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)

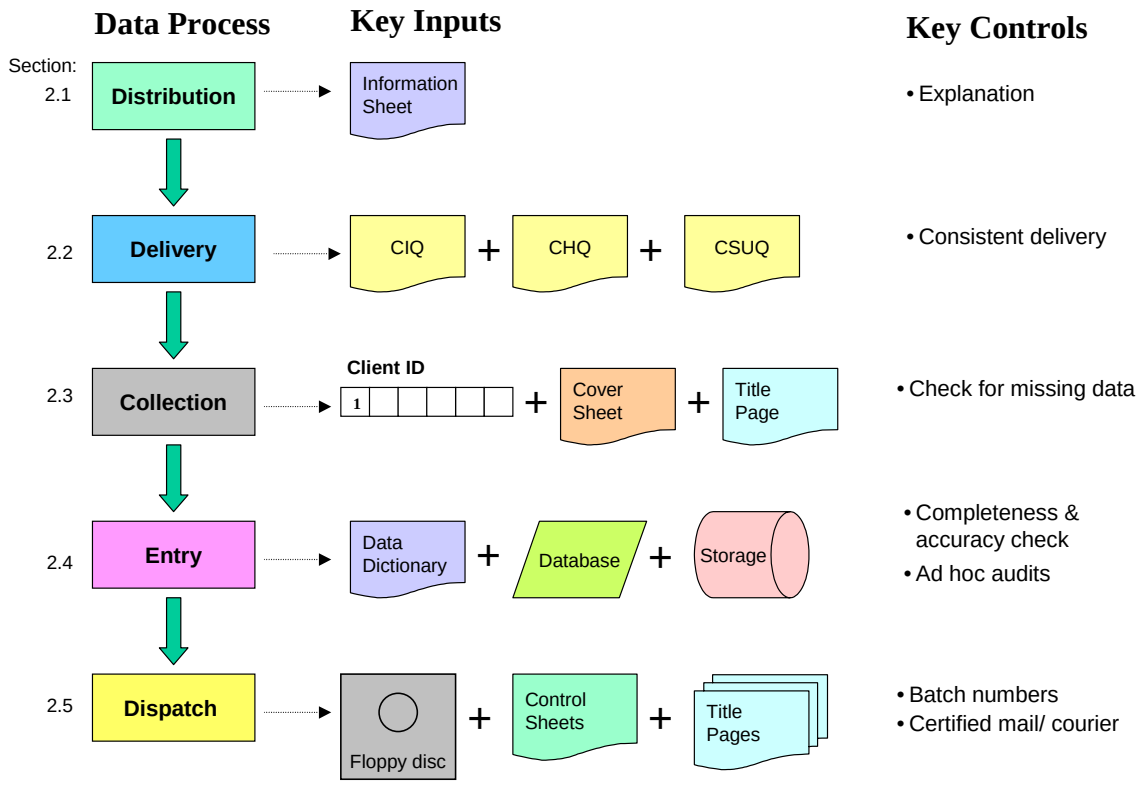
However, the primary focus of this Guide is the data collection and management requirements surrounding the questionnaires, since being at individual client level makes it a complex area with a greater risk of error. Such errors are also more difficult to retrieve.

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

2 Questionnaires

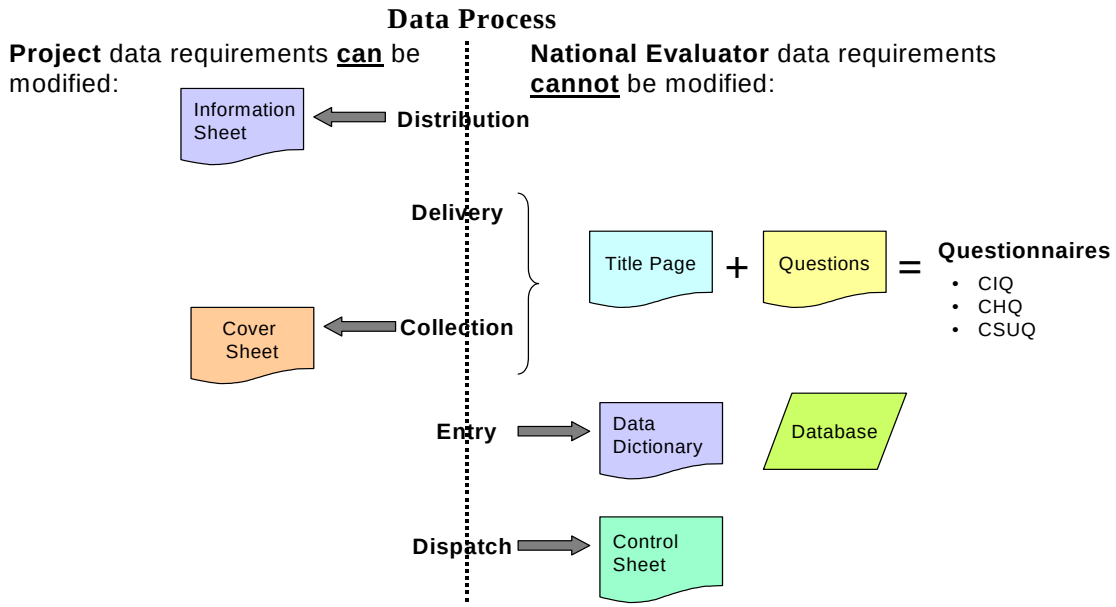
- There are three questionnaires that need to be completed by clients:
  - The Client Information Questionnaire (CIQ);
  - The Client Health Questionnaire (CHQ); and
  - The Client Service Use Questionnaire (CSUQ) – being Questions 64 to 72 of the CHQ
- The following diagram highlights the key themes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

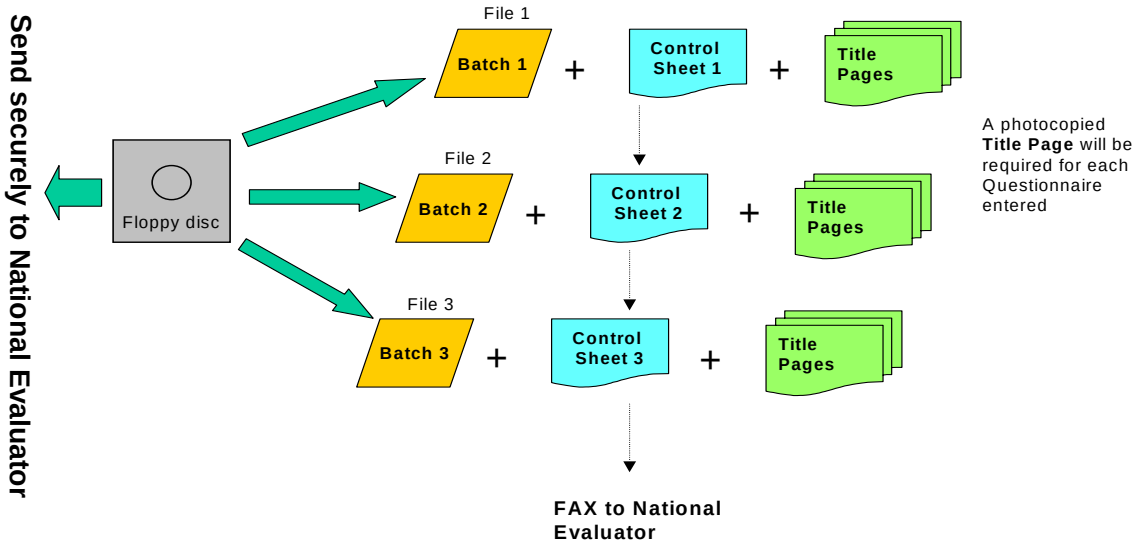
2.4.2 Data Management Database Proforma

- 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?	