, Vietnamese …….	☐	1301
Yes, Creole …….	☐	9400
Yes, Gruinji ……	☐	9800
Yes, Other …….……..	☐	####

Specify: _____

5. Are you of Aboriginal or Torres Strait Islander origin?
*Please tick **one** box.*

Office Use Only

Yes ……..……...……	☐	1
No ……..……	☐	2

6. What is your present marital status?
*Please tick **one** box.*

Never married ……..…..……	☐	1
Widowed ……..…….	☐	2
Divorced ……...	☐	3
Separated but not divorced ……...	☐	4
Married (including de facto)……..	☐	5

7. If you are female, how many babies have you ever had?

(Include live births only).

If you have had no babies, simply write '0'.

☐ ##

8. What is the highest level of primary or secondary school you have completed?

*Please tick **one** box.*

If you have returned after a break to complete your schooling, tick the highest level completed when you last left.

Still at school ……..……..…..…...	☐	1
Did not go to school …….……...….	☐	2
Year 8 or below ……..……...…….…...	☐	3
Year 9 or equivalent ……...…….….	☐	4
Year 10 or equivalent ……...…….…...	☐	5
Year 11 or equivalent …….……...…...	☐	6
Year 12 or equivalent …….……..	☐	7

Office Use Only

9. What is the highest level of qualification that you have completed? For example, trade certificate, bachelor degree, associate diploma, certificate 2, advanced diploma.

1
2
3
4
5
6

10. *How would you describe your current employment status*? Are you…
*Please tick **one** box.*

Employed full-time …….	☐ go to question 11	1
Employed part-time ...……..	☐ go to question 11	2
Unemployed ……	☐ go to question 13	3
Home duties ……..……..	☐ go to question 13	4
Student and working ……	☐ go to question 13	5
Student and not working …….	☐ go to question 13	6
Retired ……	☐ go to question 12	7

Unable to work due to heath problems …..…. ☐ go to question 13 — 8

Other ……..…….. ☐ go to question 13 — 9

Specify: _____

11. If you are employed full or part time, what is your occupation?

	Go to question 13	###

12. If you are retired, what *was* your *main* occupation? That is, the main occupation that you previously spent most time doing.

	Go to question 13	###

13. Do you currently receive income from any of these sources?
*Please tick the **appropriate** box/es.*

Office Use Only

Wages and salary ……..…...	☐	1, 2
Government pension or allowance ……..…	☐	1, 2
Child support or maintenance …….……	☐	1, 2
Superannuation or annuity …….…….	☐	1, 2
Any other regular source …….……...	☐	1, 2
Specify: _____		
No/none of the above …….….	☐	1, 2

14. Do you currently receive any of these pensions, allowances or benefits? Answering this question is **OPTIONAL.**

Please select the pension type which is ***most important*** to you.
*Please tick **one** box.*

Australian Age Pension ……..……..…...	☐	01
Newstart Allowances …….……..…	☐	02
Mature Age Allowance ……..…….……	☐	03
Service Pension (DVA) …….…….	☐	04
Disability Support Pension (Centrelink) …….	☐	05
Wife Pension ……...	☐	06
Carer Pension ……..	☐	07
Sickness Allowance ……	☐	08
Widow Allowance (Widow B Pension) (Centrelink) …….	☐	09
Special Benefit ……	☐	10
Partner Allowance. …….	☐	11
Youth Allowance ……	☐	12
No/none of the above …….	☐	13

Office Use Only

15. What are your current living arrangements?
*Please tick **one** box.*

I live alone ……...…….	☐	1
I live with family ….……...……..	☐	2
I live with others …….…..……	☐	3

16. Which of the following best describes the setting in which you live?
*Please tick **one** box.*

Private residence (e.g. owning/purchasing, public/private rental) ……....…..	☐	1
Partially supported living (e.g. independent living unit within a retirement village) …..…...	☐	2
Fully supported living (e.g. short term crisis facility, hostels for people with disabilities)…	☐	3
Temporary shelter …….……..……..…..	☐	4
Other ……...…….	☐	5

Specify: _____

*A carer is a person who may be a family member, friend, relative or other who **regularly** helps you **formally or informally** with managing your life.*

17. Which of the following, best describes your situation?
*Please tick **one** box.*

I have a carer…….	☐ go to question 18	1
I do not have a carer …….……..…..	☐ go to question 19	2

18. If you have a carer, which of the following best describes them …
*Please tick **one** box.*

My carer lives with me ……...…….	☐	1
My carer does not live with me …….…...	☐	2

19. Indicate below which chronic condition(s) you have and the ***number of years*** you have had the condition.
*Please tick the **appropriate** box/es**.***

Office Use Only

Number of years

Diabetes: ……..……..…… ☐ ☐ 1, 2

Specify _____ (e.g. Type 1 or 2 diabetes)

Arthritis or other joint/bone condition: ……. ☐ ☐ 1, 2

Specify _____

Chronic respiratory/lung condition: ……..☐ ☐ 1, 2

Specify _____

Cardiovascular disease (including stroke, high blood pressure and angina): ……..……..……...……. ☐ ☐ 1, 2

Specify _____

Renal Disease: ……...…… ☐ ☐ 1, 2

Specify _____

Depression: …… ☐ ☐ 1, 2

Osteoporosis: ……..…… ☐ ☐ 1, 2

Other chronic condition: ……...……..…….. ☐ ☐ 1, 2

Specify: _____

20. Which **one** of these conditions impacts most heavily upon your day-to-day activities?

☐ 1
2
3
4
5
6
7
8

Office Use Only

21. Which of the following best describes your smoking status?
*Please tick **one** box.*

I smoke daily ……..	☐	1
I smoke occasionally ……..	☐	2
I don't smoke now, but I used to ……...	☐	3
I have tried it a few times, but never smoked regularly …….…..	☐	4
I have never smoked ……..	☐	5

22. How often do you have an alcoholic drink of any kind?
This includes wine, beer and spirits.
*Please tick **one** box.*

Every day …….	☐ Go to question 23	01
6 days a week ……..	☐ Go to question 23	02
5 days a week ……..	☐ Go to question 23	03
4 days a week ……..	☐ Go to question 23	04
3 days a week ……..	☐ Go to question 23	05
2 days a week ……..	☐ Go to question 23	06
1 day a week ……	☐ Go to question 23	07
Fortnightly or less ……	☐ Go to question 23	08
Monthly or less ……	☐ Go to question 23	09
I don't drink alcohol ……	☐ Thank you	10

Alcoholic drinks are measured in terms of a 'standard drink'.

Office Use Only

23. On a day that you have alcoholic drinks, how many standard drinks do you have?

A standard drink is equal to:

1	*[Insert appropriate State/Territory measurement]*, ***OR***
1	*[Insert appropriate State/Territory measurement]*, ***OR***
1	*[Insert appropriate State/Territory measurement]*, ***OR***
1	*[Insert appropriate State/Territory measurement]*

*Please tick **one** box.*

1 drink ……...……...……..….	☐	01
2 drinks …….....	☐	02
3 to 4 drinks. …….....	☐	03
5 drinks …….…….……..	☐	04
6 drinks……..…….……....….	☐	05
7 to 8 drinks ……....……..…..	☐	06
9 to 12 drinks ……...…….……...	☐	07
13 drinks or more …….……....	☐	08

Thank you again for taking the time to complete this questionnaire

Appendix 13

Background Information and Rationale for the Stanford 2000

Background information and rationale for Stanford 2000

Stanford - Health Assessment Questionnaire 2000 version	
Description of the measure	Multi-component: measures participants 1 general health - SF1; 2 symptoms (12 items including health distress symptoms, pain, shortness of breath, fatigue – 3 VAS); 3 physical activity level (6 items); 4 coping with symptoms (6 items); 5 physical abilities (8 items; optional: same questions with use of aids/devices and help from another person); 6 Intrusiveness of illness into life (13 items); 7 confidence about doing things (6 items); 8 daily activities (4 items);*
Reliability/validity	Disability index and pain scale reliable and valid in different languages and contexts
Responsiveness (Sensitivity to change)	Disability Index and Pain scale sensitive to change in numerous observational studies and clinical trials.
Administration recommended	Usually self-administered but can also be administered (face-to face or telephone interviews).
Time to complete	About 10 mins (5 mins for Disability Index and Pain scale)
Number of items	56 items without medical care and demos questions
Population norms/comparisons	Disability Index and Pain scale components have been extensively used since 1980 in experimental conditions and clinical settings, with various chronic conditions, with clients from various SES, translated in several languages.
Previous use in elderly/ people with chronic & complex needs	Lorig et al have developed the above scales and validated them in short or long forms with chronic patients - lung disease, CVD, Diabetes, stroke, heart failure, HIV and arthritis;
Previous use in Australian setting	Unknown
Comments	Keep bars rather than straight line for VAS.

References

Lorig K, et al. Effect of a self-management program on patients with Chronic disease. Effective Clinical Practice 2001;4:256-62

Lorig K, Stewart A et al. Outcomes Measures for Health Education and other health care interventions, 1996; Sage Publications

McDowell I, Newell C. Measuring health; a guide to rating scale and questionnaires, Oxford, 1996

Ramey DR, Raynauld JP, Fries JF. The Health Assessment Questionnaire 1992- Status and Review

Appendix 14

Background Information and Rationale for the Kessler 10

Background information and rationale for Kessler 10

KESSLER 10	
Outcome to be assessed	'Psychosocial distress'
Reliability	N/A
Validity	It has been validated against concurrent diagnostic data in the Australian National Survey of Mental Health & Wellbeing (Unpublished)
Responsiveness	N/A
Administration recommended	Self-administration or via telephone
Time to complete	5 minutes
Number of items	10 items (4 additional items can be added to asses effect on day to day activities)
Population Norms/Comparisons	Population norms available for Australian, NSW & US populations.
Previous use in elderly/ people with chronic & complex needs	Used across a wide range of ages including the elderly.
Previous use in Australian setting	Used in the 1997 & 1998 NSW Health Surveys. Currently being used in the Victorian Primary Care Partnership & the NSW MH-OAT Project.
Description of the measure	The Kessler –10 (K10) is a 10-item questionnaire intended to yield a global measure of 'psychosocial distress' based on questions about the level of anxiety & depressive symptoms in the most recent four-week period. Following standard conventions for instruments of this type, a score of one standard deviation above the mean (that is, 60) has been found to be a useful level for further comparisons. It classifies about the same proportion of males (11.2 per cent) & females (15.2 per cent) as having high levels of psychological distress as the percentages found to meet diagnostic criteria for anxiety & depression in other population studies.) (Clinical Research Unit for Anxiety & Depression (CRUfAD))

Appendix 15

Background Information and Rationale for the Satisfaction With Life Scale

Background information and rationale for the Satisfaction with Life scale

SATISFACTION WITH LIFE SCALE	
Outcome to be assessed	The Satisfaction With Life Scales (SWLS) is designed to assess a person's global judgement of life satisfaction & measures change in subjective well-being & intervention outcomes. (Pavot & Diener 1993).
Reliability	The SWLS has shown strong internal reliability. (Diener et al,1985; Pavot et al, 1991;Yardley & Rice , 1991; Magnus et al, 1993)
Validity	Good convergent validity with other scales & with other types of assessments of subjective well-being (Diener et al, 1985; Pavot et al, 1991). Discriminant validity from emotional well-being measures (Diener et al,1985; Pavot et al. 1991). Both marital status & health have been shown to be correlated with the SWLS (Arrindell et al, 1991).
Responsiveness	SWLS has demonstrated sensitivity to be useful to detect change in life satisfaction during the course of clinical intervention (Pavot & Diener 1993). Responsiveness to change over time has been demonstrated in studies by (Vitaliano et al;1991;Diener et al, 1991)
Administration recommended	Self-administered. The SWLS is available in several languages: French, Dutch, Russian, Korean, Hebrew, & Mandarin (cited in Pavot & Diener 1993).
Time to complete	Three-Five minutes
# of items	Five items
Population Norms/Comparisons	Normative data are available for older adults (Pavot & Diener 1993).
Previous use in elderly/ people with chronic & complex needs	As above
Previous use in Australian setting	Study conducted with ICI patients in South Western Sydney.
Description of the measure	The SWLS was developed to assess satisfaction with the respondent's life as a whole. SWLS items are global rather than specific in nature allowing respondents to weight domains of their lives in terms of their own values, in arriving at a global judgement of life satisfaction.
Comments SWLS gives participants the opportunity to assess satisfaction with life not just linking it with health related quality of life. It is brief, easy to complete & has been used in ill & debilitated patients in the Australian setting.	

Appendix 16

Non-Indigenous Client Health Questionnaire

CLIENT HEALTH QUESTIONNAIRE

Office Use only:

Identification number: ☐☐☐☐☐☐

Sex: ☐
M or F

Date of Birth: ☐☐ ☐☐ ☐☐☐☐
D D M M Y Y Y Y

Date of recruitment: ☐☐ ☐☐ ☐☐☐☐
D D M M Y Y Y Y

Date of questionnaire completion: ☐☐ ☐☐ ☐☐☐☐
D D M M Y Y Y Y

Administration point:
(tick appropriate box)

Baseline ……. ☐

Six months ….……..... ☐

Eighteen months or
end of project.…….... ☐

Client Residential Postcode: ☐☐☐☐

Region: ☐

1. ***In general***, would you say your health is:
*Please tick **one** box**.*

Excellent…… ☐ 1

Very Good……. ☐ 2

Good…….. ☐ 3

Fair…… ☐ 4

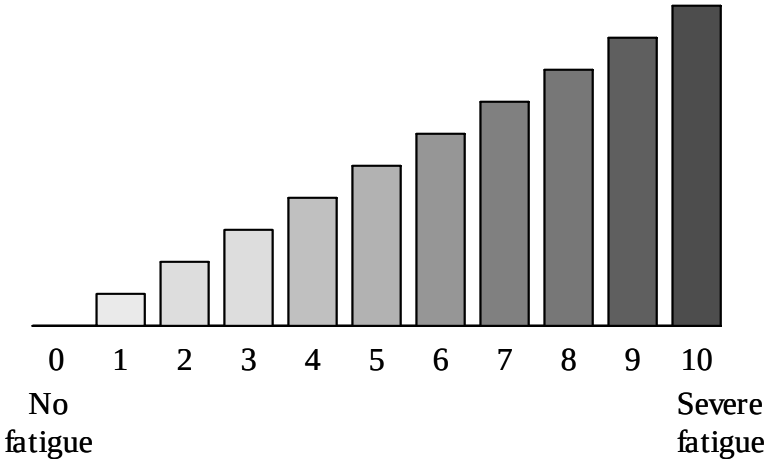
Poor…….. ☐ 5

How much time during the ***past 2 weeks***...
*Please tick **one** box for **each** question.*

	None of the time 1	**A little of the time** 2	**Some of the time** 3	**A good bit of the time** 4	**Most of the time** 5	**All of the time** 6
2. Were you discouraged by your health problems?…….….	☐	☐	☐	☐	☐	☐
3. Were you fearful about your future health? ……...….....	☐	☐	☐	☐	☐	☐
4. Was your health a worry in your life? ……..……..……...……	☐	☐	☐	☐	☐	☐
5. Were you frustrated by your health problems? …...……..……	☐	☐	☐	☐	☐	☐

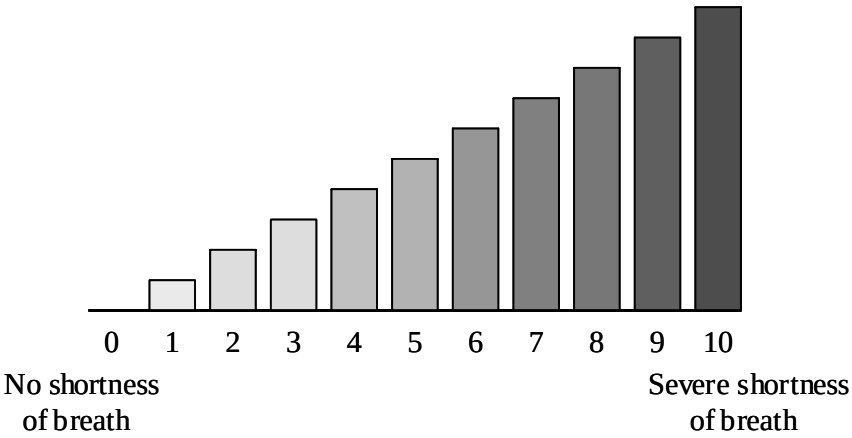
ID: ☐☐☐☐☐☐

6. We are interested in learning whether or not you are affected by fatigue.
   Please ***circle*** the number below that describes your ***fatigue*** in the ***past 2 weeks***:

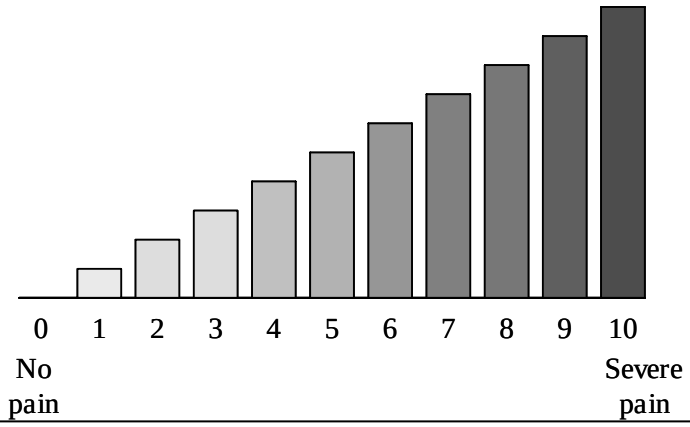


ID: | | | | | | |

7. We are interested in learning whether or not you are affected by shortness of breath. Please ***circle*** the number below that describes your ***shortness of breath*** in the ***past 2 weeks***:



8. We are interested in learning whether or not you are affected by pain.
Please ***circle*** the ***number*** below that describes your ***pain*** in the ***past 2 weeks*:**



During the past week, even if it was not a typical week, how much ***total*** time (for the ***entire week***) did you spend on ***each*** of the following?
*Please tick **one** box for **each** question.*

		None	Less than 30 mins/wk	30-60 mins/wk	1-3 hrs per week	More than 3 hrs/wk
		1	2	3	4	5
9.	Stretching or strengthening exercises (range of motion, using weights, etc.) …	☐	☐	☐	☐	☐
10.	Walk for exercise …….....	☐	☐	☐	☐	☐
11.	Swimming or water based activities for exercise ……..…….	☐	☐	☐	☐	☐
12.	Bicycling for exercise (including stationary exercise bikes) ……...	☐	☐	☐	☐	☐
13.	Other exercise equipment that made you huff and puff (step machine, rowing machine etc.) ……..	☐	☐	☐	☐	☐
14.	Other exercise which made you huff and puff …….	☐	☐	☐	☐	☐

Specify: _____

ID: ☐☐☐☐☐☐

When you are feeling down in the dumps, feeling pain or having other unpleasant symptoms, how often do you …
*Please tick **one** box for **each** question.*

		Never 1	Almost never 2	Some times 3	Fairly often 4	Very often 5	Always 6
15.	Try to feel distant from the discomfort and pretend that it is not part of your body?……...…..	☐	☐	☐	☐	☐	☐
16.	Don't think of it as discomfort but as some other sensation, like a warm, numb feeling?…….....	☐	☐	☐	☐	☐	☐
17.	Play mental games or sing songs to keep your mind off the discomfort?....	☐	☐	☐	☐	☐	☐
18.	Practice progressive muscle relaxation?	☐	☐	☐	☐	☐	☐
19.	Practice visualisation or guided imagery, such as picturing yourself somewhere else?…….……..…..	☐	☐	☐	☐	☐	☐
20.	Talk to yourself in positive ways?….....	☐	☐	☐	☐	☐	☐
21.	Do other things to help yourself? …….	☐	☐	☐	☐	☐	☐

*Specify:*_____

_____

***At the moment*, are you able to …**
*Please tick **one** box for **each** question.*

		Without any difficulty 1	With some difficulty 2	With much difficulty 3	Unable to do 4
22.	Dress yourself, including tying shoelaces and doing buttons?…….....	☐	☐	☐	☐
23.	Get in and out of bed?……...	☐	☐	☐	☐
24.	Lift a full cup or glass to your mouth?…..	☐	☐	☐	☐
25.	Walk outdoors on flat ground?……..	☐	☐	☐	☐
26.	Wash and dry your entire body?……...	☐	☐	☐	☐
27.	Bend down to pick up clothing from the floor? ……	☐	☐	☐	☐
28.	Turn taps on and off? ……...……	☐	☐	☐	☐
29.	Get in and out of a car? ……	☐	☐	☐	☐

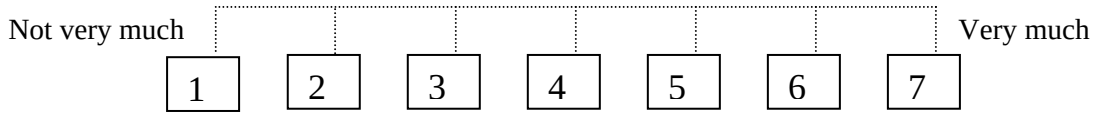
ID: ☐☐☐☐☐☐

The following items ask about how much your condition and/or its treatment interfere with your life. Please mark on the scales below the numbered box that best describes your current life situation.

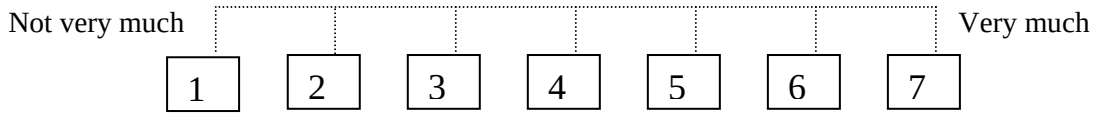
How much does your condition and/or its treatment interfere with:

*Please circle **one** number for **each** question. If an item is not relevant to you, please tick the '**not applicable'** box. Please do not leave any question unanswered.*

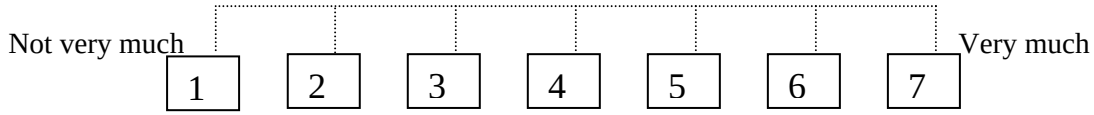
30. Your feeling of being healthy? ☐ Not applicable



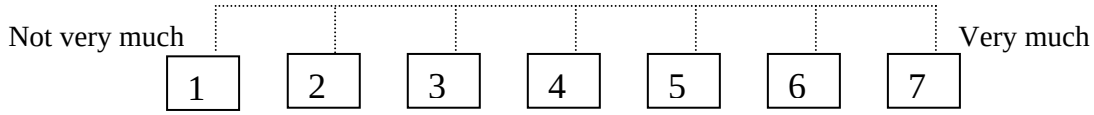
31. The things you eat and drink? ☐ Not applicable



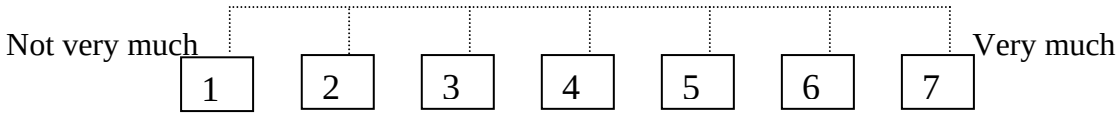
32. Your work, including job, house work, chores, or errands? ☐ Not applicable



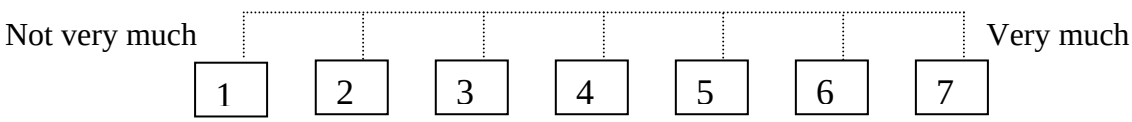
33. Playing sports, gardening, or other physical recreation or hobbies? ☐ Not applicable



34. Quiet recreation or hobbies, such as reading, TV, music, knitting etc.? ☐ Not applicable



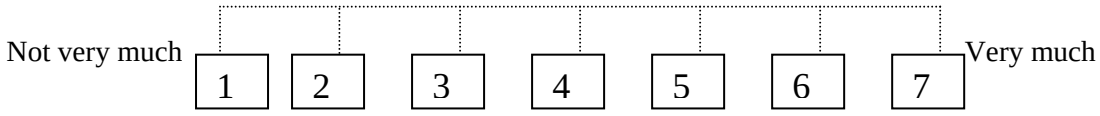
35. Your financial situation? ☐ Not applicable



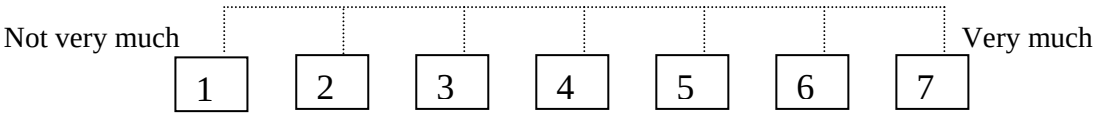
ID: ☐☐☐☐☐☐

How much does your condition and/or its treatment interfere with:

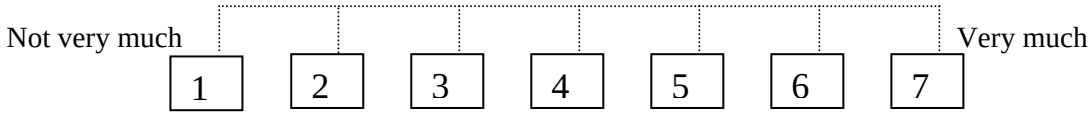
36. Your relationship with your spouse or domestic partner? ☐ Not applicable



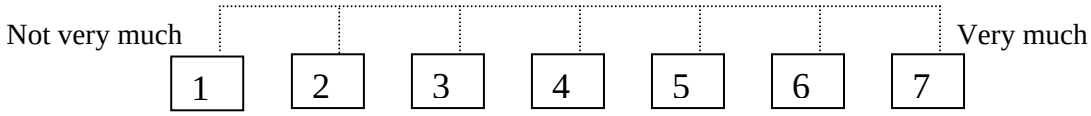
37. Your sex life? ☐ Not applicable



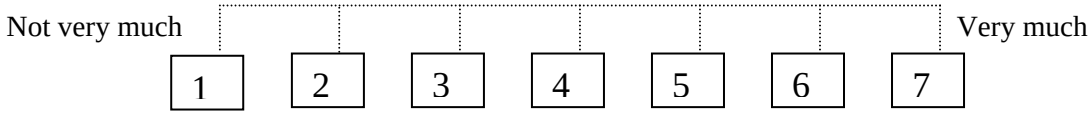
38. Your relationship and social activities with your family? ☐ Not applicable



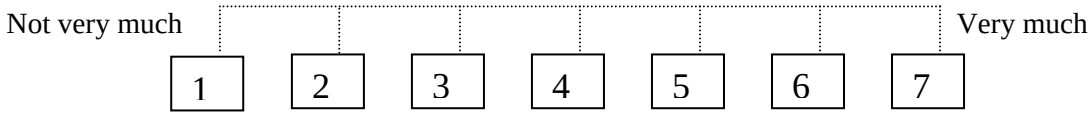
39. Social activities with your friends, neighbours, or groups? ☐ Not applicable



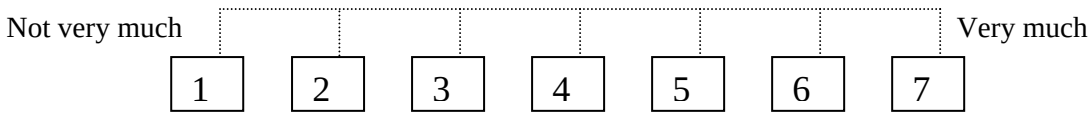
40. Your religious or spiritual activities? ☐ Not applicable



41. Your involvement in community or civic activities? ☐ Not applicable



42. Your self-improvement or self-expression activities? ☐ Not applicable



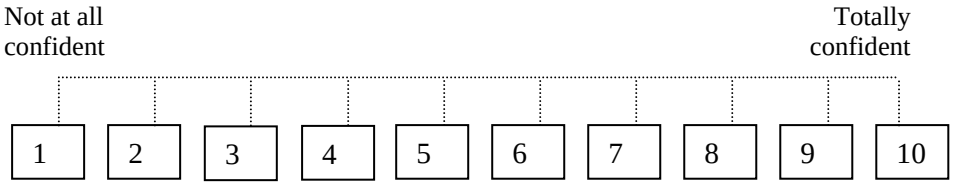
ID: | | | | | | |

You may feel that some of the questions below are not relevant to you. If this is the case, just ask yourself how confident ***would*** you feel in dealing with it if did exist.

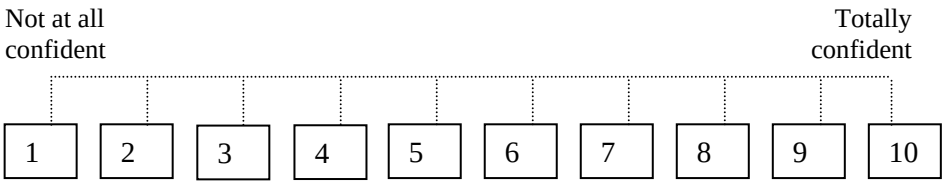
How confident are you that you can …

*For **each** of the following questions, please circle the **one** number that corresponds with your **confidence** that you can do the tasks regularly at the present time.*

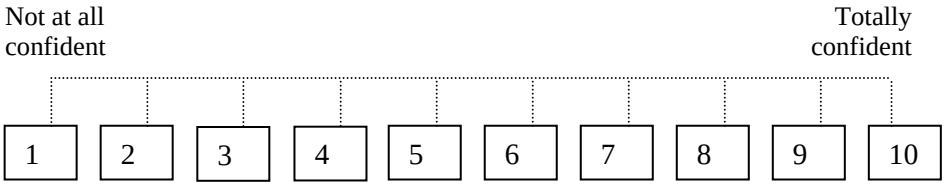
43. Keep the fatigue caused by your condition from interfering with the things you want to do?



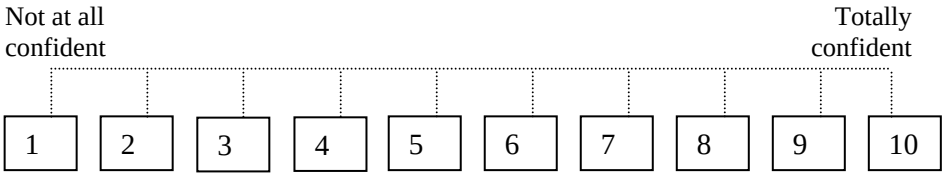
44. Keep the physical discomfort or pain of your condition from interfering with the things you want to do?



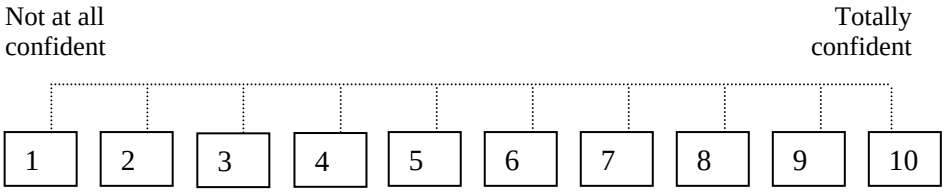
45. Keep the emotional distress caused by your condition from interfering with the things you want to do?



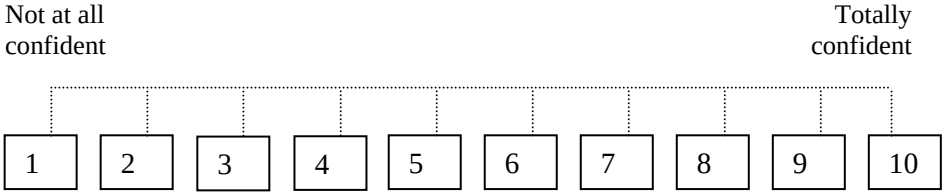
46. Keep any other symptoms or health problems you have from interfering with the things you want to do?



47. Do the different tasks and activities needed to manage your health condition so as to reduce your need to see a doctor?



48. Do things other than just taking medication to reduce how much your condition affects your everyday life?



ID: | | | | | | |

The following questions are about your feelings in the past 4 weeks.

*Please tick **one** box for **each** question.*

	All of the time 1	**Most of the time** 2	**Some of the time** 3	**A little of the time** 4	**None of the time** 5
49. *In the past 4 weeks*, about how often did you feel tired out for no good reason? ……..	☐	☐	☐	☐	☐
50. *In the past 4 weeks*, about how often did you feel nervous? ……..……..	☐	☐	☐	☐	☐
51. *In the past 4 weeks*, about how often did you feel so nervous that nothing could calm you down? …...……..	☐	☐	☐	☐	☐
52. *In the past 4 weeks*, about how often did you feel hopeless? ……...	☐	☐	☐	☐	☐
53. *In the past 4 weeks*, about how often did you feel restless or fidgety? …….....	☐	☐	☐	☐	☐
54. *In the past 4 weeks*, about how often did you feel so restless you could not sit still? ……...……....	☐	☐	☐	☐	☐
55. *In the past 4 weeks*, about how often did you feel depressed? ……..…....	☐	☐	☐	☐	☐
56. *In the past 4 weeks*, about how often did you feel that everything was an effort?..……...	☐	☐	☐	☐	☐
57. *In the past 4 weeks*, about how often did you feel so sad that nothing could cheer you up? ……..	☐	☐	☐	☐	☐
58. *In the past 4 weeks*, about how often did you feel worthless? ……..……...	☐	☐	☐	☐	☐

ID: ☐☐☐☐☐☐

Below are five statements with which you may agree or disagree. For each statement, tick **one** box to show whether you agree or disagree and how strongly you agree or disagree.

*Please tick **one** box for **each** statement*.

	Strongly disagree 1	**Disagree** 2	**Slightly disagree** 3	**Neither agree or disagree** 4	**Slightly agree** 5	**Agree** 6	**Strongly agree** 7
59. In most ways my life is close to ideal. …..	☐	☐	☐	☐	☐	☐	☐
60. The conditions of my life are excellent.	☐	☐	☐	☐	☐	☐	☐
61. I am satisfied with my life. ……	☐	☐	☐	☐	☐	☐	☐
62. So far I have gotten the important things I want in life. ……...	☐	☐	☐	☐	☐	☐	☐
63. If I could live my life over, I would change almost nothing. ……...	☐	☐	☐	☐	☐	☐	☐

In the past **6 months**, how many times have you seen each of the following providers of health services (please also consider home visits)? *Do not include visits while in hospital or to a hospital emergency room.*
(If you have not visited any of the following, simply write "0").

Number of Visits

64. A General Practitioner? …….……...…...…….…… ☐
65. A Specialist? (for example, Cardiologist) ….……... ☐
66. A Practice Nurse or a Community Nurse?……..……... ☐
67. An Aboriginal Health Worker?…….. ☐
68. Another type of health professional? (for example, Podiatrist, Occupational Therapist). …….…….. ☐

ID: ☐☐☐☐☐☐

69. In the past **6 months**, how many times have you been to hospital for **one night or more?**……...……..…..….. (Write "0" if you have not been to hospital). ☐

70. In the past **6 months**, how many times did you go to a hospital accident and emergency or casualty department? . (Write "0" if you have not been to a hospital accident and emergency or casualty department). ☐

71. Are you **currently** receiving help from any community services? (For example, respite care, home help, meals on wheels) …… 1 ☐ **Yes** 2 ☐ **No**

IF YES, how often?
*Please tick **one** box.*

Less than once a week	**Once a week**	**2 –3 times a week**	**Daily**	**More than daily**
1 ☐	2 ☐	3 ☐	4 ☐	5 ☐

Please tell us what these community services are…

Community service 1 _____

Community service 2 _____

Community service 3 _____

72. Are you **currently** going to any self-help / support groups? (For example, Huff and Puff Respiratory Support Group) ……. 1 ☐ **Yes** 2 ☐ **No**

IF YES, please tell us what these are…

Self help / support group 1 _____

Self help / support group 2 _____

Self help / support group 3 _____

IF YES, how did you find out about these self help / support groups?
*Please tick the **appropriate** boxes.*

Friend/Neighbour/Relative ……...	☐	1,2
Health Service Provider ……	☐	1,2
Television/Radio/Newspaper ……	☐	1,2
The Sharing Health Care Initiative ……	☐	1,2
Other …….	☐	1,2

Specify: _____

ID: ☐☐☐☐☐☐

Thank you again for taking the time to complete this questionnaire

Appendix 17

Non-Indigenous Client Service Use Questionnaire

CLIENT SERVICE USE QUESTIONNAIRE

Office Use only:

Identification number: | | | | | | |

Sex: | |
M or F

Date of Birth: | | | | | | | | | |
D D M M Y Y Y Y

Date of recruitment: | | | | | | | | |
D D M M Y Y Y Y

Date of questionnaire completion: | | | | | | | | |
D D M M Y Y Y Y

Administration point:

12 Months……. | |

Client Residential Postcode: | | | | |

Region: | |

In the past **6 months**, how many times have you seen each of the following providers of health services (please also consider home visits)? *Do not include visits while in hospital or to a hospital emergency room.*
If you have not visited any of the following, simply write "0".

Number of Visits

1. A General Practitioner? …….……...…...…….…… ☐
2. A Specialist? (for example, Cardiologist) ….……... ☐
3. A Practice Nurse or a Community Nurse?..……...……... ☐
4. An Aboriginal Health Worker?…….. ☐
5. Another type of health professional? (for example, Podiatrist, Occupational Therapist, Physiotherapist). …….…….. ☐

6. In the past **6 months**, how many times have you been to hospital for **one night or more?**……...……..…...….... ☐
(write "0" if you have not been to the hospital).

7. In the past **6 months**, how many times did you go to a hospital accident and emergency or casualty department?. ☐
(write "0" if you have not been to a hospital accident and emergency or casualty department).

8. Are you **currently** receiving help from any community services? (For example, respite care, home help, meals on wheels) …… 1 ☐ **Yes** 2 ☐ **No**

IF YES, how often?
*Please tick **one** box.*

Less than once a week	**Once a week**	**2 –3 times a week**	**Daily**	**More than daily**
1	2	3	4	5
☐	☐	☐	☐	☐

Please tell us what these community services are…

Community service 1 _____

Community service 2 _____

Community service 3 _____

ID: ☐☐☐☐☐☐

9. Are you **currently** going to any self-help / support groups? (For example, Huff and Puff Respiratory Support Group) ……..

	1	2
	☐ **Yes**	☐ **No**

IF YES, please tell us what these are…

Self help / support group 1 _____

Self help / support group 2 _____

Self help / support group 3 _____

IF YES, how did you find out about these self help / support groups?
*Please tick the **appropriate** boxes.*

Friend/Neighbour/Relative ……...	☐	1,2
Health Service Provider ……	☐	1,2
Television/Radio/Newspaper ……	☐	1,2
The Sharing Health Care Initiative ……	☐	1,2
Other ……..	☐	1,2

Specify: _____

ID: | | | | | | |

Thank you again for taking the time to complete this questionnaire

Appendix 18

Indigenous Client Information Questionnaire – Pika Wiya (SA)

CLIENT INFORMATION QUESTIONNAIRE

	Office Use Only
1. Are you male or female? *Please tick **one** box.* Male …….……...…….…... ☐ Female ……...…..….... ☐	 1 2
2. What is your date of birth? ☐☐ ☐☐ ☐☐☐☐ ***D D M M Y Y Y Y***	

Office Use only:

Identification number: 9 ☐☐☐☐☐

Date of recruitment: ☐☐ ☐☐ ☐☐☐☐
D D M M Y Y Y Y

Date of questionnaire completion: ☐☐ ☐☐ ☐☐☐☐
D D M M Y Y Y Y

Administration point:
(tick appropriate box)

Baseline ……. ☐

Six months ….……..... ☐

Eighteen months or end of project ……..… ☐

Client Residential Postcode: ☐☐☐☐

Region: ☐

Office Use Only

3. Do you speak a language other than English *at home*?
*Please tick **one** box.*

Yes ……..……..……... ☐ 1

No ……... ☐ 2

If Yes, specify: _____

4. Are you of Aboriginal or Torres Strait Islander origin?
*Please tick **one** box.*

Yes, Aboriginal…….…..……...…… ☐ 1

Yes, Torres Strait Islander…….…… ☐ 2

5. What is your present marital status?
*Please tick **one** box.*

Never married ……..…..…… ☐ 1

Widowed …….……. ☐ 2

Divorced ……... ☐ 3

Separated but not divorced ……... ☐ 4

Married (including de facto)…….. ☐ 5

6. If you are female, how many babies have you ever had?
(Include live births only).

☐ ##

If you have had no babies, simply write '0'.

ID: 9 | | | | | |

Office Use Only

7. What is the highest level of primary or secondary school you have completed?

*Please tick **one** box.*

If you have returned after a break to complete your schooling, tick the highest level completed when you last left.

Still at school ……..……..…..…...	☐	1
Did not go to school …….……...….	☐	2
Year 8 or below ……..……...…….....	☐	3
Year 9 or equivalent ……...……..….	☐	4
Year 10 or equivalent ……...…….....	☐	5
Year 11 or equivalent …….……...…....	☐	6
Year 12 or equivalent …….……..	☐	7

8. What is the highest level of qualification that you have completed? For example, TAFE certificate, trade certificate, bachelor degree, associate diploma, correspondence courses, nursing certificate 2, advanced diploma.

1 2 3 4 5 6

9. If you are employed full or part time, what is your occupation?

###

10. If you are retired, what *was* your *main* occupation? That is, the main occupation that you previously spent most time doing.

###

ID: 9 | | | | | |

11. Do you currently receive any of these sources of income?
Answering this question is **OPTIONAL.**

Office Use Only

Please tick the appropriate boxes.

Wages/salary …….	☐	1,2
Australian Age Pension ……..…….…...	☐	1,2
Newstart Allowances …….……..…	☐	1,2
Mature Age Allowance ……..…….……	☐	1,2
Service Pension (DVA) …….…….	☐	1,2
Disability Support Pension (Centrelink) …….	☐	1,2
Wife Pension ……...	☐	1,2
Carer Pension ……..	☐	1,2
Sickness Allowance ……	☐	1,2
Widow Allowance (Widow B Pension) (Centrelink) ……..	☐	1,2
Special Benefit ……	☐	1,2
Partner Allowance. …….	☐	1,2
Youth Allowance ……	☐	1,2
CDEP payment……	☐	1,2
No/none of the above …….	☐	1,2

12. What are your current living arrangements?
*Please tick **one** box.*

I live alone ……...……...	☐	1
I live with family ….……...……	☐	2
I live with others …….…...……..	☐	3

A carer is a person who may be a family member, friend, relative or other

ID: 9 | | | | | |

*who **regularly** helps you **formally or informally** with managing your life.*

Office Use Only

13. Which of the following, best describes your situation?
*Please tick **one** box.*

I have a carer…… ☐ 1

I do not have a carer ……..……..…… ☐ 2

14. Indicate below which chronic condition(s) you have and the ***number of years*** you have had the condition.
*Please tick the **appropriate** box/es.*

Number of years

Diabetes: ……..……..…… ☐ ☐ 1,2

Arthritis, or other joint/bone condition: ……..…..… ☐ ☐ 1,2

Specify _____

Chronic respiratory/lung condition: …….. ☐ ☐ 1,2

Specify _____

Cardiovascular disease (including stroke, high blood pressure and angina) ……..……. ☐ ☐ 1,2

Specify _____

Renal Disease: ……...…… ☐ ☐ 1,2

Specify _____

Depression: …… ☐ ☐ 1,2

Osteoporosis: …..…… ☐ ☐ 1,2

Other chronic condition: ……...……..…….. ☐ ☐ 1,2

Specify: _____

15. Which condition gives you most trouble?

☐ 1
☐ 2
☐ 3
☐ 4
☐ 5
☐ 6
☐ 7
☐ 8

ID: 9 | | | | | |

16. Which of the following best describes your smoking status?
*Please tick **one** box.*

Office Use Only

I smoke daily ……..	☐	1
I smoke occasionally ……...	☐	2
I don't smoke now, but I used to ……...	☐	3
I have tried it a few times, but never smoked regularly ……..	☐	4
I have never smoked ……..	☐	5

17. How often do you have an alcoholic drink of any kind?
This includes wine, beer and spirits.
*Please tick **one** box.*

Every day …….	☐ Go to question 18	01
6 days a week ……..	☐ Go to question 18	02
5 days a week ……..	☐ Go to question 18	03
4 days a week ……..	☐ Go to question 18	04
3 days a week ……..	☐ Go to question 18	05
2 days a week ……..	☐ Go to question 18	06
1 day a week ……	☐ Go to question 18	07
Fortnightly or less ……	☐ Go to question 18	08
Monthly or less ……	☐ Go to question 18	09
I don't drink alcohol ……	☐ Thank you	10

ID: 9 | | | | | |

Alcoholic drinks are measured in terms of a 'standard drink'.

Office Use Only

18. On a day that you have alcoholic drinks, how many standard drinks do you have?

A standard drink is equal to:

1	Schooner of regular beer, ***OR***
1	Pint of light beer, ***OR***
1	Glass of wine, ***OR***
1	Nip of spirits

*Please tick **one** box.*

1 drink ……...……...……..….	☐	01
2 drinks …….....	☐	02
3 to 4 drinks. …….....	☐	03
5 drinks …….……..……..	☐	04
6 drinks……..…….……....….	☐	05
7 to 8 drinks …….....……..…..	☐	06
9 to 12 drinks ……...…….……....	☐	07
13 drinks or more …….……....	☐	08

ID: 9 | | | | | |

Thank you again for taking the time to complete this questionnaire

Appendix 19

Indigenous Client Information Questionnaire – Kalkaringi and Lajamanu (NT)

FORM 1

CLIENT INFORMATION QUESTIONNAIRE

Office use only:

Identification number: ☐☐☐☐☐☐

Date of recruitment: ☐☐ ☐☐ ☐☐☐☐

D D M M Y Y Y Y

Date of questionnaire completion: ☐☐ ☐☐ ☐☐☐☐

D D M M Y Y Y Y

Administration point:
(tick appropriate box)

Baseline……☐

Six months……☐

End of project……☐

Community: 2….☐

3….☐

 ID: ☐☐☐☐☐☐

1) Sex ☐ M or F

2) Date of Birth: ☐☐ ☐☐ ☐☐☐☐

D D M M Y Y Y Y

Age: ☐☐

3) Do you speak a language other than English at home?

Yes……. ☐

No…….. ☐

4) Are you of Aboriginal or Torres Strait Islander origin?

Yes, Aboriginal…….. ☐

Yes, Torres Strait Islander……. ☐

5) What is your present marital status?

Never married…… ☐

Married…….. ☐

Widowed…… ☐

Single again……... ☐

6) If you are female, how many children have you ever had?

If you have had no babies, simply write '0'. ☐

7) How far did you go at school?

Did not go to school……. ☐

Year 1…… ☐

Year 2…… ☐

Year 3…… ☐

Year 4…… ☐

Year 5…… ☐

Year 6…… ☐

Year 7…… ☐

Year 8…… ☐

Year 9…… ☐

Year 10…… ☐

Year 11…… ☐

Year 12…… ☐

8) What is the highest level of qualification that you have completed?

Trade certificate…. ☐

Tafe certificate….. ☐

Bachelor degree…. ☐

Other: ……

9) If you are employed full time, what is your occupation?

……..

10) If you are retired, what was your main occupation? That is the main occupation that you previously spent most time doing?

……..

11) Do you currently receive any of these sources of income?
Answering this question is **OPTIONAL**.

Wages/Salary…….. ☐

Centrelink payment……. ☐

CDEP…….. ☐

Other income…… ☐

No income…… ☐

12) What are your current living arrangements?

I live alone……. ☐

I live with family…… ☐

I live with a friend…….. ☐

13) Do you have people who really look after you?

I do not have a carer…….. ☐

My carer is:

Mother…….. ☐

Father……. ☐

Sister……. ☐

 ID: ☐☐☐☐☐☐

Brother…… ☐

Daughter…… ☐

Son……. ☐

Wife / husband. ☐

Cousin…… ☐

Uncle…….. ☐

Aunty……. ☐

Grandmother.. ☐

Grandfather… ☐

14) Can you tell me which chronic illnesses you have

I don't know……. ☐

Diabetes……. ☐

Cardiovascular (like high blood pressure, stroke, angina)…… ☐

Renal (kidney) disease……. ☐

15) Which one gives you the most trouble?

……

16) About smoking

I smoke every day…… ☐

I only smoke sometimes…… ☐

I don't smoke now, but I used to…… ☐

I have never smoked…… ☐

 ID: ☐☐☐☐☐☐

17) About chewing tobacco

I chew tobacco every day…… ☐

I only chew tobacco sometimes……. ☐

I don't chew tobacco now, but I used to…… ☐

I have never chewed tobacco……. ☐

18) About drinking

I never drink……..…. ☐

I drink sometimes…… ☐

I drink every day…… ☐

I used to drink, but I don't anymore….. ☐

 ID: ☐☐☐☐☐☐

CLIENT INFORMATION QUESTIONNAIRE

Office use only:

Identification number: ☐☐☐☐☐☐

Date of recruitment: ☐☐ ☐☐ ☐☐☐☐

D D M M Y Y Y Y

Date of questionnaire completion: ☐☐ ☐☐ ☐☐☐☐

D D M M Y Y Y Y

Administration point:
(tick appropriate box)

Baseline……☐ Community: ☐

Six months……☐

End of project……☐

1) Sex ☐ M or F

2) Date of Birth: ☐☐ ☐☐ ☐☐☐☐

D D M M Y Y Y Y

Age: ☐☐

3) Do you speak a language other than English at home?

Yes…….☐

No……..☐

4) Are you of Aboriginal or Torres Strait Islander origin?

Yes, Aboriginal……..☐

Yes, Torres Strait Islander…….☐

5) What is your present marital status?

Never married……☐

Married……..☐

Widowed……☐

Single again……...☐

6) If you are female, how many children have you ever had?

If you have had no babies, simply write '0'. ☐

7) How far did you go at school?

Did not go to school……. ☐

Year 1…… ☐

Year 2…… ☐

Year 3…… ☐

Year 4…… ☐

Year 5…… ☐

Year 6…… ☐

Year 7…… ☐

Year 8…… ☐

Year 9…… ☐

Year 10…… ☐

Year 11…… ☐

Year 12…… ☐

8) What is the highest level of qualification that you have completed?

Trade certificate…. ☐

Tafe certificate….. ☐

Bachelor degree…. ☐

Other: ……

9) If you are employed full time, what is your occupation?

……..

10) If you are retired, what was your main occupation? That is the main occupation that you previously spent most time doing?

……..

11) Do you currently receive any of these sources of income?
Answering this question is **OPTIONAL**.

Wages/Salary…… ☐

Centrelink payment…… ☐

CDEP…… ☐

Other income…… ☐

No income…… ☐

12) What are your current living arrangements?

I live alone…… ☐

I live with family…… ☐

I live with a friend……. ☐

13) Do you have people who really look after you?

I do not have a carer…… ☐

My carer is:

Mother…….. ☐

Father……. ☐

Sister……. ☐

Brother…… ☐

 ID: ☐☐☐☐☐☐

Daughter…… ☐

Son……. ☐

Wife / husband. ☐

Cousin…… ☐

Uncle…….. ☐

Aunty……. ☐

Grandmother.. ☐

Grandfather… ☐

14) Can you tell me which chronic illnesses you have

I don't know……. ☐

Diabetes……. ☐

Cardiovascular (like high blood pressure, stroke, angina)….. ☐

Renal (kidney) disease……. ☐

15) Which one gives you the most trouble?

……

16) About smoking

I smoke every day……. ☐

I only smoke sometimes……. ☐

I don't smoke now, but I used to… ☐

I have never smoked……. ☐

 ID: ☐☐☐☐☐☐

17) About chewing tobacco

I chew tobacco every day…… ☐

I only chew tobacco sometimes……. ☐

I don't chew tobacco now, but I used to…… ☐

I have never chewed tobacco……. ☐

18) About drinking

I never drink……..…. ☐

I drink sometimes…… ☐

I drink every day…… ☐

I used to drink, but I don't anymore….. ☐

 ID: ☐☐☐☐☐☐

Appendix 20

Indigenous Client Health Questionnaire – Pika Wiya (SA)

CLIENT HEALTH QUESTIONNAIRE

Office Use only:

Identification number: 9 | | | | | |

Sex: | |

M or F

Date of Birth: | | | | | | | | |

D D M M Y Y Y Y

Date of recruitment: | | | | | | | |

D D M M Y Y Y Y

Date of questionnaire completion: | | | | | | | |

D D M M Y Y Y Y

Administration point:
(tick appropriate box)

Baseline ……. ☐

Six months ……..... ☐

Eighteen months or end of project……..... ☐

Client Residential Postcode: | | | | |

Region: | |

ID: 9 | | | | | |

1. ***In general***, do you think your health is:
*Please tick **one** box.*

Excellent…… ☐ 1

Very Good……. ☐ 2

Good…….. ☐ 3

Fair…… ☐ 4

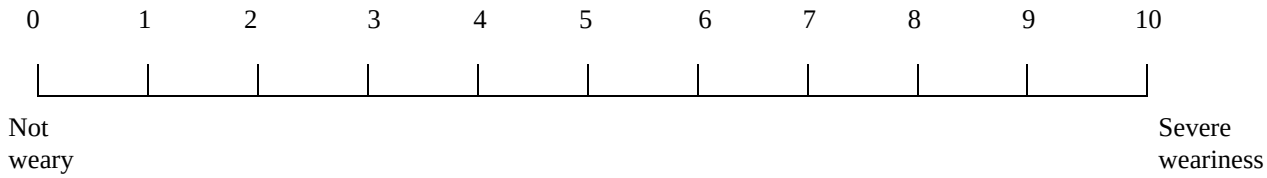
Poor…….. ☐ 5

How much of the time...
*Please tick **one** box for **each** question.*

	None of the time 1	A little of the time 2	Some of the time 3	A good bit of the time 4	Most of the time 5	All of the time 6
2. Are you discouraged by your health problems?……	☐	☐	☐	☐	☐	☐
3. Are you fearful about your future health? ……...….....	☐	☐	☐	☐	☐	☐
4. Is your health a worry in your life? ……..……..……...……	☐	☐	☐	☐	☐	☐
5. Are you frustrated by your health problems? …...……..……	☐	☐	☐	☐	☐	☐

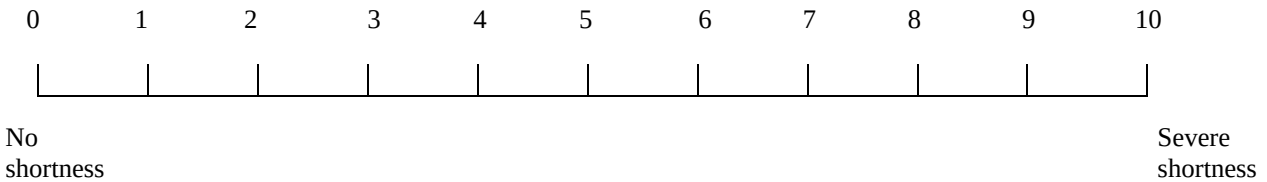
---

6. We are interested in learning whether or not you are affected by tiredness.
Please ***circle*** the number below that describes how ***weary you feel***:



---

7. We are interested in learning whether or not you are affected by shortness of breath.
Please ***circle*** the number below that describes your ***shortness of breath***:

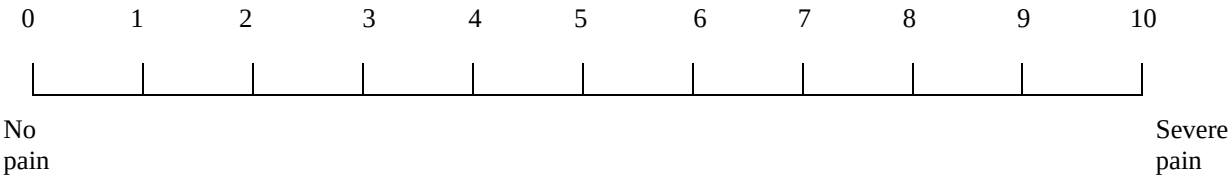


Specify Cause(s): _____

_____

ID: 9 | | | | | |

7. We are interested in learning whether or not you are affected by pain *anywhere in your body.*
Please ***circle*** the ***number*** below that describes your ***pain*****:**



How much time do you spend on ***each*** of the following?
*Please tick **one** box for **each** question.*

		None	Less than 30 mins/wk	30-60 mins/wk	1-3 hrs per week	More than 3 hrs/wk
		1	2	3	4	5
9.	Stretching or strengthening exercises (range of motion, using weights, etc.) ……	☐	☐	☐	☐	☐
10.	Walk for exercise …….....	☐	☐	☐	☐	☐
11.	Other exercise which makes you huff and puff ……. *Specify:* _____	☐	☐	☐	☐	☐

At the moment**,** are you able to …
*Please tick **one** box for **each** question.*

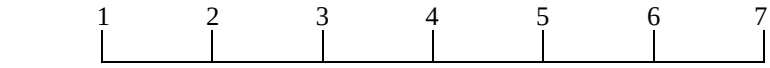
		Without any difficulty	With some difficulty	With much difficulty	Unable to do
		1	2	3	4
12.	Dress yourself, including tying shoelaces and doing buttons?…….	☐	☐	☐	☐
13.	Get in and out of bed?……..……...	☐	☐	☐	☐
14.	Lift a full cup or glass to your mouth?……	☐	☐	☐	☐
15.	Walk outdoors on flat ground?……..…….	☐	☐	☐	☐
16.	Wash and dry your entire body?…….…..……....	☐	☐	☐	☐
17.	Bend down to pick up clothing from the floor? …….	☐	☐	☐	☐
18.	Turn taps on and off? ……...…….	☐	☐	☐	☐
19.	Get in and out of a car? ……	☐	☐	☐	☐

ID: 9 | | | | | |

***How much does your condition and/or its treatment affect**:*

*Please circle **one** number for **each** question. If an item is not relevant to you, please tick the '**not applicable'** box. Please do not leave any question unanswered.*

20. How healthy you feel now? ☐ Not applicable



Not very much — Very much

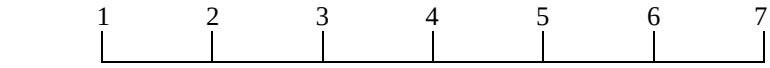
21. The things you eat and drink? ☐ Not applicable

Not very much — Very much

22. Your work, including job, house work, chores, or errands? ☐ Not applicable

Not very much — Very much

23. Playing sports, gardening, or other physical recreation or hobbies? ☐ Not applicable



Not very much — Very much

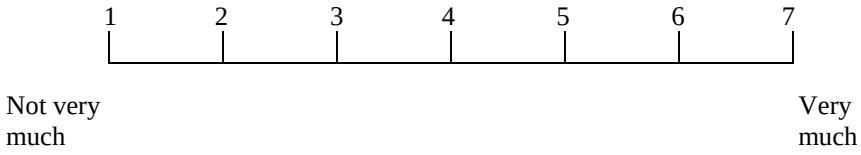
24. Quiet recreation or hobbies, such as reading, TV, music, knitting etc.? ☐ Not applicable

Not very much — Very much

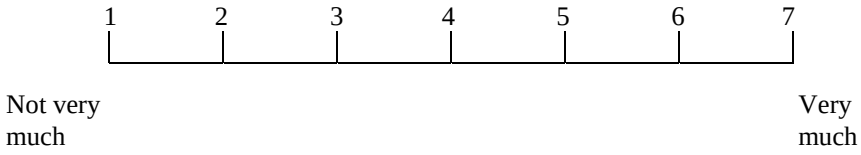
ID: 9 | | | | | |

How much does your condition and/or its treatment affect:

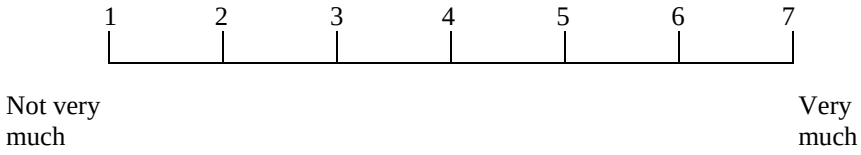
25. Your financial situation? ☐ Not applicable



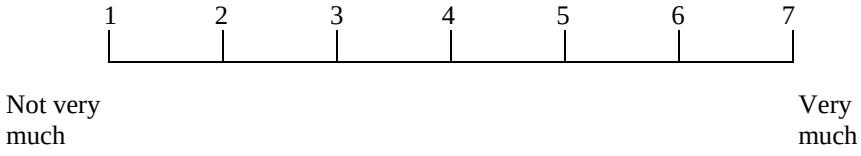
26. Your relationship with your spouse or domestic partner? ☐ Not applicable



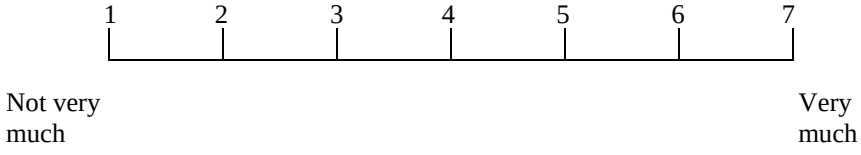
27. Your relationship and social activities with your family? ☐ Not applicable



28. Social activities with your friends, neighbours, or groups? ☐ Not applicable



29. Your religious or spiritual activities? ☐ Not applicable

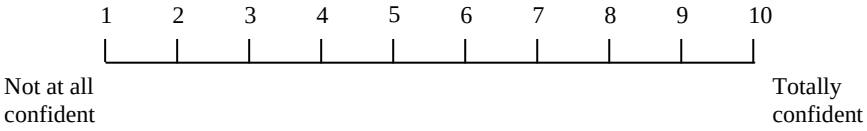


ID: 9 | | | | | |

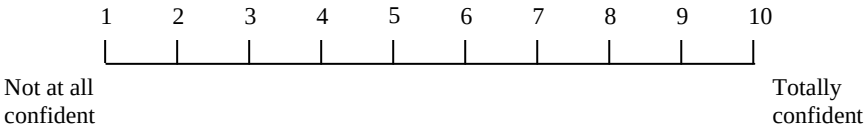
How confident are you that you can …

Please ***circle*** one number for ***each*** question which matches your ***confidence*** about doing these tasks.

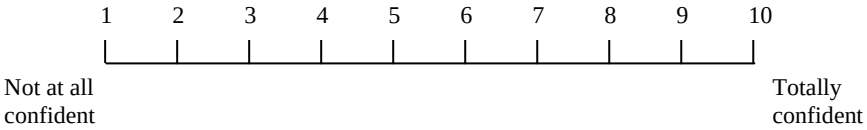
30. Keep the weariness caused by your condition from getting in the way of the things you want to do?



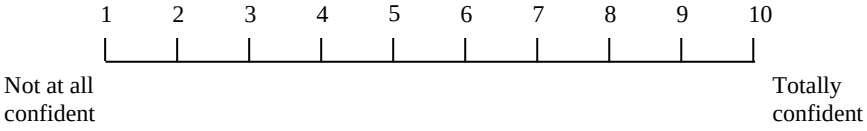
31. Keep the physical discomfort or pain of your condition from getting in the way of the things you want to do?



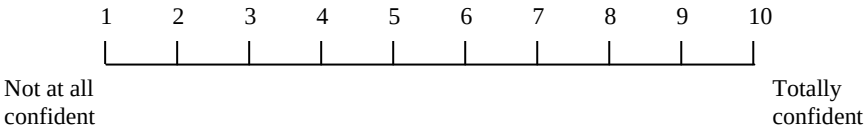
32. Keep the emotional distress (e.g. being angry, down in the dumps, upset) caused by your condition from getting in the way of the things you want to do?



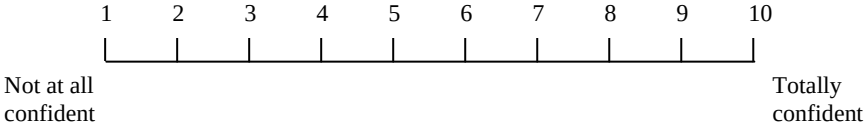
33. Keep any other symptoms or health problems you have from getting in the way of the things you want to do?



34. Do the different tasks and activities (e.g. diet, exercise) needed to manage your health condition so as to reduce your need to see a doctor?



35. Do things other than just taking medication to reduce the effects of your condition on your everyday life (e.g. take bush medicine)?



ID: 9

Thinking about the last **month**, that is since _____[*if helpful, insert appropriate point of reference*], overall how many times did you see each of the following providers of health services (please also consider home visits)? *Do not include visits while in hospital or to a hospital emergency room.*

	More than 5 days a week 1	**4-5 days a week** 2	**2-3 days a week** 3	**About 1 day a week** 4	**2-3 days a month** 5	**About 1 day a month** 6	**Never** 7
36. A General Practitioner?	☐	☐	☐	☐	☐	☐	☐
37. A Specialist? (for example, Cardiologist)	☐	☐	☐	☐	☐	☐	☐
38. A Practice Nurse or a Community Nurse?	☐	☐	☐	☐	☐	☐	☐
39. An Aboriginal Health Worker?	☐	☐	☐	☐	☐	☐	☐
40. Another type of health professional? (for example, Podiatrist, Occupational Therapist, Physiotherapist)	☐	☐	☐	☐	☐	☐	☐

41. In the past **6 months**, how many times have you been to hospital for **one night or more?** (If you have not visited any of the following, simply write "0")…….. ☐

42. In the past **6 months**, how many times did you go to a hospital accident and emergency or casualty department?(If you have not visited any of the following, simply write "0")…... ☐

43. Are you **currently** receiving help from any community services? (For example, respite care, home help, meals on wheels) ……..…… 1 ☐ **Yes** 2 ☐ **No**

IF YES, how often?
*Please tick **one** box.*

Less than once a week 1	**Once a week** 2	**2 –3 times a week** 3	**Daily** 4	**More than daily** 5
☐	☐	☐	☐	☐

Please tell us what these community services are…

Community service 1 _____

Community service 2 _____

Community service 3 _____

ID: 9 | | | | | |

44. Are you **currently** going to any self-help / support groups? (For example, Huff and Puff Respiratory Support Group)……..

1	2
☐ **Yes**	☐ **No**

IF YES, please tell us what these are…

Self help / support group 1 _____

Self help / support group 2 _____

Self help / support group 3 _____

IF YES, how did you find out about these self help / support groups?
*Please tick the **appropriate** boxes.*

Friend/Neighbour/Relative ……...	☐	1,2
Health Service Provider ……	☐	1,2
Television/Radio/Newspaper ……	☐	1,2
The Sharing Health Care Initiative ……	☐	1,2
Other ……..	☐	1,2

Specify: _____

ID: 9 | | | | | |

Thank you again for taking the time to complete this questionnaire

Appendix 21

Indigenous Client Health Questionnaire – Kalkaringi and Lajamanu (NT)

FORM 2

CLIENT HEALTH QUESTIONNAIRE

Office use only:

Identification number: ☐☐☐☐☐☐

Sex ☐ M or F

Date of Birth: ☐☐ ☐☐ ☐☐☐☐

D D M M Y Y Y Y

Age: ☐☐

Date of recruitment: ☐☐ ☐☐ ☐☐☐☐

D D M M Y Y Y Y

Date of questionnaire completion: ☐☐ ☐☐ ☐☐☐☐

D D M M Y Y Y Y

Administration point:
(tick appropriate box)

Baseline……☐ Community: 2….☐

Six months……☐ 3….☐

End of project……☐

 ID: ☐☐☐☐☐☐

1) This is about your health now. Are you feeling

Very, very good…… ☐

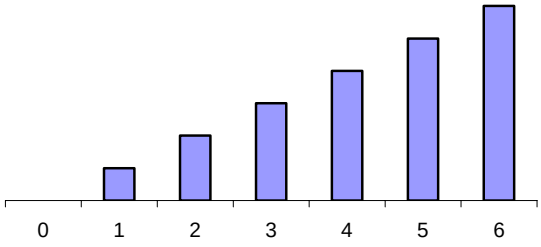
Just good…… ☐

Not so good…….. ☐

	Never 1	A little bit of the time 2	A good bit of the time 3	All the time 4
2) Are you worried about your health life?	☐	☐	☐	☐
3) Are you upset about how you are feeling?	☐	☐	☐	☐
4) Are you fearful about your future health?	☐	☐	☐	☐
5) Are you angry about your health problems?	☐	☐	☐	☐

---

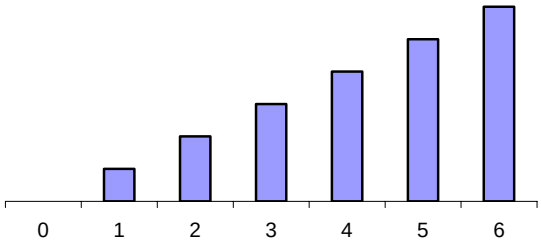
6) Do you get tired?



Not at all Sometimes All the time

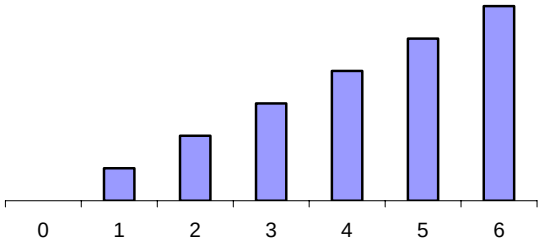
 ID: ☐☐☐☐☐☐

7) Do you get short breath?



Not at all Sometimes All the time

8) Do you get pain sometimes?



No pain Little bit Really bad pain

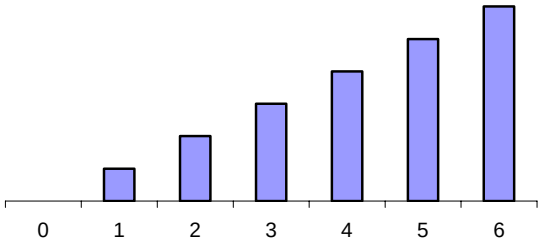
	Not much 1	Sometimes 2	Almost Everyday 3	Everyday 4
9) Do you walk for exercise?	☐	☐	☐	☐

10) How far do you go?
Short way……. ☐
Long way……. ☐

	Not much 1	Sometimes 2	Almost Everyday 3	Everyday 4
11) Do you do other exercise that makes you huff and puff (besides walking)?	☐	☐	☐	☐
12) Do you do things that make you stretch?	☐	☐	☐	☐

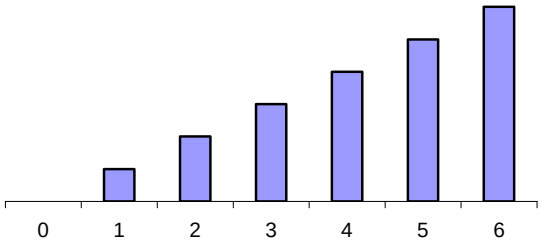
 ID: ☐☐☐☐☐☐

13) How much does your illness or your treatment affect the things you eat and drink (like fruit juice, water, tea)?



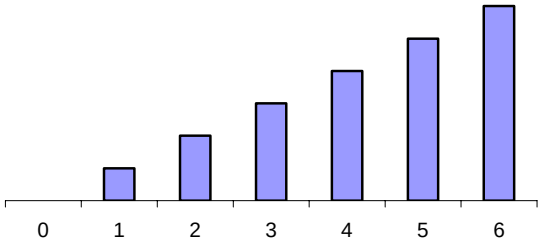
Not at all Sometimes All the time

14) How much does your illness or your treatment affect looking after your family?



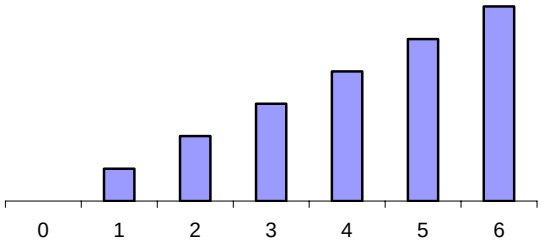
Not at all Sometimes All the time

15) How much does your illness or its treatment affect you playing sports or doing other things you want to do?



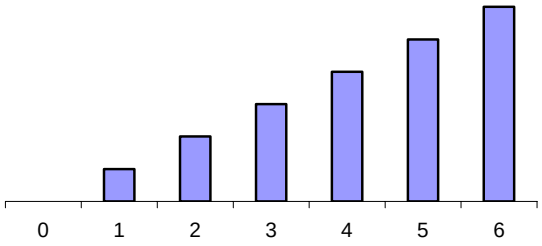
Not at all Sometimes All the time

16) How much does your illness or its treatment affect you when you are relaxing like watching TV?



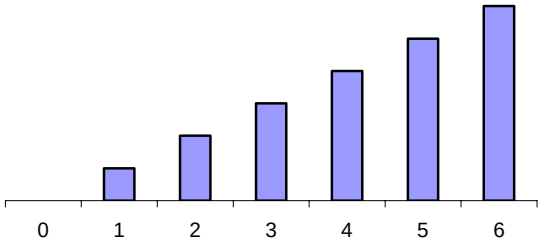
Not at all Sometimes All the time

17) How much does your illness or its treatment affect your financial situation?



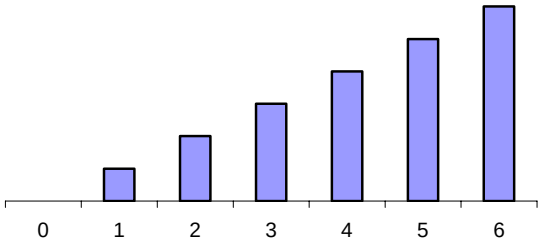
Not at all Sometimes All the time

18) How much does your illness or its treatment affect your relationship with your husband / wife?



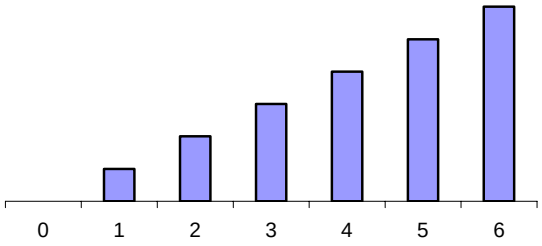
Not at all Sometimes All the time

19) How much does your illness or its treatment affect your relationship with your family?



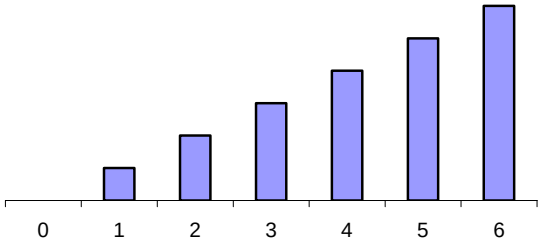
Not at all Sometimes All the time

20) How much does your illness or its treatment affect your relationship with your neighbours?



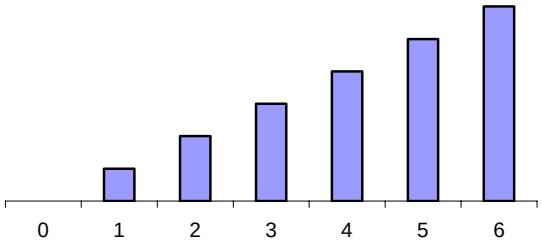
Not at all Sometimes All the time

21) How confident are you that you can stop the tiredness keeping you from the things you want to do?



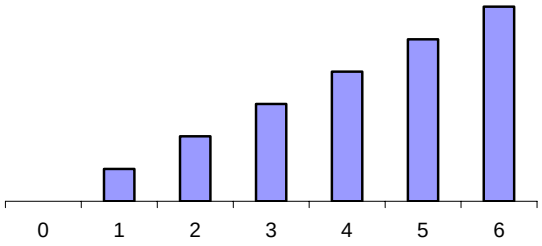
Not at all confident Sometimes confident Totally confident

22) How confident are you that you can keep physically active (like walking and playing with the kids) when you want to?



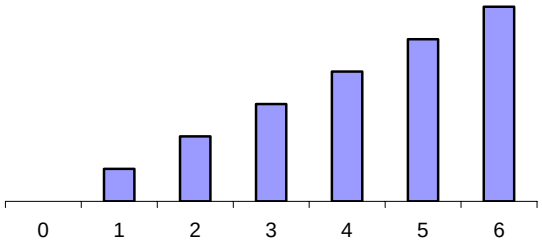
Not at all confident | Sometimes confident | Totally confident

23) How confident are you that you can stop the illness or treatment feeling you down?



Not at all confident | Sometimes confident | Totally confident

24) How confident are you that you can do the different things you need to do to manage your illness?



Not at all confident | Sometimes confident | Totally confident

Thankyou for talking about this with me.

 ID: ☐☐☐☐☐☐

CLIENT HEALTH QUESTIONNAIRE

Office use only:

Identification number: ☐☐☐☐☐☐

Sex ☐ M or F

Date of Birth: ☐☐ ☐☐ ☐☐☐☐

D D M M Y Y Y Y

Age: ☐☐

Date of recruitment: ☐☐ ☐☐ ☐☐☐☐

D D M M Y Y Y Y

Date of questionnaire completion: ☐☐ ☐☐ ☐☐☐☐

D D M M Y Y Y Y

Administration point:
(tick appropriate box)

Baseline……☐

Six months……☐ Community: ☐

End of project……☐

1) This is about your health now. Are you feeling

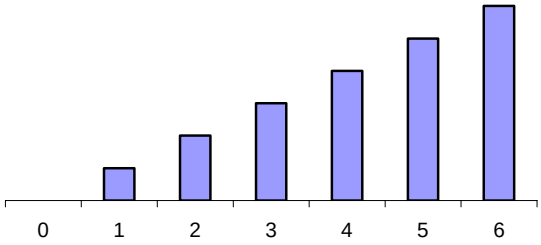
Much, much good……. ☐

Just OK…….. ☐

Not so good…….. ☐

	Never 1	A little bit of the time 2	A good bit of the time 3	All the time 4
2) Is your health a worry in your life?	☐	☐	☐	☐
3) Are you upset by your health problems?	☐	☐	☐	☐
4) Are you fearful about your future health?	☐	☐	☐	☐
5) Are you fed up by your health problems?	☐	☐	☐	☐

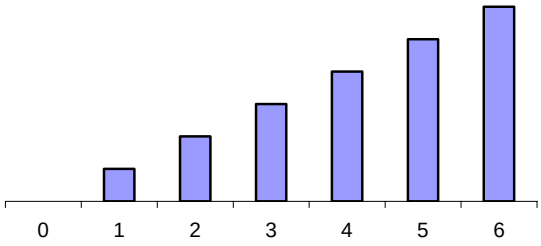
6) Do you get tired?



Not at all All the time

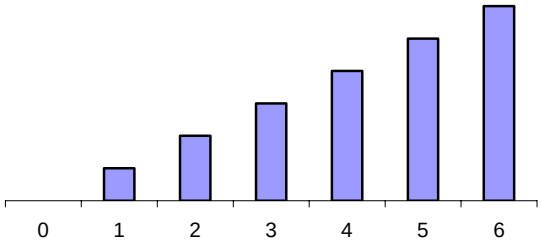
 ID: ☐☐☐☐☐☐

7) Do you get short breath?



Not at all All the time

8) Do you get pain sometimes?



No pain Really bad pain

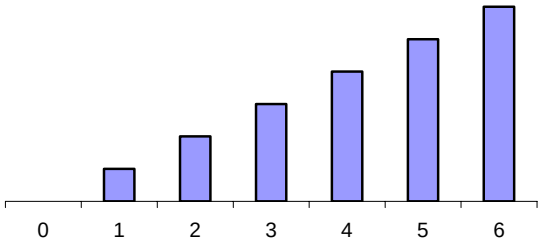
	Not much	Sometimes	Almost Everyday	Everyday
	1	2	3	4
9) Do you walk for exercise?	☐	☐	☐	☐

10) How far do you go?
Short way……. ☐
Long way……. ☐

	Not much	Sometimes	Almost Everyday	Everyday
	1	2	3	4
11) Do you do other exercise that makes you huff and puff (besides walking)?	☐	☐	☐	☐
12) Do you do things that make you stretch?	☐	☐	☐	☐

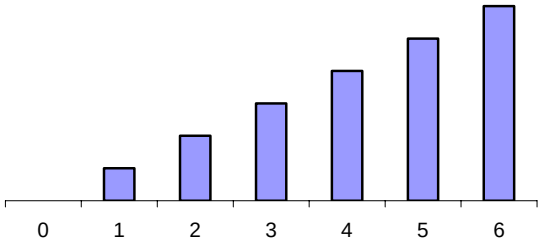
 ID: ☐☐☐☐☐☐

13) How much does your illness or your treatment affect the things you eat and drink?



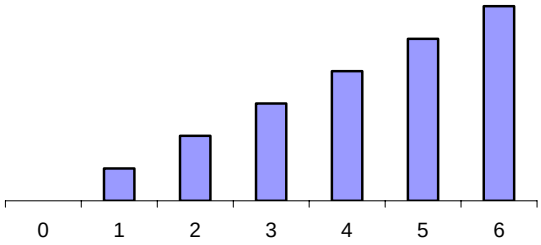
Not at all Lots

14) How much does your illness or your treatment affect you looking after your family?



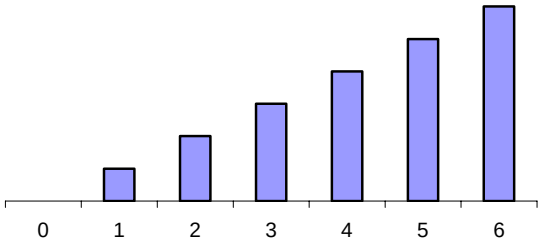
Not at all Lots

15) How much does your illness or your treatment affect you playing sports or doing other things you want to do?



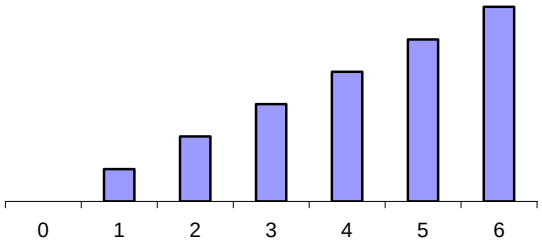
Not at all Lots

16) How much does your illness or your treatment affect you doing quiet activities (like watching TV)?



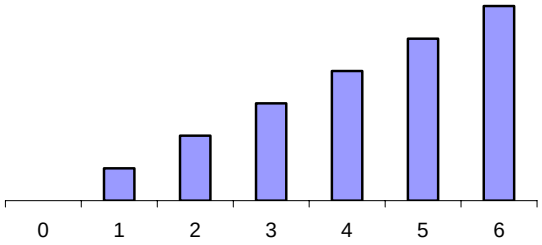
Not at all Lots

17) How much does your illness or your treatment affect your financial situation?



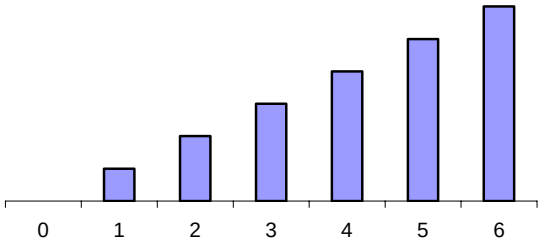
Not at all Lots

18) How much does your illness or your treatment affect your relationship with your husband / wife?



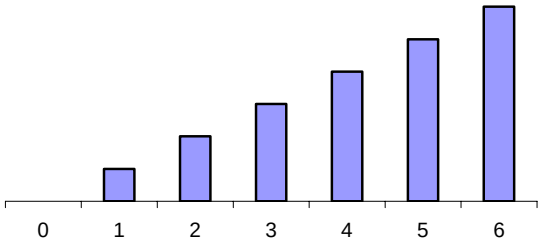
Not at all Lots

19) How much does your illness or your treatment affect your relationship with your family?



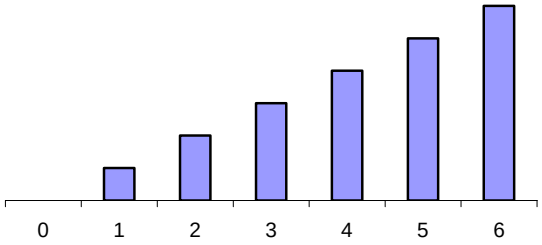
Not at all Lots

20) How much does your illness or your treatment affect your relationship with your neighbours?



Not at all Lots

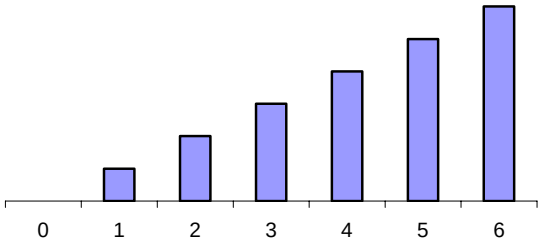
21) How confident are you that you can stop the tiredness keeping you from the things you want to do?



Not at all confident Totally confident

 ID: ☐☐☐☐☐☐

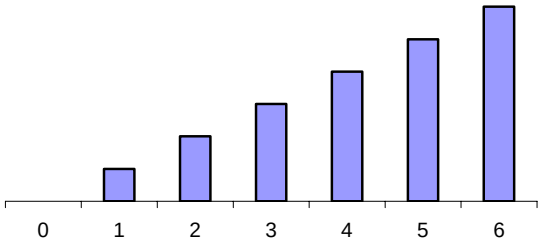
22) How confident are you that you can keep physically active (like walking and playing with the kids) when you want to?



Not at all confident

Totally confident

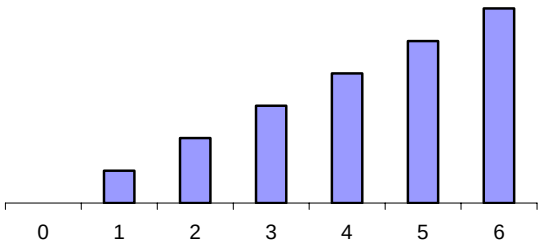
23) How confident are you that you can stop the illness or treatment getting you down?



Not at all confident

Totally confident

24) How confident are you that you can do the different things you need to do to manage your illness?



Not at all confident

Totally confident

Thankyou for talking about this with me.

Appendix 22

Indigenous Client Service Use Questionnaire – Pika Wiya (SA)

CLIENT SERVICE USE QUESTIONNAIRE

Office Use only:

Identification number: 9 | | | | | |

Sex: | |

M or F

Date of Birth: | | | | | | | | |

D D M M Y Y Y Y

Date of recruitment: | | | | | | | | |

D D M M Y Y Y Y

Date of questionnaire completion: | | | | | | | | |

D D M M Y Y Y Y

Administration point:

12 Months……. |

Client Residential Postcode: | | | | |

Region: |

Thinking about the last **month**, that is since _____[*if helpful, insert appropriate point of reference*], overall how many times did you see each of the following providers of health services (please also consider home visits)? *Do not include visits while in hospital or to a hospital emergency room.*

	More than 5 days a week 1	**4-5 days a week** 2	**2-3 days a week** 3	**About 1 day a week** 4	**2-3 days a month** 5	**About 1 day a month** 6	**Never** 7
1. A General Practitioner?	☐	☐	☐	☐	☐	☐	☐
2. A Specialist? (for example, Cardiologist)	☐	☐	☐	☐	☐	☐	☐
3. A Practice Nurse or a Community Nurse?	☐	☐	☐	☐	☐	☐	☐
4. An Aboriginal Health Worker?	☐	☐	☐	☐	☐	☐	☐
5. Another type of health professional? (for example, Podiatrist, Occupational Therapist, Physiotherapist)	☐	☐	☐	☐	☐	☐	☐

6. In the past **6 months**, how many times have you been to hospital for **one night or more?** (If you have not visited any of the following, simply write "0")…….. ☐

7. In the past **6 months**, how many times did you go to a hospital accident and emergency or casualty department?(If you have not visited any of the following, simply write "0")…... ☐

8. Are you **currently** receiving help from any community services? (For example, respite care, home help, meals on wheels) ……..…… 1 ☐ **Yes** 2 ☐ **No**

IF YES, how often?
*Please tick **one** box.*

Less than once a week 1	**Once a week** 2	**2 –3 times a week** 3	**Daily** 4	**More than daily** 5
☐	☐	☐	☐	☐

Please tell us what these community services are…

Community service 1 _____

Community service 2 _____

Community service 3 _____

9					

9. Are you **currently** going to any self-help / support groups? (For example, Huff and Puff Respiratory Support Group)…….. 1 ☐ **Yes** ☐ **No**

IF YES, please tell us what these are…

Self help / support group 1 _____

Self help / support group 2 _____

Self help / support group 3 _____

IF YES, how did you find out about these self help / support groups?
*Please tick the **appropriate** boxes.*

Friend/Neighbour/Relative ……...	☐	1,2
Health Service Provider ……	☐	1,2
Television/Radio/Newspaper ……	☐	1,2
The Sharing Health Care Initiative ……	☐	1,2
Other ……..	☐	1,2

Specify: _____

9					

Thank you again for taking the time to complete this questionnaire

Appendix 23

Indigenous Client Service Use Questionnaire – Kalkaringi and Lajamanu (NT)

FORM 3

CLIENT SERVICE USE QUESTIONNAIRE

Office use only:

Identification number: ☐☐☐☐☐☐

Sex ☐ M or F

Date of Birth: ☐☐ ☐☐ ☐☐☐☐

D D M M Y Y Y Y

Age: ☐☐

Date of recruitment: ☐☐ ☐☐ ☐☐☐☐

D D M M Y Y Y Y

Date of questionnaire completion: ☐☐ ☐☐ ☐☐☐☐

D D M M Y Y Y Y

Administration point:
(tick appropriate box)

Baseline……☐ Community: 2…..☐

Six months……☐ 3…..☐

End of project……☐

 ID: ☐☐☐☐☐☐

1) Have you been to the clinic during the past six months?

Yes…… ☐

No…….. ☐

If yes, how often have you been?

……..

2) Have you been treated in a hospital in the last six months?

Yes…… ☐

No…….. ☐

If yes, which one?

Katherine……. ☐

Darwin…… ☐

Adelaide……. ☐

How often have you been there?

……

3) Do you get any help from

Meals on wheels…….. ☐

Aged care…… ☐

How often?

……

 ID: ☐☐☐☐☐☐

4) Are you going to any self-help / support groups?

Yes…… ☐

No…….. ☐

If yes, which one?

…….

How did you find out about this group?

Friend…… ☐

Family…… ☐

Clinic…… ☐

Ngali-wa-ma ngunalu karra-wurru punyuk jangang-nura-malung workers… ☐

Other…… ☐

 ID: ☐☐☐☐☐☐

FORM 3

CLIENT SERVICE USE QUESTIONNAIRE

Office use only:

Identification number: ☐☐☐☐☐☐

Sex ☐ M or F

Date of Birth: ☐☐ ☐☐ ☐☐☐☐

D D M M Y Y Y Y

Age: ☐☐

Date of recruitment: ☐☐ ☐☐ ☐☐☐☐

D D M M Y Y Y Y

Date of questionnaire completion: ☐☐ ☐☐ ☐☐☐☐

D D M M Y Y Y Y

Administration point:
(tick appropriate box)

Baseline……☐ Community: 2…..☐

Six months……☐ 3…..☐

End of project……☐

1) Have you been to the clinic during the past six months?

Yes…… ☐

No…….. ☐

If yes, how often have you been?

……..

2) Have you been treated in a hospital in the last six months?

Yes…… ☐

No…….. ☐

If yes, which one?

Katherine……. ☐

Darwin…… ☐

Adelaide……. ☐

How often have you been there?

……

3) Do you get any help from

Meals on wheels…….. ☐

Aged care…… ☐

How often?

……

 ID: ☐☐☐☐☐☐

4) Are you going to any self-help / support groups?

Yes…… ☐

No…….. ☐

If yes, which one?

…….

How did you find out about this group?

Friend…… ☐

Family…… ☐

Clinic…… ☐

Ngali-wa-ma ngunalu karra-wurru punyuk jangang-nura-malung workers… ☐

Other…… ☐

 ID: ☐☐☐☐☐☐

Appendix 24

Client Intervention Schedule

Individual client experience post recruitment and client attrition.
State:

	Intervention received by client																											Reason for client attrition		
Client ID	Self-management/ action plan			EPC Care Plan			EPC care plan follow-up			Non EPC Care Plan			Non EPC care plan follow-up			Lorig training			Lorig group or Lorig one-on-one			Other education and training			Support from project provided			Dropped out of project	Dropped out of evaluation, but remains in the project	Unknown (Missing)
	Yes	No	Don't know	Yes	No	Don't know	Yes	No	Don't know	Yes	No	Don't know	Yes	No	Don't know	Yes	No	Don't know	Group	1 on 1	Don't know	Yes	No	Don't know	Yes	No	Don't know			
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Appendix 25

Non-Indigenous process mapping thematic analysis

Thematic analysis of client Process Models at baseline

The thematic analysis identified common themes within each of the processes to capture:

- variability both within a given Model and within a given DP
- similarity both within a given Model and within a given DP.

For each of identified theme, a four-way classification was developed based upon the process mapping, and the DPs were then plotted along this continuum.

Examples are identified below, highlighting where variation and similarity existing within each of the four Models. As there was only one DP in Model D, examples of variation and similarity within the Model were not applicable.

The examples of variation and similarity in process that are provided below are examples of where the DPs within a given Model were most similar, or where there was the greatest amount of variation in process.

Process Model A

Variation within Process Model A

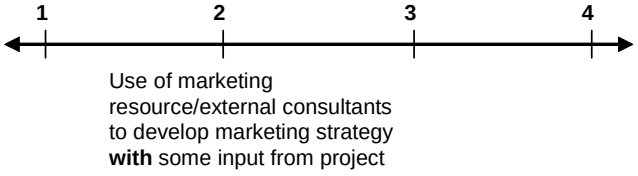
Theme: Support from SM personnel – nature of support

- Some DPs in Model A were at one end of the spectrum where the structure and regularity of formal support was based upon a set policy/framework that was offered to all clients. There was evidence that a plan was in place and this was communicated to all clients. The other DPs in Model A were at the other end of the spectrum where there was no structure for the type or regularity of support offered to clients, and support occurred on an ad hoc basis.

Similarity within Process Model A

Theme: Marketing approach – strategy and implementation

- All DPs in Model A used a dedicated marketing resource (outside of the project team) or an external consultant to develop the marketing strategy, with some input from project staff.

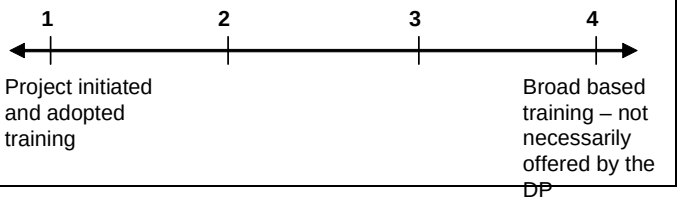


Process Model B

Variation within Process Model B

Theme: Education and training of SM personnel – basis of training

- Within Model B, some of the DPs were at one end of the spectrum whereby all the training that was provided to SM personnel was project based (i.e. project initiated and adopted), the remaining DPs were at the other end of the spectrum where the training offered was broadly based as

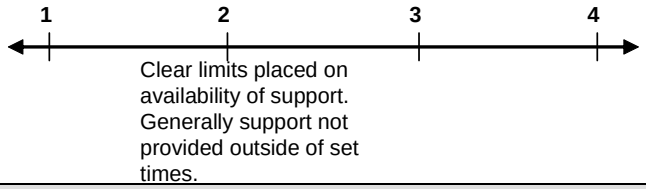


indicated by the degree of choice available. This training was not necessarily offered specifically by the project, but was a reflection of what was available in the community in which the DP operated.

Similarity within Process Model B

Theme: Support from SM personnel - support availability

- All DPs in Model B, placed clear limits either formally or informally on the availability of support to clients and in the majority of cases it was never provided outside of the set times defined by the DPs.

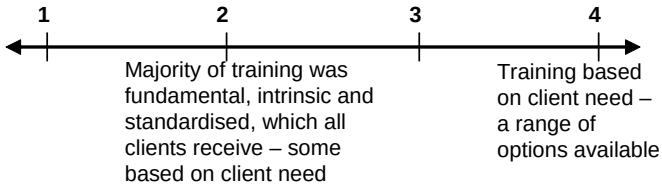


Process Model C

Variation within Process Model C

Theme: Education and training of clients – determinants of client training

- Some DPs in Model C were at one end of the spectrum for determinants of client training, where the majority of education and training of clients was fundamental, intrinsic and standardised to the DP, which all clients received – with some components being based on client need. At the other end of the spectrum, the remaining DPs offered education and training to clients that was based upon client need, with a range of education and training options available.

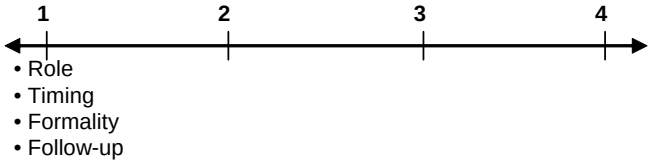


Similarity within Process Model C

Theme: Care planning – role, timing, formality and follow-up

For all DPs in Model C:

- The role of care planning was an intrinsic part of the project, where all clients received a care plan
- All of the care plan was completed at the time of recruitment
- A set framework and qualification for MBS was followed for each client
- There was a set follow-up procedure that was intrinsic to the care planning process.



Thematic analysis of client Process Models at middle measurement point

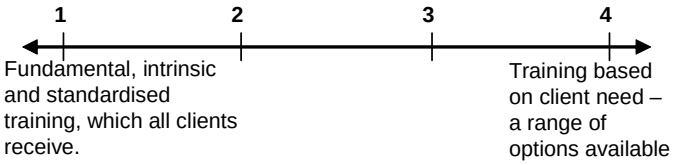
As there was only one DP in Model D and Model Cii, examples of variation and similarity within the Model are not applicable.

Process Model A

Variation within Process Model A

Theme: Education and training of clients - determinants of client training

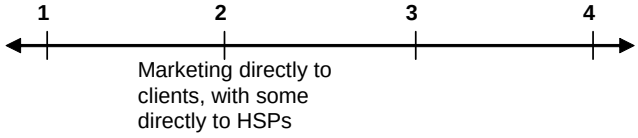
- Some DPs in Model A were at one end of the spectrum for determinants of client training, where education and training of clients was a fundamental, intrinsic and standardised activity that all clients received. The remaining DPs were at the other end of the spectrum education and training was based upon client need with a range of education and training options available.



Similarity within Process Model A

Theme: Marketing – focus (direct/indirect)

- The marketing focus of all DPs in Model A was on marketing directly to clients, with some direct marketing to HSPs.

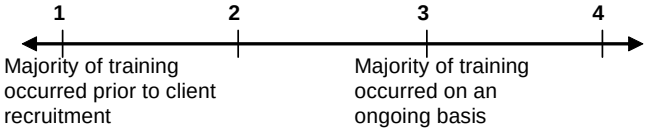


Process Model B

Variation within Process Model B

Theme: Education and training of SM personnel

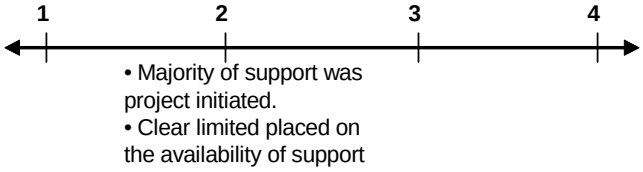
- In Model B, some DPs were at one end of the spectrum for the education and training of SM personnel whereby all training of SM personnel occurred before the recruitment of clients to the program. The remaining DPs were further along the spectrum indicating that the majority of the training occurred on an ongoing basis (post the recruitment of clients) with some occurring pre-client recruitment.



Similarity within Process Model B

Theme: Support from SM personnel – initiated and support availability

- For all DPs in Model B, support was generally initiated by the DP, with some being initiated from client requests. Clear limits were placed on the availability of support, and in the majority of cases support was not provided outside of the set times.

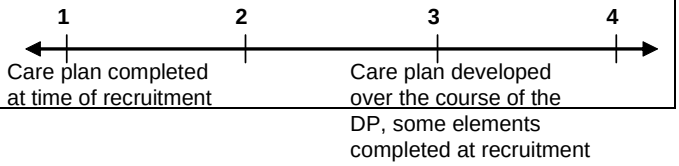


Process Model Ci

Variation within Process Model Ci

Theme: Care planning - timing

- In Model Ci, some projects were at one end of the spectrum for the timing of care plans, where the entire care plan was completed at the time of recruitment. The

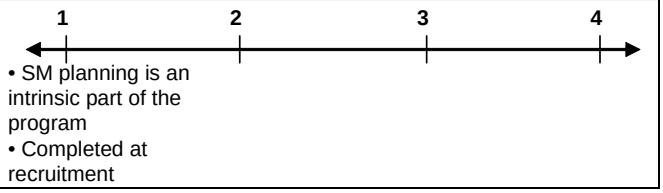


remaining DPs were further along the spectrum indicating that elements of the care plan were completed at the time of recruitment, with the remainder being developed and refined over the course of the DP.

Similarity within Process Model Ci

Theme: SM planning – role and timing

- For all DPs in Model Ci, SM planning was an intrinsic part of the program, where all clients in the DP received a SM plan which was completed at the time of recruitment.



Thematic analysis of client Process Models at last measurement point

As there was only one DP in Model D, examples of variation and similarity within the Model are not applicable.

Process Model A

Variation within Process Model A

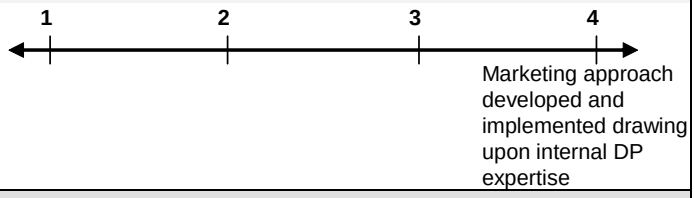
Theme: Education and training of clients - determinants of client training

- See thematic analysis of client Process Model at the middle measurement point.

Similarity within Process Model A

Theme: Marketing approach – strategy and implementation

- For all DPs in Model A, the marketing strategy was devised drawing upon the internal expertise of the DP to develop it and implement it at the last measurement point.

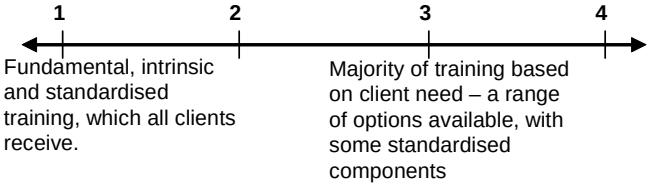


Process Model B

Variation within Process Model B

Theme: Education and training of clients - determinants of client training

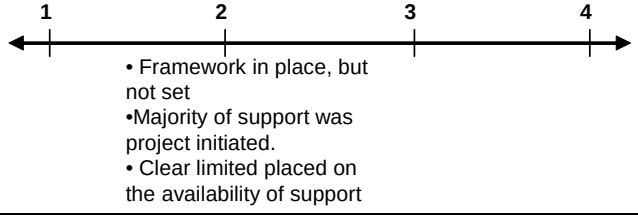
- For some DPs in Model B education and training was a fundamental, intrinsic and standardised activity that all clients received. Further along the spectrum, the remaining DPs in Model B provided training based upon client need with a range of education/training options available, with some standardised components that all clients received.



Similarity within Process Model B

Theme: Support from SM personnel – nature, initiated and support availability

- For all DPs in Model B, the nature of support was quite formal (i.e. a framework was in place, but may not always be followed), support was generally initiated by the DP, with some being initiated from client requests. Clear limits were placed on the availability of support, and in the majority of cases support was not provided outside of



the set times.

Process Model C

Variation within Process Model C

Theme: Care planning - timing

- See thematic analysis of client Process Model at the middle measurement point.

Similarity within Process Model C

Theme: SM planning – role and timing

- See thematic analysis of client Process Model at the middle measurement point.

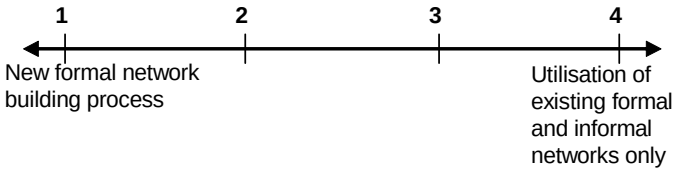
Thematic analysis of HSP Process Models at baseline

Process Model A

Variation within Process Model A

Theme: Recruitment of GPs - approach

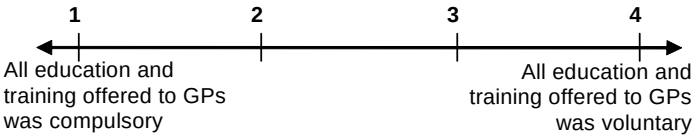
- For some DPs in Model A, the approach to developing relationships with GPs for recruitment purposes required the DPs to undertake a new formal network building process 'from scratch' (i.e. potential GP partnerships were identified in an objective and structured format). The remaining DPs were further along the spectrum, indicating that they utilised existing formal and informal networks only.



Variation within Process Model A

Theme: Education and training of HSPs – participation of GPs

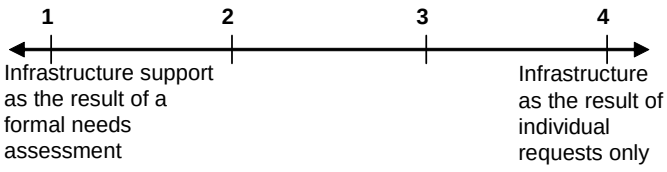
- In Model A, at one end of the spectrum the education and training is compulsory for those GPs who have been recruited to the DP, whilst some DPs are at the other end of the spectrum indicating that all education and training offered to GPs was voluntary.



Variation within Process Model A

Theme: Support from SM personnel – infrastructure

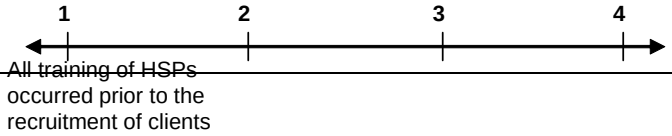
- For some DPs in Model A the infrastructure support from the DPs was a result of a formal needs analysis, whilst for those DPs at the other end of the spectrum, infrastructure support to HSPs was the result of individual requests only.



Similarity within Process Model A

Theme: Education and training - timing

- For all DPs in Model A, the timing of the education and training of HSPs occurred prior to the recruitment of



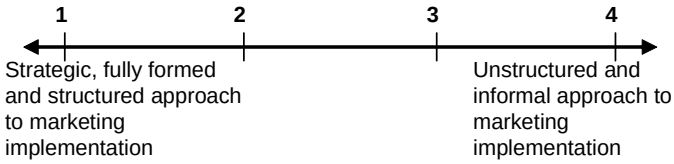
clients to the programs.

Process Model B

Variation within Process Model B

Theme: Marketing – mechanism

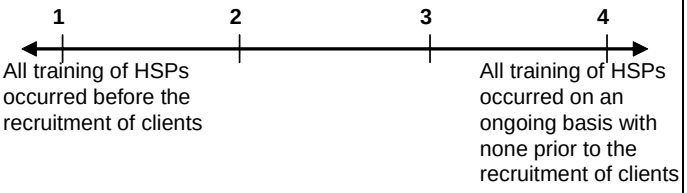
- For some DPs in Model B, the overarching approach to marketing the program to HSPs involved a fully formed strategic approach to marketing implementation as indicated by the following: evidence of a marketing strategy; marketing implementation in line with the strategy; evidence of the marketing strategy being monitored, reviewed and updated; and full documentation of the process. Those DPs at the other end of the spectrum undertook an informal and unstructured approach to marketing implementation as indicated by: a non-systematic/unstructured marketing strategy; informal methods of marketing; and methods of marketing dependent on informal relationships between the DP and HSPs.



Variation within Process Model B

Theme: Education and training – timing

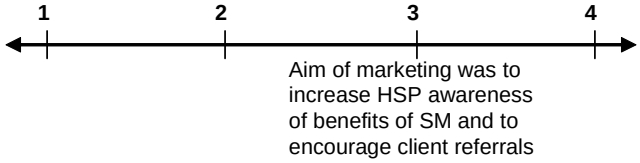
- In Model B, the education and training of HSPs for some DPs occurred prior to the recruitment of clients, whilst some of the other DPs were further along the spectrum indicating that the training of HSPs occurred on an ongoing basis, with none being provided prior to the recruitment of clients.



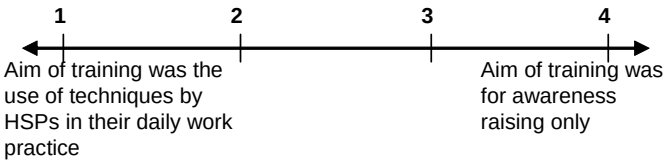
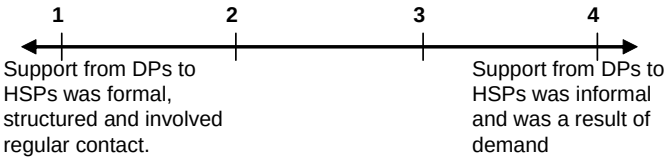
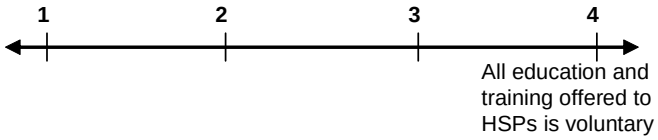
Similarity within Process Model B

Theme: Marketing - purpose

- For all DPs in Model B, the purpose of the marketing strategy was to increase awareness amongst the HSP community of the benefits of SM and to also encourage HSP to refer clients to the DP.



Thematic analysis of HSP Process Models at middle measurement point

Process Model	
Variation within Process Model *Theme:* Education and training of HSPs – aim of training • In Model A, the aim of education and training of HSPs for some DPs was for use of SM techniques within their daily work practice as active and integral members of the program. At the other end of the spectrum, the aim of HSP education and training was for awareness raising only, without the expectation that SM techniques would be adopted.	
Variation within Process Model *Theme:* Support from SM personnel – the type of support • Some of the DPs in Model A were at one end of the spectrum for type of support from SM personnel indicating that support offered to HSPs was formal, structured, planned and resulted in regular contact. Those DPs at the other end of the spectrum, offered informal support which was less regular and occurred as a result of demand.	
Similarity within Process Model *Theme:* Education and training – participation of HSPs • For all DPs in Model A, the participation of HSPs in all education and training is voluntary.	

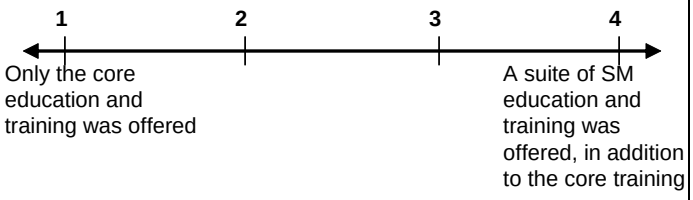
Thematic analysis of HSP Process Models at last measurement point

Process Model A

Variation within Process Model

Theme: Education and training – type of training

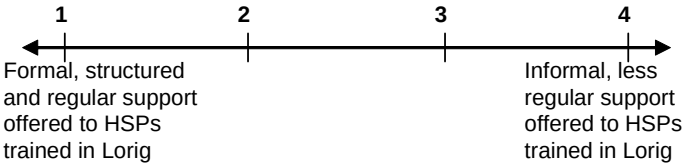
- Within Model A, some DPs were at one end of the spectrum indicating that only core education and training was being offered to HSPs (e.g. Lorig, Flinders, and RACGP). For those DPs at the other end of the spectrum, the type of education and training offered to HSPs included a complete suite of SM education and training, in addition to the core training.



Variation within Process Model

Theme: Support from SM personnel - Lorig

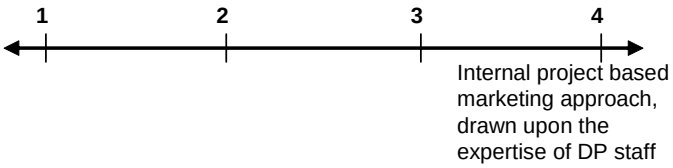
- Some of the DPs in Model A were at one end of the spectrum for Lorig support from the DP, indicating that formal, structured and regular support is offered to those HSPs trained as Lorig leaders. At the other end of the spectrum, those DPs offered informal support to those HSPs trained as Lorig leaders and occurred on a more impromptu basis.



Similarity within Process Model

Theme: Marketing - implementation

- At the last measurement point, the implementation of the marketing approach for all DPs in Model A was internal project based and dew upon the internal expertise of the group to implement the marketing strategy.



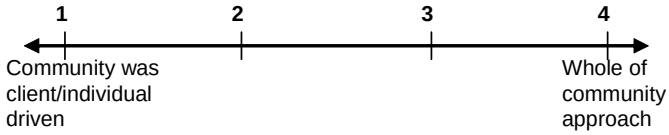
Thematic analysis of community Process Model at baseline

Process Model

Variation within Process Model

Theme: Definition of community – scope

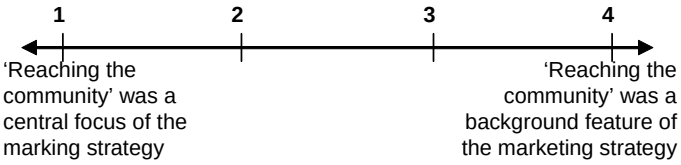
- How the DPs defined community resulted in some DPs being at one end of the spectrum indicating that their definition of community were those current/potential clients/consumers who could benefit from SM (i.e. it was client/individual driven). Those DPs who were at the other end of the spectrum had a whole of community approach.



Variation within Process Model

Theme: Marketing strategy – DP goals

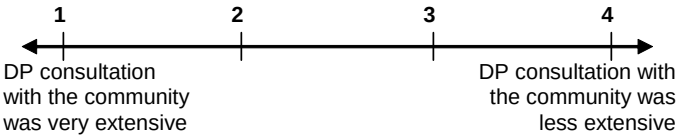
- At one end of the spectrum of DPs goals to reach community were those DPs for whom the concept of 'reaching the community' was a central focus of the marketing strategy. Those DPs at the other end of the spectrum, the concept of 'reaching the community' was a background feature of the DPs goals only, and was not a focus of the strategy.



Variation within Process Model

Theme: Indicators of implementation - consultation

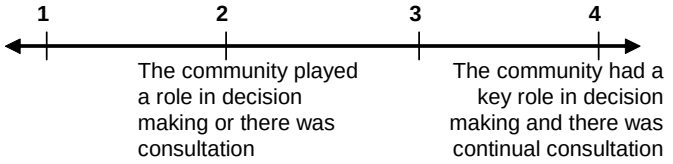
- The extent of consultation with community varied amongst the DPs. At one end of the spectrum were those DPs who undertook extensive consultation with the community as indicated by: ongoing and regular consultation; a range of community groups were consulted; a number of consultation methods were used; and had a wide focus of discussion. Those DPs at the other end of the spectrum undertook less extensive consultation with the community as indicated by: one off consultations; a limited number of community groups were consulted; a very limited number of consultation methods were used; and there was a narrow focus of discussion.



Similarity within Process Model

Theme: Indicators of implementation - participation

- The process whereby the DPs were most similar was the level of participation by the community in the DP (i.e. the level of integration of the community into the DP). Some of the DPs were at a point on the spectrum indicating that the community played a role in decision making or there was some community consultation. For those DPs that were further along the spectrum, the community had a key role in decision making and there was continual community consultation.



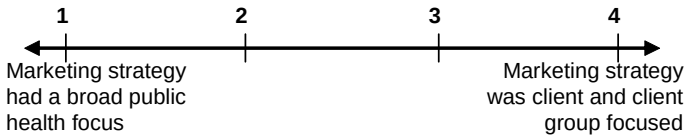
Thematic analysis of community Process Model at middle measurement point

Process Model

Variation within Process Model

Theme: Marketing strategy – client v community focus

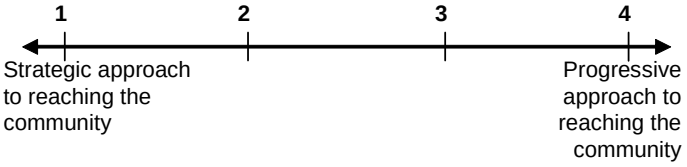
- The breadth of focus of the DPs marketing strategy ranged from those DPs who undertook a broad public health focus, which was wider than the client or client group, and community engagement was a major focus of the DP. At the other end of the spectrum were those DPs whose marketing strategy was client and client group focused, and community engagement was a by-product of client recruitment needs.



Variation within Process Model

Theme: Implementation strategy - structure

- The structure of the approach to reaching the community at one end of the spectrum was strategic whereby DPs had clearly identified definition of community, its role and how to achieve that role. Those DPs at the other end of the spectrum had a more progressive approach to reaching the community, where the process of identifying the community and its role evolved across the life of the program.



Similarity within Process Model

Theme: Indicators of implementation - participation

- See thematic analysis of community Process Model at baseline.

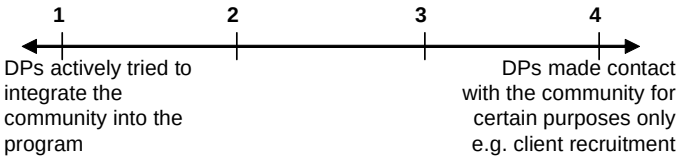
Thematic analysis of community Process Models at last measurement point

Process Model

Variation within Process Model

Theme: Implementation strategy - nature

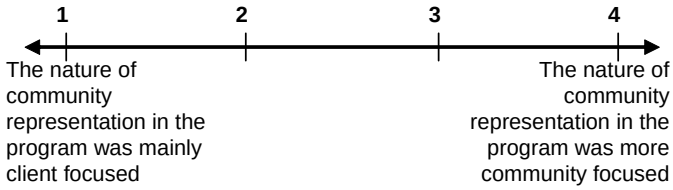
- The nature of the relationship being developed with the community ranged between the DPs. At one end of the spectrum were those DPs who aimed to actively integrate the community into the DP, as indicated by: evidence that the community has an active and key role in decision making; and evidence that other community consultation was occurring and ongoing. At the other end of the spectrum were those DPs who aimed to 'seek the community out', and made contact with the community for certain purposes only e.g. client recruitment, where community engagement is a by product of the recruitment process.



Variation within Process Model

Theme: Indicators of implementation - representation

- The nature of the representation of the community in the projects varied across the DPs. At one end of the spectrum were those DPs whereby the nature of community representation was mainly client focused (e.g. consumer group representation on committees). Those DPs at the other end of the spectrum, were those DPs that had more community focused representation in the program (e.g. community group representation on committees).



Similarity within Model

Theme: Indicators of implementation - participation

- See thematic analysis of community Process Model at the middle measurement point.

Appendix 26

Summary of Project Reports

Table 1: Detailed Project Report Information for the Client Domain

Process	*Barriers*	*Facilitators*
Marketing / reach	• Low awareness of the project by potential referrers (particularly GPs). • Marketing material was not reaching specific groups of people, especially those who were not currently using existing services. • Difficulty in engaging GPs to i) explain the concept of SHCI and ii) to encourage them to refer potential clients. • The lack of culturally relevant marketing material especially for Aboriginal and Torres Strait Islander people.	• Targeted mail outs and presentations • Adopting a 'settings' approach which involved targeting individuals at the places they frequent. • Face to face presentations which led to a sense of trust being developed between potential clients and projects. • Ensuring marketing material was suitable for the target group. • Utilising a number of communication strategies, particularly with GPs (through Divisions of General Practice), in order to promote referral to the projects. • Developing a memory aid to assist GPs remember the existence of SCHI. • Identifying the most disadvantaged groups and areas and targeting the marketing to these groups.
Recruitment of clients	• Severity of the illness (presenting problems) of potential clients. • Concept of being in a demonstration project and its associated evaluation forms and activities (e.g. focus groups). • Inexperienced recruitment facilitators which led to clients being reluctant to participate in the projects. • Lack of cultural relevance of questionnaires (evaluation) and the SHCI approach. • Lack of a previous experience with the project. • Potential referral sources (including GPs) expressed	• Skilled recruiters, who were able to recruit clients directly and inform other potential referral sources of the benefits of the SHCI. • The endorsement of the project by a trusted source (of the clients e.g. GPs). • Key health service provider involvement and support. • Targeted information and talks to motivated individuals. • The opportunistic approach adopted by GPs in the recruitment of clients at the time of the client consultation. • Establishing good working

Process	*Barriers*	*Facilitators*
	concerns about the initiative e.g. self management strategies would not meet the needs of their patients.	relationships between the project and recruiters (engaged outside of the project).
Self management orientation	• Lack of leader availability. • Difficulty encouraging stakeholders not directly responsible to the project to complete paperwork required (e.g. feedback about courses). • Accessing training was difficult for some clients (lack of transport).	• Participation in a group environment increased client awareness of and confidence to participate in other group interventions/courses (e.g. Tai Chi). • Continue training of Master Trainers. • Setting up accessible venues for education and training. • Creating opportunities for training and education in other languages for clients from CALD backgrounds and those who were not group focused.
Enrolment	• Capacity of staff to undertake the data collection, given time constraints and other responsibilities. • Lack of client's previous experience with group activities. • Course timing (time of day) did not suit potential attendees. • Lack of family support for clients to attend courses. • Exacerbation of client's illness.	• Engaging a data collector specifically with the role of recruiting clients and enrolling them to appropriate courses. • Supportive family whom assisted clients to attend courses. • Client's previous experience with group work.
Education and training of clients	• Some clients were more interested in physical than educational programs. • Other commitment of clients. • Perceived lack of relevancy for of the training for some clients. • Timing of course • Course timing (time of day) did not suit potential attendees. • Personal style of trainers.	• Increased local ownership of courses with local leaders arranging courses on their own initiative with their own and other clients. • Practical/administrative procedures which supported education and training courses (e.g. identifying accessible venues for education and training,

Process	*Barriers*	*Facilitators*
	• Practical/administrative issues with courses (e.g. difficulty with securing venues). • Educational leader issues (e.g. difficulty recruiting leaders, leader availability, difficult in aligning leader's objectives with course objectives. • Client issues (e.g. exacerbation of a clients health issues, preference for one on one training rather than group training).	providing on the web, offering education and training in another language). • Pursuing a buddy system for people who were not group focussed, and providing the opportunity for clients to improve courses.
Education and training of SM program personnel	• Insufficient resources to enable potential self management program personnel to attend training (e.g. lack of back up staff to allow participants to attend courses).	• Identifying different opportunities to provide training to SM program personnel (e.g. in-service sessions for community health teams). • Ability of participants to use elements of the Lorig course outside the context of the project (e.g. in rehabilitation programs).
Disease-specific education and training	• There was limited access for clients to GPs and specialist health staff for education activities.	• Courses run for both English and Arabic speaking clients.
Care/self management planning	• Low awareness of GPs to the enhanced primary care (EPC) items and how these might support their care planning activities. • Complexity of care/self management approach led to reluctance of GPs to participate in the Initiative. • Time pressures on staff meant their limited capacity to participate. • Project fatigue experience by staff due to multiple roles within the Initiative. • Difficulty of staff to 'withhold' advice and information in an effort to encourage and support the self management approach. • Some clients whilst happy to be a part of the project were reluctant to enter into a 'contract' for self management and behavioural	• Electronic care plans. • Close working relationships with GPs and service providers, including increasing the awareness of enhanced primary care (EPC) items.

Process	*Barriers*	*Facilitators*
	change.	
Support from SM program personnel	• Low awareness amongst clients/carers regarding support services available.	• Increased involvement of volunteer and community groups in the support of clients and carers. • Monthly email newsletters to clients.

Table 2: Detailed Project Report Information for the Community domain

Process	*Barrier*	*Facilitators*
Reach	• Other projects requirements (e.g. marketing and recruitment and care planning) took a precedence (over reach) thereby reducing the capacity to undertake community reach activities.	• Reach was increased through public information and promotions, mail outs to targeted community groups and diverse marketing strategies including community presentations. • State policy changes (in management of chronic and complex conditions) have seen heightened awareness of self management.
Health promotion	• Difficulties in engaging GPs to appreciate and undertake health promotion activities. • Instability and/or closure of community health organisations. • Notion of capacity building through health promotion was not well understood in the community.	• Financial incentive for GPs. • Extending the reach of projects through contact with local clinicians and collaboration with local providers.
Health planning	• Lack of communication of client progress to GPs, saw their reluctance to participate in health planning activities.	• Self management courses were planned for extension to surrounding districts. • Consumer based organisations were consulted for formal consumer and social health input (into health planning).
Community support processes	• Not all support processes/service were readily identifiable in the community.	• Integrating project interventions with existing organisations (so as to target sustainability).

Process	*Barrier*	*Facilitators*
Organisational development	• Despite building organisational capacity over the life of the project; a submitted grant application for mainstream implementation of CDSM was unsuccessful.	• Funding submissions and proposals have been developed with existing groups/organisations to develop funding submissions to aid integration of chronic disease self management interventions. • The inclusion of key State/Territory health personnel on steering committees increased the opportunities to discuss projects at a more policy and strategic level. • Development of more targeted education to consumers and health workers, in response to specific areas of concern. • Working more closely with State/Territory Departments in looking at the policy implications of self management.
Workforce development	• Lack of financial resources has prevented workforce development being targeted effectively.	• Development of more targeted education in response to specific areas of concern to consumers and health workers. • Communication networks developed between network groups and health worker forums on a wide range of topics. • Working at the policy level to get closer connection with health services in terms of looking at policy implications of self management. • Development of volunteer networks. • Workshops with services keen to embed self management practices into their workplace.

Table 3: Detailed Project Report Information for the Health Service Provider Domain

Process	*Barrier*	*Facilitators*
Marketing / reach	• The capacity to reach HSPs is affected by the size of the organisation, work load pressures, philosophical base, client profile, and the level of control staff feel they have over their work priorities. It appeared easier to engage smaller organisations that were prepared to try and do new things.	• Extending the number of forums for providing information to health service providers (including GPs) about SHCI. • Identifying that information on specific clients (rather than a hypothetical client) attracts the attention of health service providers, in particular GPs. • Engaging champions to promote SHCI • The availability of financial incentives.
Recruitment of HSPs	• Lack of active involvement from Divisions of General Practice, so as to assist in the recruitment of GPs. • Recruitment of GPs required a 'personal' touch and was therefore resource intensive. • With SHCI seen as an 'extra curricular' activity, increasing administrative burden on GPs made it difficult to engage GPs. • GPs were unfamiliar with working with a third party in the care of their patients, thereby impacting on the capacity to engage GPs. • HSPs (including GPs) saw the concept of self-management to be a new one, therefore, requiring lead time to raise awareness of new models of care and benefits.	• Adopting a model of ongoing recruitment of HSPs, rather that a campaign (limited term) focussed recruitment. • Providing incentives for HSP involvement (e.g. free training as leaders). • More one-on-one, targeted recruitment of HSPs (including GPs). • Involvement of senior management in stakeholder organisations to champion self-management. • Capacity of project staff to be flexible and alter their recruitment strategies to best met the needs of their target group.
Education & training of HSPs	• Time pressures on HSP to be able to attend education and training opportunities. • Ineffective briefing during enrolment process, lead to misconceptions about the level of	• Using feedback from education and training modules to modify course material to best meet the needs of HSPs. • Workshops with HSPs being adopted as part of the Area

Process	*Barrier*	*Facilitators*
	professional development for HSPs.	Calendar.
Support of HSPs	• GPs poor perception to the use of case conferencing as a means of 'supporting' them in their daily work. • Limited capacity for project staff to follow-up HSPs. • Finding a balance between not over burdening HSPs, whilst at the same time providing enough information to maintain their involvement.	• Offering assistance and in-service training as requested by HSPs. • Providing peer support for less experiences program leaders.

Table 4: Detailed Project Report Information for the Health Service System Domain

Process	*Barrier*	*Facilitators*
Infrastructure development	• Remoteness and multi-site projects make infrastructure development more difficult. • Inadequate space to house computer hardware.	• Linking projects with local Divisions of General Practice, thereby providing a positive relationship between projects and local GPs. • Use of locally based administration and data support to assist site managers.
Governance and management framework	• None identified.	• Establishment of appropriate management groups and local advisory groups. • Members of steering and advisory committees having links to other State/Territory initiatives.
Integration	• Restructuring of area health services may have an adverse impact on self-management. • Lack of feedback on the findings of the project to consumers and stakeholders may influence the direction of project.	• Restructuring of the area health service may have a positive impact on self-management. • Project management and advisory groups have representatives from important stakeholders.

Appendix 27

Full analysis of effect sizes associated with changes over time in non-Indigenous DPs

General Health (SF-1)

Table 1 Table of difference scores stratified by baseline level of General Health

		Mean	SD	n	Effect size*
Baseline to Middle	Whole group	-0.1	0.83	867	0.12
	Excellent to Very good	0.42	0.85	129	0.49
	Good	0.11	0.74	334	0.15
	Fair to Poor	-0.44	0.75	404	-0.59
Baseline to Last	Whole group	-0.87	0.85	871	0.082
	Excellent to Very good	0.48	0.84	128	0.57
	Good	0.13	0.76	338	0.17
	Fair to Poor	-0.41	0.79	405	-0.52

* Estimate of Effect size = Mean difference/Standard Deviation of differences

Psychological Distress (Kessler 10)

Table 2 Table of difference scores stratified by baseline level of Psychological Distress:

Difference Score		Mean	SD	n	Effect size
Baseline to Middle	Whole group	-0.79	5.98	838	0.13
	10-15	1.25	4.19	324	0.30
	16-21	-0.06	5.33	261	-0.01
	22-29	-2.45	6.72	149	-0.36
	30-50	-6.62	9.62	104	-0.69
Baseline to Last	Whole group	-1.36	5.90	835	0.23
	10-15	0.98	3.59	321	0.27
	16-21	-0.45	5.11	261	-0.09
	22-29	-2.77	6.83	147	-0.41
	30-50	-8.75	9.23	106	-0.95

NB. Small effect size classed as 0.2

Satisfaction with Life

Table 3 Table of difference scores stratified by Baseline level of Satisfaction with Life

Difference Score		Mean	SD	n	Effect size
Baseline to Middle	Whole group	0.36	5.90	854	0.06
	26-35 High	-2.10	4.80	333	-0.44
	15-25 Medium	0.81	5.54	348	0.15
	<15 Low	4.20	6.27	173	0.67
Baseline to Last	Whole group	0.45	6.39	752	0.07
	26-35 High	-2.66	5.42	279	-0.49
	15-25 Medium	1.18	5.80	317	0.20
	<15 Low	4.50	6.44	156	0.70

Health Distress

Table 4 Table of difference scores stratified by baseline level of Health Distress:

Difference Score		Mean	SD	n	Effect size
Baseline to Middle	Whole group	-0.207	1.05	843	0.19
	0-1	0.32	0.67	249	0.48
	1-2	-0.07	0.88	258	0.08
	2-3	-0.44	1.05	191	-0.42
	3-4	-1.02	1.26	145	-0.81
Baseline to Last	Whole group	-0.205	1.11	824	0.18
	0-1	0.36	0.84	242	0.43
	1-2	-0.07	0.87	253	0.08
	2-3	-0.41	1.09	187	-0.38
	3-4	-1.10	1.28	142	-0.86

Coping with Symptoms

Table 5 Table of difference scores stratified by baseline level of Coping with Symptoms

Raw data - Difference Score		Mean	SD	n	Effect size
Baseline to Middle	Whole group	0.17	0.90	781	0.19
	0-1	0.46	0.71	307	0.65
	1-2	0.10	0.86	240	0.12
	2-3	-0.19	0.97	119	-0.20
	3-4	-1.02	1.39	26	-0.73
Baseline to Last	Whole group	0.22	0.93	778	0.24
	0-1	0.50	0.74	306	0.68
	1-2	0.13	0.88	233	0.15
	2-3	-0.04	0.99	121	-0.04
	3-4	-1.01	1.38	27	-0.73

Social Functioning

Table 6Table of difference scores stratified by baseline level of Social Functioning

Raw data - Difference Score		Mean	SD	n	Effect size
Baseline to Middle	Whole group	-0.89	13.01	792	0.07
	0-24	4.33	9.88	239	0.44
	25-49	-0.92	11.66	400	-0.08
	50 or more	-8.98	16.22	153	-0.55
Baseline to Last	Whole group	-0.43	13.98	792	0.03
	0-24	5.45	11.18	242	0.49
	25-49	-0.53	11.98	397	-0.04
	50 or more	-9.47	17.53	153	-0.54

Self Efficacy

Table 7 Table of difference scores stratified by baseline level of Self Efficacy

Raw data - Difference Score		Mean	SD	n	Effect size
Baseline to Middle	Whole group	0.32	2.20	778	0.12
	0 - 5	1.53	2.09	255	0.73
	5 - 7.5	0.16	2.02	282	0.08
	7.6 to high	-0.76	1.89	241	-0.40
Baseline to Last	Whole group	0.18	2.40	772	0.08
	0 - 5	1.37	2.28	255	0.68
	5 - 7.5	0.20	2.09	277	0.01
	7.6 to high	-1.09	2.20	240	-0.50

Visits to GP

Table 8 Table of difference scores stratified by baseline level of Visits to GP

Difference Score		Mean	SD	n	Effect size
Baseline to Middle	Whole group	-0.37	6.99	856	0.05
	0-3	1.09	2.97	289	0.37
	4-7	0.60	5.33	345	0.11
	8 or more	-3.77	10.84	222	-0.35
Baseline to Last	Whole group	-0.35	6.24	851	0.06
	0-3	1.37	4.94	287	0.20
	4-7	0.38	4.42	343	0.09
	8 or more	-3.74	8.5	221	-0.44

Hospital Visits (one night or more)

Table 9 Table of difference scores stratified by baseline level of Hospital Visits

Difference Score		Mean	SD	n	Effect size
Baseline to Middle	Whole group	-0.19	1.28	855	0.14
	None	0.16	0.57	654	0.28
	Once	-0.63	0.70	118	-0.9
	More than once	-2.27	2.87	83	-0.79
Baseline to Last	Whole group	-0.15	1.46	853	0.10
	None	0.25	0.87	653	0.29
	Once	-0.71	0.77	119	-0.92
	More than once	-2.49	2.91	81	-0.86

Appendix 28

Full results of ANCOVA for change in health over time by Intervention Model

General Health (SF-1) by Model

Table 1 Table of adjusted data by Model type

Measure: MEASURE_1

New Model	SF1	Mean	95% Confidence Interval	
			Lower Bound	Upper Bound
1.00	Base	3.41[a]	3.37	3.44
	Middle	3.32[a]	3.23	3.41
	Last	3.38[a]	3.29	3.47
2.00	Base	3.42[a]	3.38	3.46
	Middle	3.38[a]	3.29	3.48
	Last	3.44[a]	3.34	3.53
3.00	Base	3.39[a]	3.35	3.43
	Middle	3.22[a]	3.12	3.32
	Last	3.23[a]	3.12	3.33
4.00	Base	3.37[a]	3.31	3.43
	Middle	3.18[a]	3.02	3.33
	Last	3.15[a]	2.99	3.30

a. Covariates appearing in the model are evaluated at the following values: SFGROUP = 2.3194.

Psychological Distress (Kessler 10) by Model

Table 2 Table of adjusted data by model type

Measure: MEASURE_1

Model type	K10	Mean	95% Confidence Interval	
			Lower Bound	Upper Bound
1.00	Base	19.07[a]	18.77	19.38
	Middle	18.77[a]	18.05	19.48
	Last	18.54[a]	17.89	19.19
2.00	Base	19.34[a]	19.03	19.65
	Middle	18.52[a]	17.79	19.25
	Last	17.88[a]	17.21	18.55
3.00	Base	19.35[a]	18.98	19.71
	Middle	17.98[a]	17.12	18.84
	Last	17.27[a]	16.49	18.06
4.00	Base	18.89[a]	18.39	19.39
	Middle	17.91[a]	16.73	19.08
	Last	16.94[a]	15.87	18.00

a. Covariates appearing in the model are evaluated at the following values: K10 category1 - baseline = 2.0403.

Satisfaction with Life by Model

Table 3 Table of adjusted data by model type:

Measure: MEASURE_1

Model type	SWL	Mean	95% Confidence Interval	
			Lower Bound	Upper Bound
1.00	Base	21.74[a]	21.54	21.93
	Middle	21.64[a]	21.00	22.29
	Last	21.30[a]	20.62	21.98
2.00	Base	21.90[a]	21.70	22.10
	Middle	22.64[a]	21.98	23.30
	Last	22.81[a]	22.11	23.51
3.00	Base	21.76[a]	21.53	21.99
	Middle	22.37[a]	21.61	23.13
	Last	22.85[a]	22.05	23.66

a. Covariates appearing in the model are evaluated at the following values: Satisfaction with life - baseline category = 3.5806.

Health Distress by Model

Table 4 Table of adjusted data by model type

Measure: MEASURE_1

Model type	DISTRESS	Mean	95% Confidence Interval	
			Lower Bound	Upper Bound
1	Base	1.69[a]	1.64	1.73
	Middle	1.58[a]	1.46	1.69
	Last	1.62[a]	1.50	1.74
2	Base	1.66[a]	1.61	1.71
	Middle	1.49[a]	1.37	1.60
	Last	1.49[a]	1.37	1.62
3	Base	1.66[a]	1.61	1.72
	Middle	1.33[a]	1.20	1.47
	Last	1.30[a]	1.16	1.45
4	Base	1.66[a]	1.58	1.74
	Middle	1.33[a]	1.14	1.52
	Last	1.27[a]	1.07	1.47

a. Covariates appearing in the model are evaluated at the following values: Distress group = 2.28.

Coping with Symptom by Model

Table 5 Table of adjusted data by Model type

Measure: MEASURE_1

Model type	SYMPTS	Mean	95% Confidence Interval	
			Lower Bound	Upper Bound
1	Base	1.12[a]	1.08	1.15
	Middle	1.46[a]	1.35	1.57
	Last	1.28[a]	1.17	1.40
2	Base	1.09[a]	1.05	1.12
	Middle	1.30[a]	1.19	1.41
	Last	1.48[a]	1.37	1.59
3	Base	1.12[a]	1.08	1.17
	Middle	1.09[a]	.96	1.23
	Last	1.19[a]	1.05	1.33
4	Base	1.05[a]	.99	1.11
	Middle	1.01[a]	.82	1.19
	Last	1.18[a]	1.00	1.37

a. Covariates appearing in the model are evaluated at the following values: SYMGROUP = 1.81.

Social Functioning by Model

Table 6 Table of adjusted data by model type

Measure: MEASURE_1

Model type	INTRUS	Mean	95% Confidence Interval	
			Lower Bound	Upper Bound
1	Base	35.04[a]	34.14	35.93
	Middle	36.22[a]	34.64	37.80
	Last	36.49[a]	34.78	38.19
2	Base	35.56[a]	34.70	36.43
	Middle	35.09[a]	33.56	36.62
	Last	35.22[a]	33.57	36.87
3	Base	33.45[a]	32.36	34.55
	Middle	30.90[a]	28.97	32.83
	Last	30.94[a]	28.86	33.02
4	Base	33.99[a]	32.60	35.39
	Middle	29.62[a]	27.16	32.08
	Last	32.90[a]	30.25	35.55

a. Covariates appearing in the model are evaluated at the following values: INTRGRP = 1.89.

Self Efficacy by Model

Table 7 Table of adjusted data by model type

Measure: MEASURE_1

Model type	SELF	Mean	95% Confidence Interval	
			Lower Bound	Upper Bound
1	Base	6.00[a]	6.00	6.11
	Middle	6.23[a]	5.98	6.48
	Last	5.94[a]	5.67	6.22
2	Base	5.98[a]	5.87	6.10
	Middle	6.16[a]	5.91	6.41
	Last	6.04[a]	5.77	6.32
3	Base	6.16[a]	6.02	6.30
	Middle	6.61[a]	6.30	6.91
	Last	6.74[a]	6.41	7.08
4	Base	6.04[a]	5.85	6.23
	Middle	6.85[a]	6.43	7.27
	Last	6.33[a]	5.87	6.79

a. Covariates appearing in the model are evaluated at the following values: SEFFGRP = 1.96.

Number of GP Visits by Model

Table 8 Table of adjusted data by model type

Measure: MEASURE_1

Model type	GPS	Mean	95% Confidence Interval	
			Lower Bound	Upper Bound
1	Base	6.45[a]	6.05	6.85
	Middle	6.45[a]	5.90	6.99
	Last	6.41[a]	5.82	6.99
2	Base	5.30[a]	4.87	5.73
	Middle	5.79[a]	5.21	6.37
	Last	5.62[a]	4.99	6.24
3	Base	5.91[a]	5.40	6.42
	Middle	4.64[a]	3.95	5.32
	Last	4.69[a]	3.95	5.42
4	Base	6.05[a]	5.38	6.73
	Middle	5.37[a]	4.46	6.28
	Last	4.84[a]	3.86	5.82

a. Covariates appearing in the model are evaluated at the following values: GPGROUP = 1.92.

Number of Hospital Visits by Model

Table 9 Table of adjusted data by model type

Measure: MEASURE_1

Model type	HOSP	Mean	95% Confidence Interval	
			Lower Bound	Upper Bound
1	Base	.48[a]	.39	.58
	Middle	.27[a]	.18	.36
	Last	.34[a]	.23	.46
2	Base	.46[a]	.36	.56
	Middle	.32[a]	.23	.42
	Last	.33[a]	.22	.45
3	Base	.43[a]	.31	.55
	Middle	.24[a]	.13	.34
	Last	.22[a]	.09	.36
4	Base	.44[a]	.28	.60
	Middle	.19[a]	.04	.34
	Last	.34[a]	.16	.53

a. Covariates appearing in the model are evaluated at the following values: HOSGROUP = 1.33.

Appendix 29

Factors which predict changes in health status over time for non-Indigenous DPs

Results table

Change in Health Outcome between Baseline and Middle	Dataset – improved score		Dataset – stable or worse score		Dataset – worse score	
	Variables included	% of variance explained	Variables included	% of variance explained	Variables included	% of variance explained
Kessler 10	Kessler1 0 at Baseline Mid point change – Social Functioning Mid point change – Health Distress Mid point change - Self Efficacy Mid point change - Satisfaction with Life Age	52.9%	Mid point change - Self Efficacy Mid point change – Social Functioning Kessler 10 at Baseline Mid point change - Satisfaction with Life	8.7%	Mid point change - Self Efficacy Mid point change - Satisfaction with Life	5.4%
General Health	Mid point change - Satisfaction with Life	3.3%	General Health at Baseline Mid point change – Health Distress Mid point change - Self Efficacy	17.2%	General Health at Baseline Mid point change – Health Distress	20.0%
Health Distress	Health Distress at Baseline Mid point change - General Health Mid point change - Self Efficacy	35.6%	Mid point change – Social Functioning Mid point change - Self Efficacy Mid point change - General Health Mid point change – Kessler 10	15.9%	Mid point change – Social Functioning Mid point change - General Health	14.0%
Coping with Symptoms	Mid point change - Satisfaction with Life Model type Coping with Symptoms at Baseline Mid point change - Health Distress	8.3%	Symptom Control at Baseline Mid point change – Social Functioning Model type	29.3%	Symptom Control at Baseline Mid point change – Social Functioning Model type	22.0%
Social Functioning	Social Functioning at Baseline Mid point change – Kessler 10 Sex Mid point change - Self Efficacy	37.9%	Mid point change – Kessler 10 Mid point change - General Health	6.3%	Mid point change – Kessler 10	4.6%
Self Efficacy	Self Efficacy at Baseline Mid point change – Health Distress Model type Mid point change – Social Functioning	25.5%	Mid point change – Social Functioning	7.9%	Mid point change – Social Functioning Self Efficacy at Baseline	7.9%
Satisfaction with Life	Satisfaction with Life at Baseline Mid point change – Kessler 10 Mid point change – Coping with Symptoms Mid point change – Social Functioning	30.5%	Satisfaction with Life at Baseline Mid point change – Kessler 10 Mid point change – Health Distress	9.0%	Satisfaction with Life at Baseline Mid point change – Kessler 10 Mid point change – Social Functioning	8.7%

Appendix 30

Indigenous process mapping thematic analysis

Thematic analysis of Indigenous client Process Models at baseline

The thematic analysis identified common themes within each of the processes to capture:

- variability both within a given Model and within a given DP
- similarity both within a given Model and within a given DP.

For each of identified theme, a four-way classification was developed based upon the process mapping, and the DPs were then plotted along this continuum.

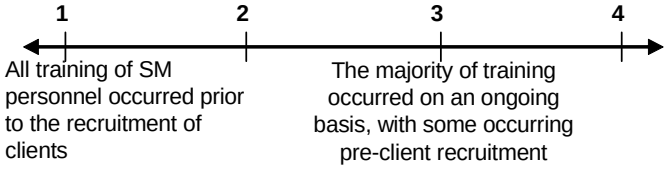
Examples are identified below, highlighting where variation and similarity existing within each of the four Models. As there was only one DP in Model D, examples of variation and similarity within the Model were not applicable. The examples of variation and similarity in process that are provided below are examples of where the DPs within a given Model were most similar, or where there was the greatest amount of variation in process.

Process Model C

Variation within Process Model C

Theme: Education and training of SM personnel - timing

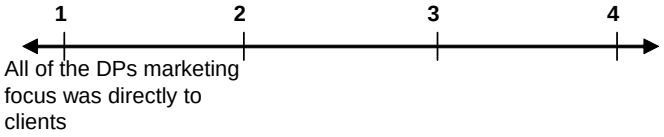
- The timing of the training of SM personnel varied across the Indigenous DPs. At one end of the Spectrum, the Indigenous DP undertook training of SM personnel prior to the recruitment of clients. Further along the spectrum, was the DP who undertook the majority of training on an ongoing basis, with some occurring prior to client recruitment.



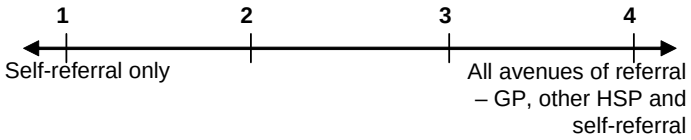
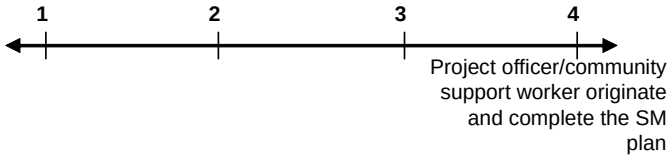
Similarity within Process Model C

Theme: Nature of marketing – direct/indirect

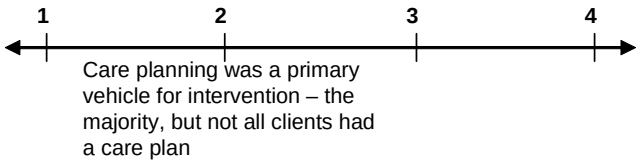
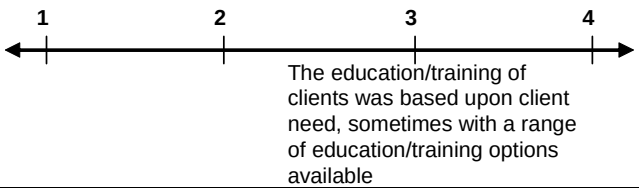
- The marketing focus of both Indigenous DPs at baseline was on marketing the program directly to clients/potential clients.



Thematic analysis of Indigenous client Process Models at the middle measurement point

Process model Ci
Variation within Process Model Ci *Theme:* Recruitment - referral • In model Ci, the way in which clients were first introduced to the DP varied across the Indigenous DPs. At one end of the spectrum, one of the Indigenous DPs had clients who self-referred to the program only, whilst the other Indigenous DP was at the other end of the spectrum indicating that clients could be self-referred, GP referred or referred by other HSPs. 
Similarity within Process Model Ci *Theme:* SM planning - driver • The driver of the SM planning process for the Indigenous DPs was the project officers/community support workers, who originated and completed the SM plan without assistance/sign-off from a GP/practice nurse/other HSP. 

Thematic analysis of the Indigenous client Process Model at last measurement point

Process model C
Variation within Process Model C *Theme:* Recruitment - referral • See thematic analysis of client Process Model at the middle measurement point.
Similarity within Process Model C *Theme:* Care planning - role • The role of care planning was similar across the Indigenous DPs in that care planning was a primary vehicle for intervention. Indicating that the majority (but not all) of the clients in the program will have a care plan. 
Similarity within Process Model C *Theme:* Education and training of clients - determinants of client training • For all Indigenous DPs, the education and training of clients was based upon client need, and in some cases a range of education options were available. 

Thematic analysis of Indigenous HSP Process Model at baseline

As the two Indigenous DPs were in different models at baseline, a thematic analysis was not applicable.

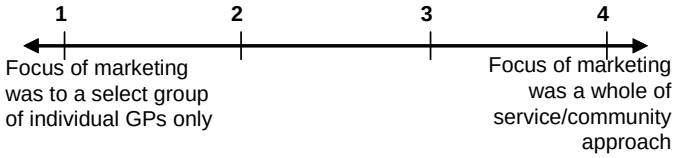
Thematic analysis of HSP Process Model at the middle measurement point

Process model A

Variation within Process Model A

Theme: Marketing - focus

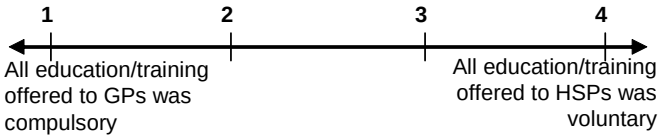
- In model A, the focus of marketing to HSPs varied across the Indigenous DPs. At one end of the spectrum were those Indigenous DPs who focused on marketing to a select group of individual GPs only. At the other end of the spectrum were those DPs who focused on a whole of service/community approach to marketing.



Variation within Process Model A

Theme: Education and training – participation of GPs

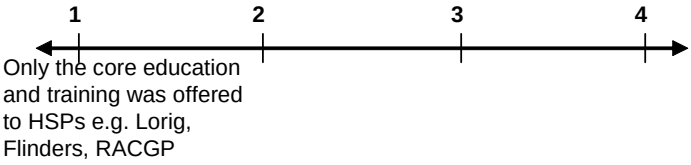
- The extent of GP participation in education and training varied across the Indigenous DPs. At one end of the spectrum were those DPs for whom the education and training offered to GPs was compulsory. At the other end of the spectrum were those DPs whereby all the education and training offered to GPs was voluntary.



Similarity within Process Model A

Theme: Education and training – type of training

- All the Indigenous DPs offered only the core education and training to HSPs e.g. Lorig, Flinders, RACGP.



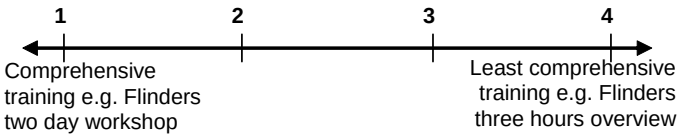
Thematic analysis of Indigenous HSP Process Model at the last measurement point

Process model A

Variation within Process Model A

Theme: Education and training – extent other HSPs

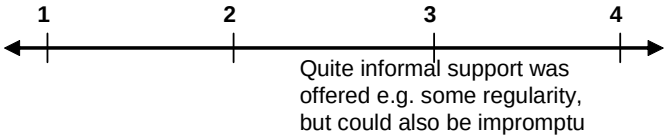
- The extent or comprehensiveness of the education and training being provided to HSPs, as indicated by the length of the training and level of its detail, varied between the Indigenous DPs. At one end of the spectrum were those DPs who were providing comprehensive education and training at the last measurement point (e.g. Flinders two day workshop). However, those DPs at the other end of the spectrum were providing less comprehensive training at the last measurement point (e.g. Flinders three hour overview).



Similarity within Process Model A

Theme: Support from SM personnel – other support

- At the end measurement point, the type of support from the Indigenous DPs to HSPs was quite informal in that it had some regularity, but support could also be impromptu.



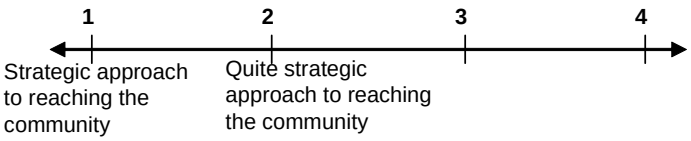
Thematic analysis of Indigenous community Process Model at baseline

Process model A

Variation within Process Model A

Theme: Implementation strategy - structure

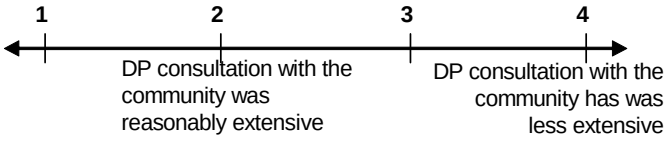
- The structure and approach to reaching the community undertaken by the Indigenous DPs varied slightly. At one end of the spectrum were those DPs who were strategic in their approach to reaching the community as indicated by a clearly identified definition of community, its role and how to achieve that role in the program. Further along the spectrum were those DPs who had a quite strategic approach to reaching the community as indicated by a clear identification of community and its role, but less clarity about how to achieve that role in the program.



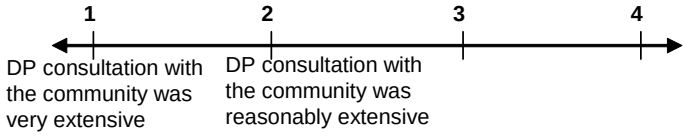
Variation within Process Model A

Theme: Indicators of implementation - consultation

- The extent of the DPs consultation with the community varied amongst the Indigenous DPs. Towards one end of the spectrum were those DPs who undertook reasonably extensive consultation with the community as indicated by: consultation was on a repeated (but limited and not ongoing) basis; quite a number of community groups were consulted; quite a few of avenues of consultation were used; and there was a rather wide focus of discussion. At the other end of the spectrum were those DPs who undertook less extensive consultation with the community as indicated by: one off consultations; a limited number of community groups were consulted; a very limited number of avenues of consultation were used; and there was a narrow focus of discussion.



Thematic analysis of Indigenous community Process Model at the middle measurement point

Process model A	
Variation within Process Model A *Theme:* Implementation strategy - structure • See thematic analysis of community Process Model at baseline.	
Variation within Process Model A *Theme:* Indicators of implementation - consultation • At the middle measurement point, there was less variation between the Indigenous DPs for the extent of consultation with the community. At one end of the spectrum were those DPs who undertook very extensive consultation with the community as indicated by: ongoing and regular consultation; a range of community groups were consulted; many avenues of consultation were used; and had a wide focus of discussion. Further along the spectrum were those DPs who undertook reasonably extensive consultation with the community (see middle community thematic analysis for indicators).	

Thematic analysis of the Indigenous community Process Model at the last measurement point

There were no changes in the thematic analysis from the middle measurement ponit to the last measurement point.