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?	☐	☐	☐	☐

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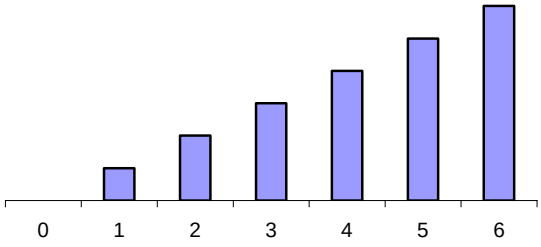
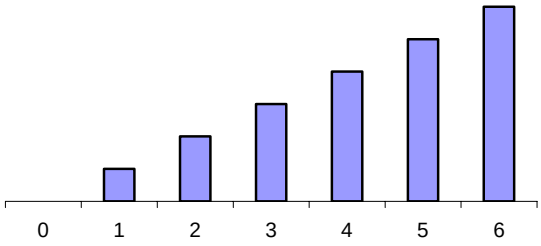
6) Do you get tired?



Not at all Sometimes All the time

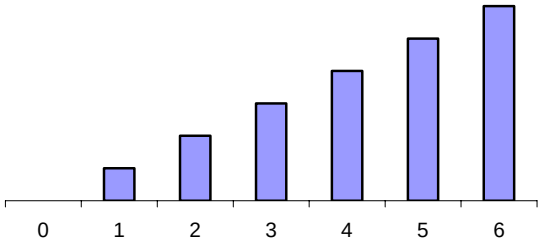
 ID: ☐☐☐☐☐☐

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

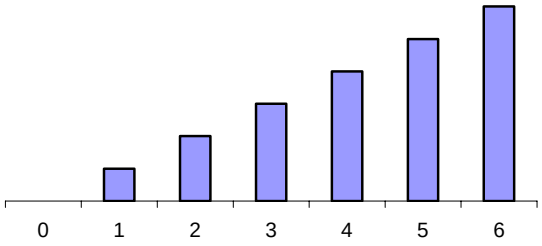
	Not much 1	Sometimes 2	Almost Everyday 3	Everyday 4
9) Do you walk for exercise?	☐	☐	☐	☐

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?	☐	☐	☐	☐

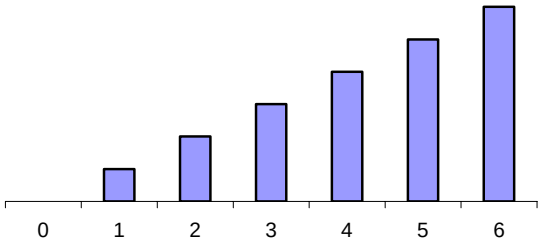
 ID: ☐☐☐☐☐☐

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



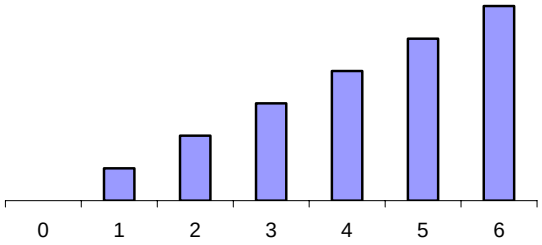
Not at all Sometimes All the time

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



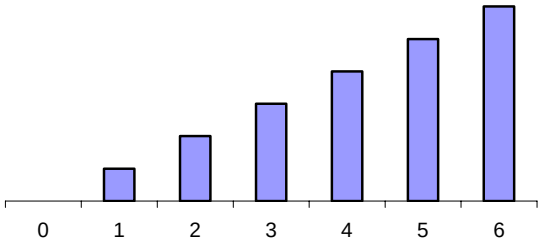
Not at all Sometimes All the time

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



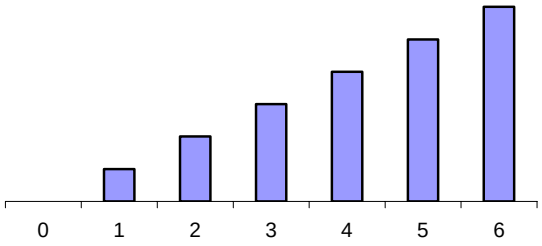
Not at all Sometimes All the time

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



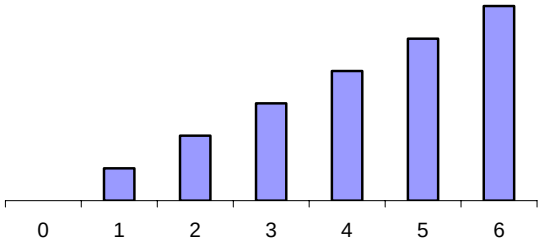
Not at all Sometimes All the time

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



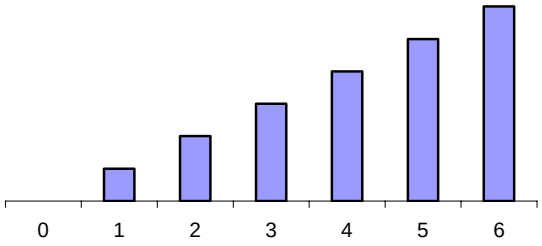
Not at all Sometimes All the time

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



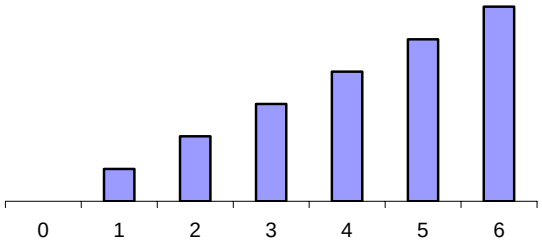
Not at all Sometimes All the time

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



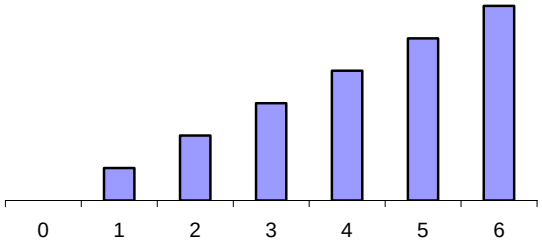
Not at all Sometimes All the time

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



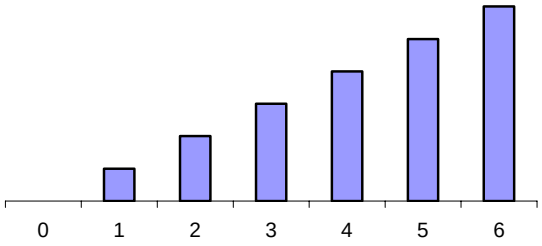
Not at all Sometimes All the time

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



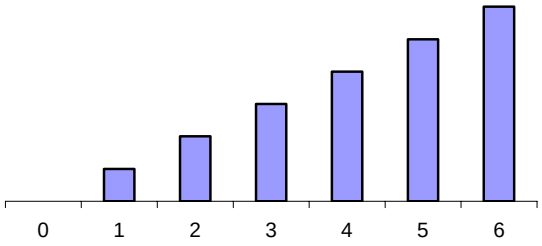
Not at all confident Sometimes confident Totally confident

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



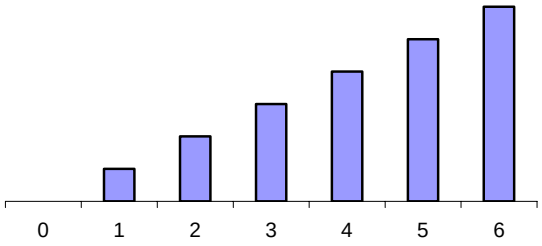
Not at all confident | Sometimes confident | Totally confident

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

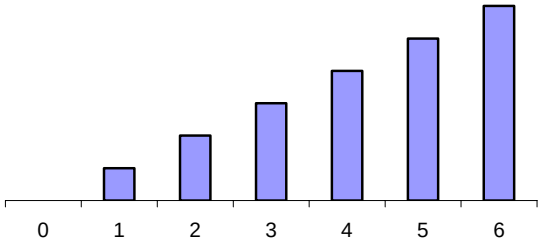
Much, much good……. ☐

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?	☐	☐	☐	☐

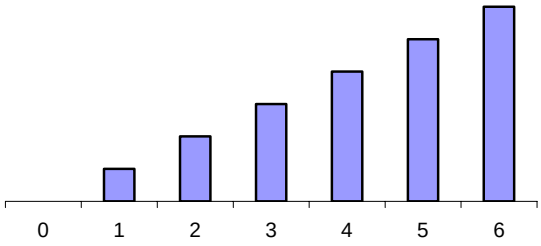
6) Do you get tired?



Not at all All the time

 ID: ☐☐☐☐☐☐

7) Do you get short breath?



Not at all All the time

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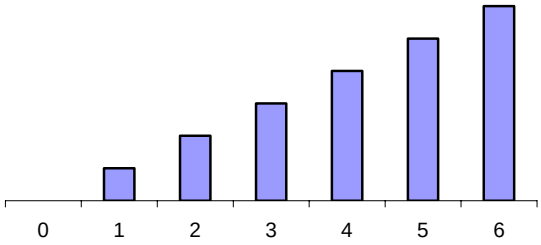


No pain Really bad pain

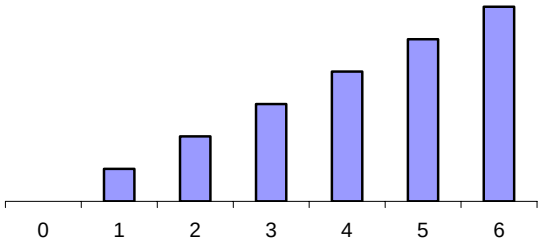
	Not much	Sometimes	Almost Everyday	Everyday
	1	2	3	4
9) Do you walk for exercise?	☐	☐	☐	☐

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?	☐	☐	☐	☐

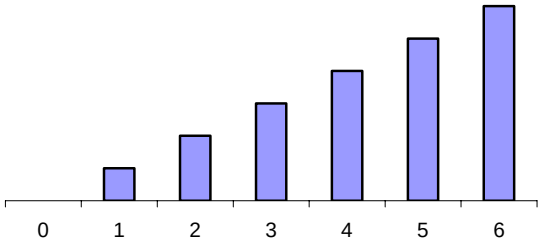
 ID: ☐☐☐☐☐☐

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?



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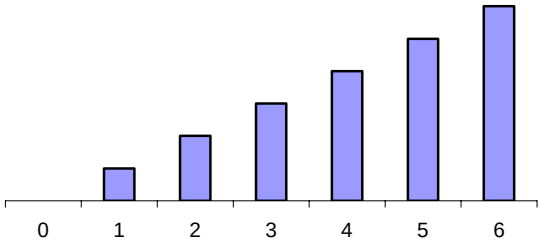
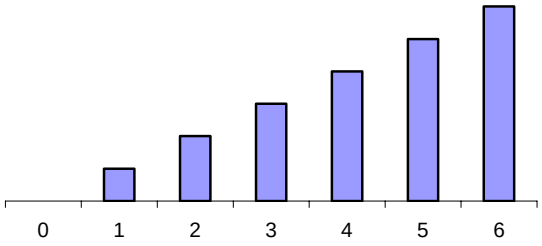


Not at all Lots

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



Not at all Lots

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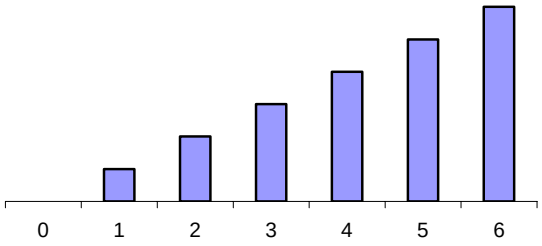
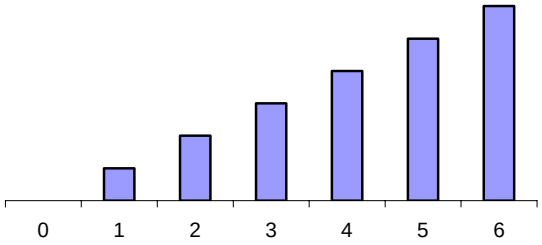


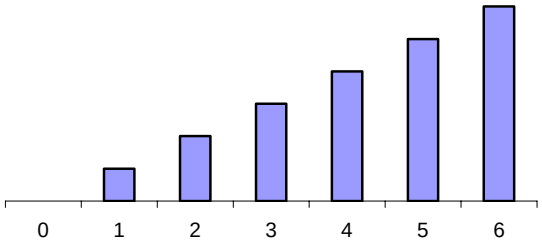
Not at all Lots

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



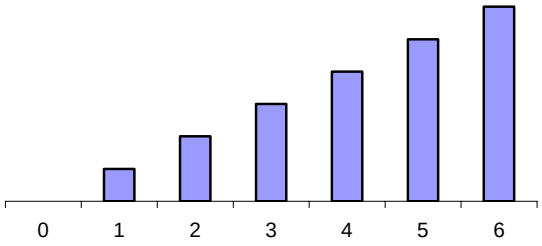
Not at all Lots

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



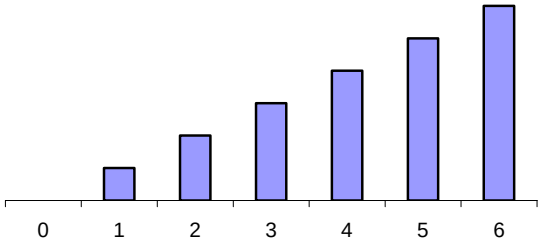
Not at all Lots

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



Not at all Lots

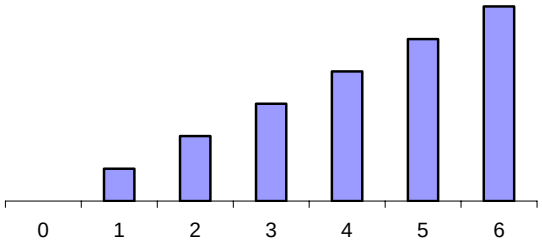
21) How confident are you that you can stop the tiredness keeping you from the things you want to do?



Not at all confident Totally confident

 ID: ☐☐☐☐☐☐

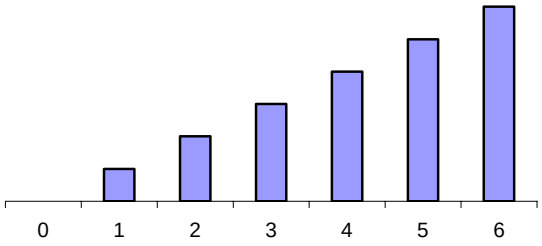
22) How confident are you that you can keep physically active (like walking and playing with the kids) when you want to?



Not at all confident

Totally confident

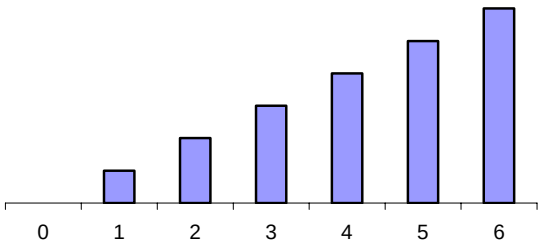
23) How confident are you that you can stop the illness or treatment getting you down?



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:

Client ID	Intervention received by client																											Reason for client attrition		
	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

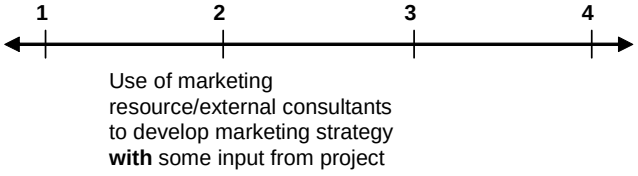
Theme: Support from SM personnel – nature of support

- 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.

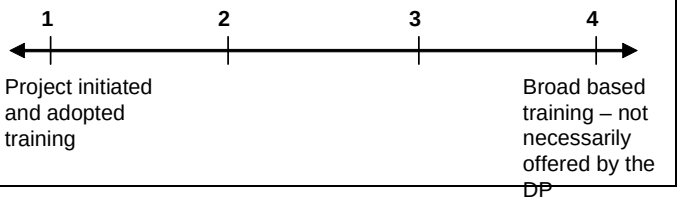


Process Model B

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

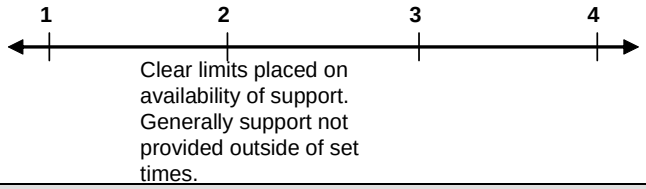


indicated by the degree of choice available. This training was not necessarily offered specifically by the project, but was a reflection of what was available in the community in which the DP operated.

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.

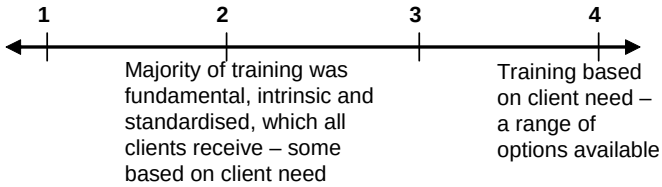


Process Model C

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.

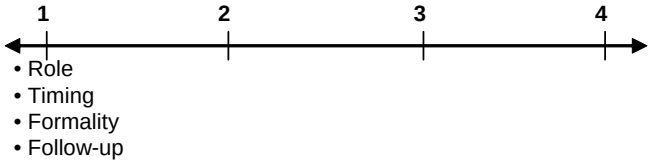


Similarity within Process Model C

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

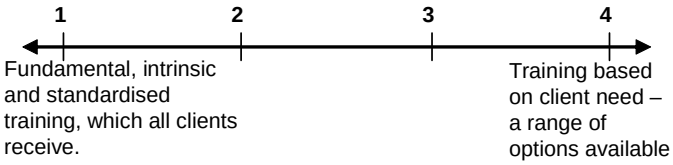
As there was only one DP in Model D and Model Cii, examples of variation and similarity within the Model are not applicable.

Process Model A

Variation within Process Model A

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

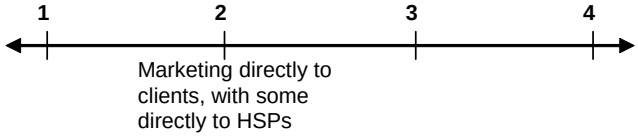
- Some DPs in Model A were at one end of the spectrum for determinants of client training, where education and training of clients was a fundamental, intrinsic and standardised activity that all clients received. The remaining DPs were at the other end of the spectrum education and training was based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

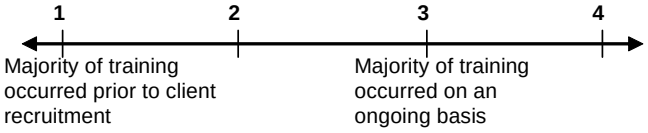


Process Model B

Variation within Process Model B

Theme: Education and training of SM personnel

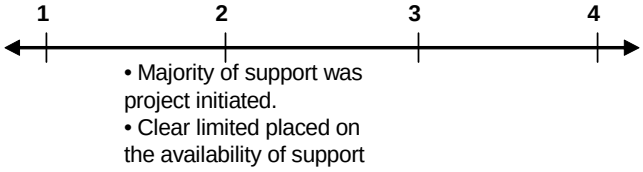
- In Model B, some DPs were at one end of the spectrum for the education and training of SM personnel whereby all training of SM personnel occurred before the recruitment of clients to the program. The remaining DPs were further along the spectrum indicating that the majority of the training occurred 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.

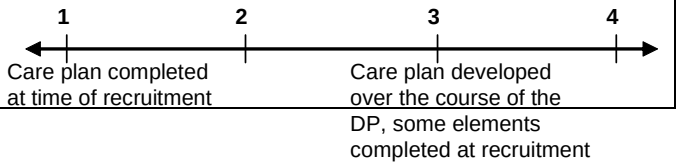


Process Model Ci

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

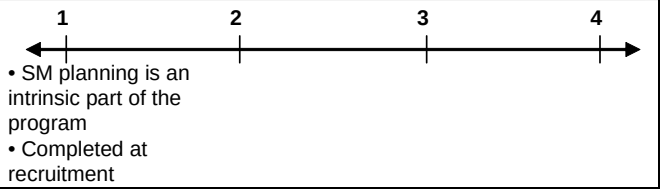


remaining DPs were further along the spectrum indicating that elements of the care plan were completed at the time of recruitment, with the remainder being developed and refined over the course of the DP.

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

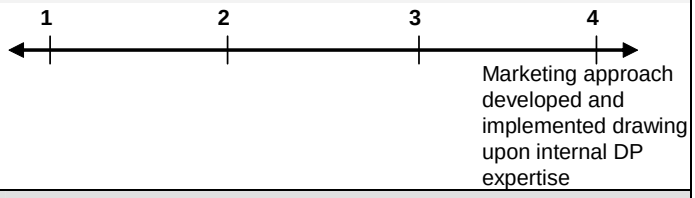
Theme: Education and training of clients - determinants of client training

- 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.

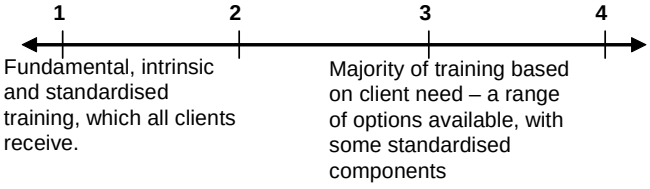


Process Model B

Variation within Process Model B

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

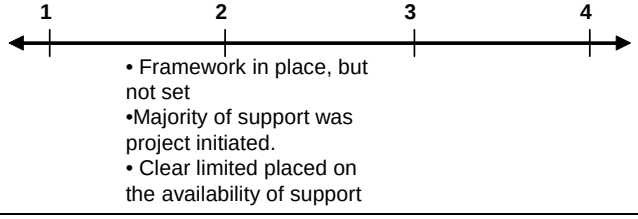
- For some DPs in Model B education and training was a fundamental, intrinsic and standardised activity that all clients received. Further along the spectrum, the remaining DPs in Model B provided training based upon client need with a range of education/training options available, with some standardised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

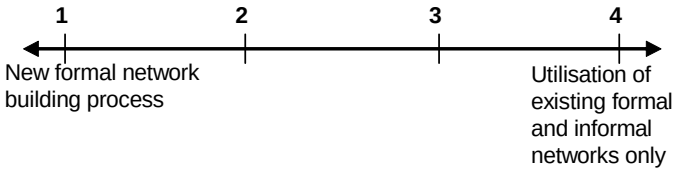
Thematic analysis of HSP Process Models at baseline

Process Model A

Variation within Process Model A

Theme: Recruitment of GPs - approach

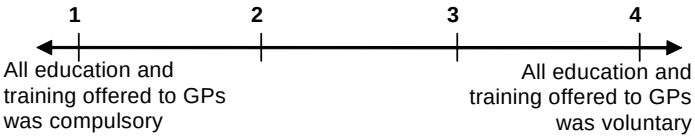
- For some DPs in Model A, the approach to developing relationships with GPs for recruitment purposes required the DPs to undertake a new formal network building process 'from scratch' (i.e. potential GP partnerships were identified in an objective and structured format). The remaining DPs were further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

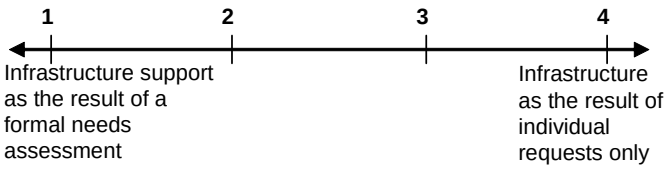
- In Model A, at one end of the spectrum the education and training is compulsory for those GPs who have been recruited to the DP, whilst some DPs are at the other end of the spectrum indicating that all education and training offered to GPs was voluntary.



Variation within Process Model A

Theme: Support from SM personnel – infrastructure

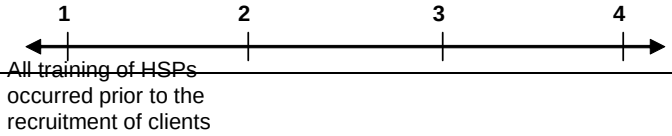
- For some DPs in Model A the infrastructure support from the DPs was a result of a formal needs analysis, whilst for those DPs at the other end of the spectrum, infrastructure support to HSPs was the result of individual requests only.



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



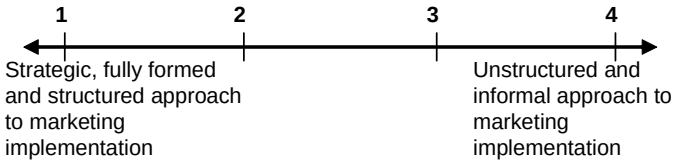
clients to the programs.

Process Model B

Variation within Process Model B

Theme: Marketing – mechanism

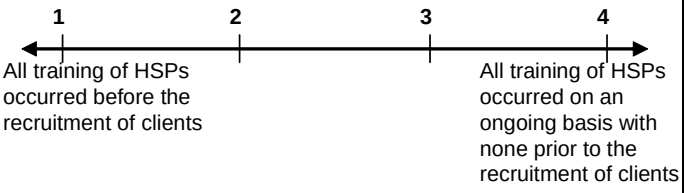
- For some DPs in Model B, the overarching approach to marketing the program to HSPs involved a fully formed strategic approach to marketing implementation as indicated by the following: evidence of a marketing strategy; marketing implementation in line with the strategy; evidence of the marketing strategy 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

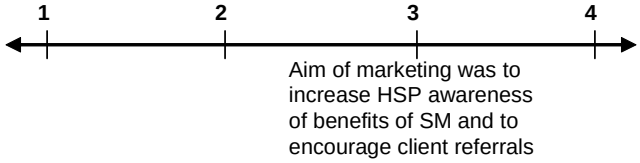
- In Model B, the education and training of HSPs for some DPs occurred prior to the recruitment of clients, whilst some of the other DPs were further along the spectrum indicating that the training of HSPs occurred on an ongoing basis, with none being provided prior to the recruitment of clients.



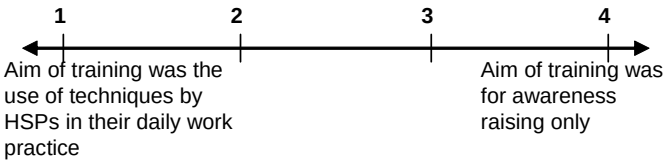
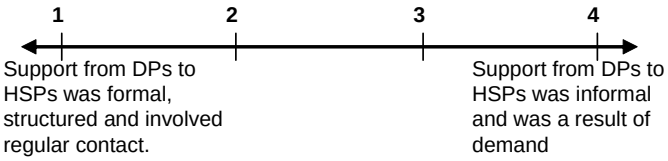
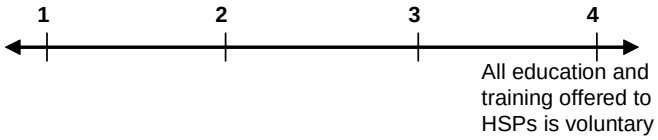
Similarity within Process Model B

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.	

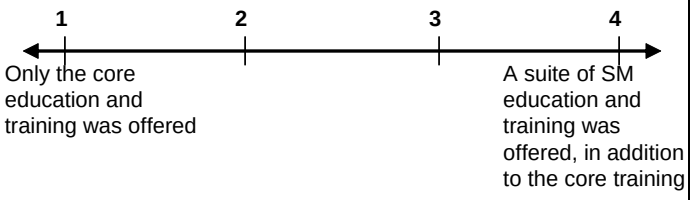
Thematic analysis of HSP Process Models at last measurement point

Process Model A

Variation within Process Model

Theme: Education and training – type of training

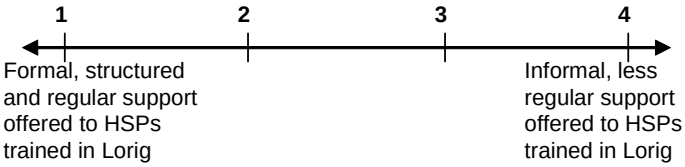
- Within Model A, some DPs were at one end of the spectrum indicating that only core education and training was being offered to HSPs (e.g. Lorig, Flinders, and RACGP). For those DPs at the other end of the spectrum, the type of education and training offered to HSPs included a complete suite of SM education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



Variation within Process Model

Theme: Support from SM personnel - Lorig

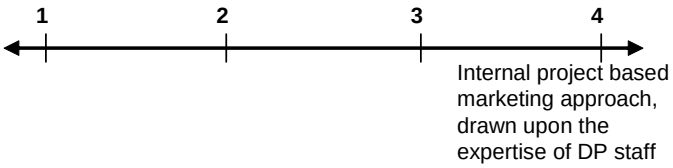
- Some of the DPs in Model A were at one end of the spectrum for Lorig support from the DP, indicating that formal, structured and regular support is offered to those HSPs trained as Lorig leaders. At the other end of the spectrum, those DPs offered informal support to those HSPs trained as Lorig leaders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



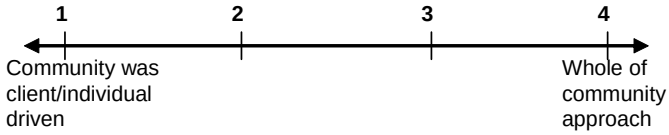
Thematic analysis of community Process Model at baseline

Process Model

Variation within Process Model

Theme: Definition of community – scope

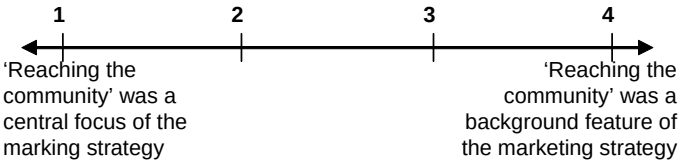
- How the DPs defined community resulted in some DPs being at one end of the spectrum indicating that their definition of community were those current/potential clients/consumers who could benefit from SM (i.e. it was client/individual driven). Those DPs who were at the other end of the spectrum had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



Variation within Process Model

Theme: Marketing strategy – DP goals

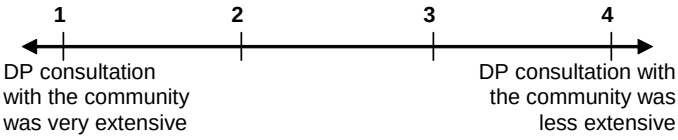
- At one end of the spectrum of DPs goals to reach community were those DPs for whom the concept of 'reaching the community' was a central focus of the marketing strategy. Those DPs at the other end of the spectrum, the concept of 'reaching the community' was a background feature of the DPs goals only,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



Variation within Process Model

Theme: Indicators of implementation - consultation

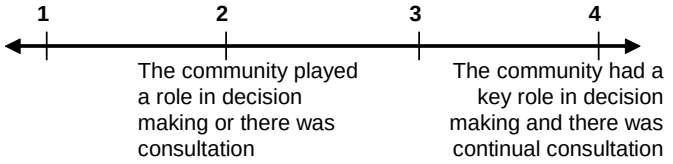
- The extent of consultation with community varied amongst the DPs. At one end of the spectrum were those DPs who undertook extensive consultation with the community as indicated by: ongoing and regular consultation; a range of community groups were consulted; a number of consultation methods were used; 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.



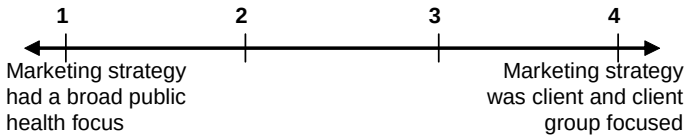
Thematic analysis of community Process Model at middle measurement point

Process Model

Variation within Process Model

Theme: Marketing strategy – client v community focus

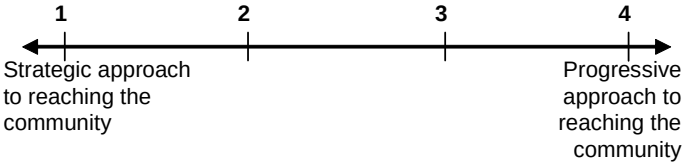
- The breadth of focus of the DPs marketing strategy ranged from those DPs who undertook a broad public health focus, which was wider than the client or client group, and community engagement was a major focus of the DP. At the other end of the spectrum were those DPs whose marketing strategy was client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

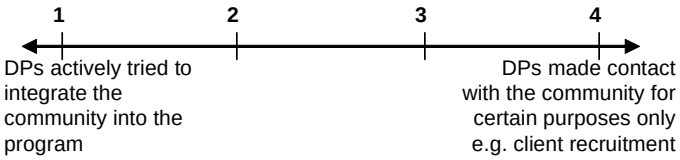
Thematic analysis of community Process Models at last measurement point

Process Model

Variation within Process Model

Theme: Implementation strategy - nature

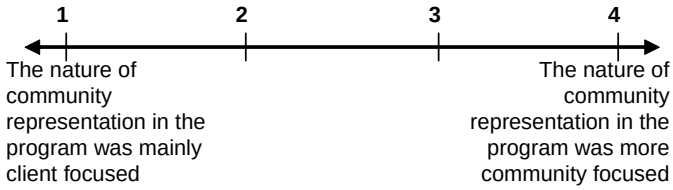
- The nature of the relationship being developed with the community ranged between the DPs. At one end of the spectrum were those DPs who aimed to actively integrate the community into the DP, as indicated by: evidence that the community has an active and key role in decision making; and evidence that 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.

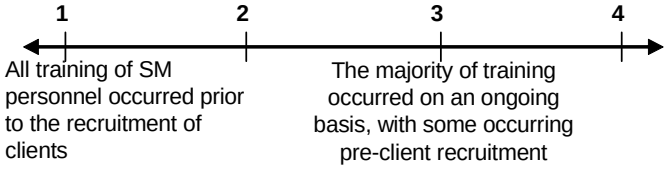
Examples are identified below, highlighting where variation and similarity existing within each of the four Models. As there was only one DP in Model D, examples of variation and similarity within the Model were not applicable. The examples of variation and similarity in process that are provided below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

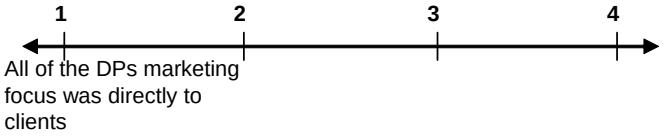
- The timing of the training of SM personnel varied across the Indigenous DPs. At one end of the Spectrum, the Indigenous DP undertook training of SM personnel prior to the recruitment of clients. Further along the spectrum, was the DP who undertook the majority of training on an ongoing basis, with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



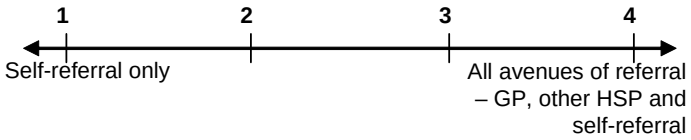
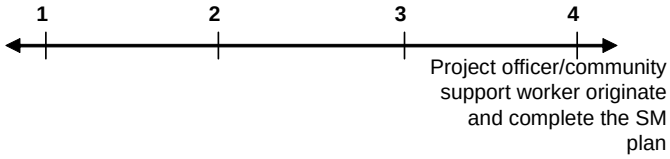
Similarity within Process Model C

Theme: Nature of marketing – direct/indirect

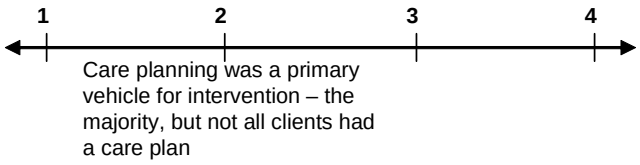
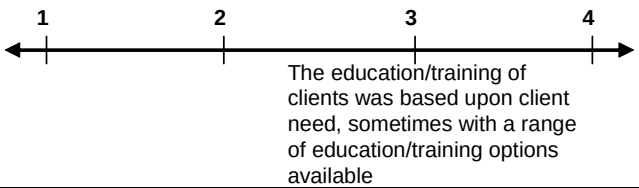
- The marketing focus of both Indigenous DPs at baseline was on marketing the program directly to clients/potential clients.



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.

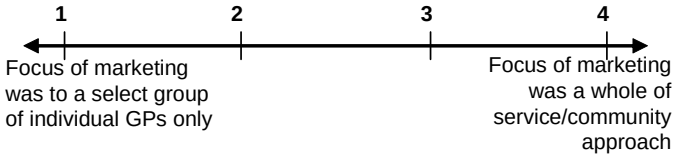
Thematic analysis of HSP Process Model at the middle measurement point

Process model A

Variation within Process Model A

Theme: Marketing - focus

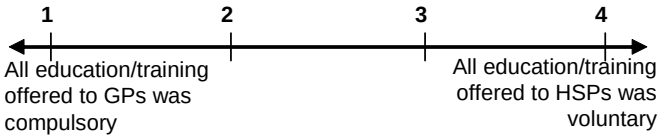
- In model A, the focus of marketing to HSPs varied across the Indigenous DPs. At one end of the spectrum were those Indigenous DPs who focused on marketing to a select group of individual GPs only. At the other end of the spectrum were those DPs who focused on a whole of service/community approach to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



Variation within Process Model A

Theme: Education and training – participation of GPs

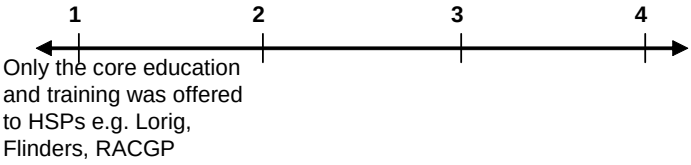
- The extent of GP participation in education and training varied across the Indigenous DPs. At one end of the spectrum were those DPs for whom the education and training offered to GPs was compulsory. At the other end of the spectrum were those DPs whereby all the education and training offered to GPs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



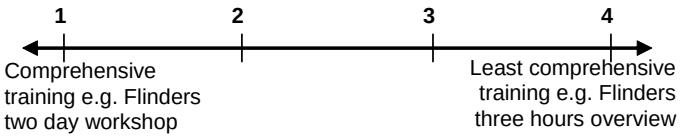
Thematic analysis of Indigenous HSP Process Model at the last measurement point

Process model A

Variation within Process Model A

Theme: Education and training – extent other HSPs

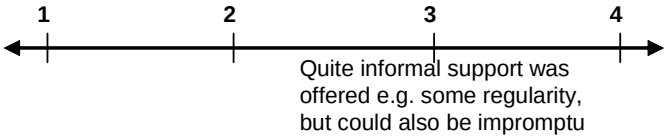
- The extent or comprehensiveness of the education and training being provided to HSPs, as indicated by the length of the training and level of its detail, varied between the Indigenous DPs. At one end of the spectrum were those DPs who were providing comprehensive education and training at the last 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.



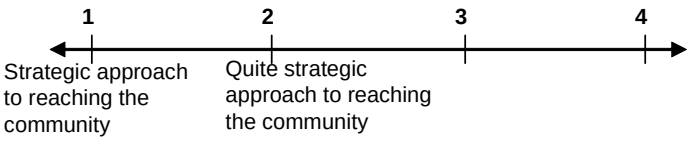
Thematic analysis of Indigenous community Process Model at baseline

Process model A

Variation within Process Model A

Theme: Implementation strategy - structure

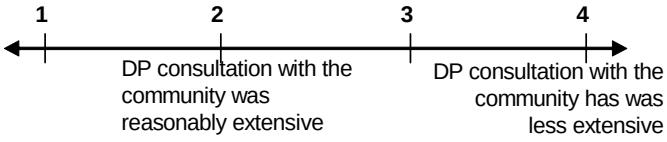
- The structure and approach to reaching the community undertaken by the Indigenous DPs varied slightly. At one end of the spectrum were those DPs who were strategic in their approach to reaching the community as indicated by a clearly identified definition of community, its role and how to achieve that 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.



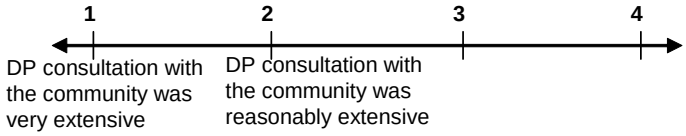
Variation within Process Model A

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.