
1 Introduction

This is the final report of the National Evaluation of the Sharing Health Care Initiative (SHCI). The final report comprises: *the Executive Summary* and *abridged Discussion, the Technical Report (this report) and Appendices (which are attached to this report)*.

The primary purpose of the Technical Report is to present the results from the process, impact and outcome evaluation components of the National Evaluation of the SHCI. All of the analyses presented here is in aggregated, de-identified form and covers the period from Demonstration Project 'go-live' in June 2002 through to their completion in June 2004.

1.1 Background to the Sharing Health Care Initiative

Arising from the 1999/2000 federal budget, the Australian Government Department of Health and Ageing (DoHA) initiated the Enhanced Primary Care (EPC) package for older Australians and those with chronic and complex conditions. The SHCI was part of this package and represented a generic rather than a condition-focused approach to using self-management in addressing the common debilitating features of chronic conditions. The SHCI had three components:

1. The SHCI Demonstration Projects (DPs);
2. Education and training for Health Service Providers (HSPs); and the
3. National Evaluation of the DPs.

The National Evaluation of the SHCI focused on the first of these three components i.e. the DPs and their capacity to meet the SHCIs overall objectives, which were to:

- Improve the health-related quality of life for people with chronic conditions, particularly those with co-morbidities;
- Improve the use of the health care system by people with chronic conditions; and
- Encourage collaboration between clients, their families and HSPs in the management of chronic conditions.

However, reference is made in this report to the education and training programs for HSPs provided through the Flinders University Human Behaviour and Health Research Unit and the Royal Australian College of General Practitioners (RACGP) (1) and associated self-management tools (for example, Partner's in Health [PIH] Scale (2) and clinical guidelines for general practitioners (GPs), allied health professionals and nurses that were developed and tested within the DPs. Separate evaluations on these education

and training programs have been developed by the Flinders Unit and RACGP (Western Australia Research Unit).

The SHCI targeted mature aged adults i.e. 50 years or older (or 35 years or older for Indigenous adults, however some Indigenous clients were recruited who fell into the 20-35 age group) with chronic and complex conditions focussing upon the following conditions:

- Diabetes;
- Osteoporosis;
- Arthritis;
- Respiratory disorders;
- Cardio-vascular disease; and
- Depression (as a co-morbidity).

1.2 Rationale for the SHCI

1.2.1 The burden of chronic conditions

Over the next 10-20 years, the impact of the rising prevalence of chronic conditions will be one of the greatest challenges for the Australian health system. It is estimated that three million Australians are currently living with chronic conditions and this is likely to increase over the coming years (3) to the point that it is estimated that by 2020, chronic conditions will be the primary cause of death and disability. It is therefore imperative to consider approaches to address the increasing numbers of patients with chronic conditions (and associated morbidity) and the escalating costs to the health service system associated with this increase (4).

1.2.2 Definition and purpose of self-management interventions

Self-management has been defined as “the individual’s ability to manage the symptoms, treatment, physical and psychosocial consequences and lifestyle changes inherent in living with a chronic condition. Efficacious self-management encompasses the ability to monitor ones condition and to effect the cognitive, behavioural and emotional responses necessary to maintain a satisfactory quality of life” (5).

Self-management interventions (SMIs), therefore, aim to increase a client’s involvement and control in the treatment of their condition(s) and in the management of its effect on their life (4). As a consequence, the client moves from being a passive recipient of care to being a proactive partner in the management of their condition(s) with their HSP and thus the best client outcome is achieved (4).

SMIs aim to support the development and strengthening of such collaborative relationships between chronic condition clients and their HSPs and the broader health service system by:

- Assisting clients in developing their skills, knowledge and confidence to manage their condition by addressing a range of factors including biological, lifestyle, psychological and cultural influences (6); and
- Promoting better communication strategies between HSPs, clients and their carers (7, 8).

It has been suggested that for a self-management intervention to be effective it should include the following four components (to varying degrees):

1. **Collaborative problem solving:** programs should enable the client to define their problems in conjunction with their HSPs;
2. **Targeting, goal setting and planning:** programs should target the issues that are of greatest importance to the client and health care provider, set realistic goals and develop a care plan tailored to client needs;
3. **Self-management training and support services:** programs that include instruction on disease management, behavioural support programs, physical activity and interventions that address the emotional demands of having a chronic condition are relevant; and
4. **Active and sustained follow-up:** evidence shows that reliable follow-up at regular intervals, initiated by the provider, leads to better outcomes (9, 10).

The extent to which DPs of the SHCI explored some or all of these components were addressed in the process evaluation of the National Evaluation (Section 2).

The SHCI is about the implementation of the self-management approach in the wider Australian context with a view to understanding the potential population-based impact of widespread dissemination of such a public health innovation i.e. effectiveness. The effectiveness of the SHCI was measured through the various elements of the National Evaluation for example, the process evaluation contributed to the understanding of what was successful and could potentially be rolled out at a national level.

1.2.3 Support for self-management interventions

The growing research literature on SMIs for chronic conditions ranges from client-centred studies concentrating on disease-specific programs using various forms of self-management education/training (11) through to more broadly based programs integrating self-management into appropriately organised health care systems linked with necessary resources based in the broader community (10, 12).

From the available literature, it is clear that self-management approaches can achieve improved outcomes for many chronic conditions. In particular, there is overwhelming evidence which supports the efficacy of SMIs (7, 13, 14) which assist people with chronic conditions to improve their quality of life and reduce their health service use (5, 7, 13). However, less evidence exists to support their effectiveness in the ‘real world’ i.e. in terms of whether the benefits of interventions are still evident when integrated into wider health care services (for example, Glasgow and others) (4).

The distinction between efficacy and effectiveness is illustrated in Box 1.

Box 1 Definitions for Efficacy and Effectiveness

Efficacy: the ability of an intervention to achieve its intended effect in those individuals who comply with it under optimal conditions; effect in an *ideal* world. Efficacy concerns the question ‘*Can it work?*’ (15).

Effectiveness: the ability of an intervention to achieve its intended effect in those to whom it is offered, that is its effect in practice or effect in the *real* world. Effectiveness concerns the question ‘*Does it work?*’ (15).

A recent review (5) indicated that there appears to be little difference in effect due to the delivery of approach, for example lay leader versus health professional, or individual versus group approaches, face to face or remotely (for example, internet or telephone) with change reported for a wide range of chronic conditions including asthma, diabetes, arthritis and cardiovascular conditions. Importantly, there is evidence in the literature that the approach is equally effective among those located in rural communities as for urban residents (5), and that the approach is effective in a range of cultural settings (5, 16).

However, it is also worth noting that differences in approach have been found to be appropriate for different chronic conditions. For example, it has been observed (4) that programs for asthma sufferers focused on monitoring symptoms, whilst, programs for clients with arthritis and diabetes had a broader focus on behavioural changes regarding lifestyle (for example, diet and exercise) and cognitive aspects. For this reason, SMIs for asthmatics tended to be shorter in duration. Furthermore, while education and action plans were found to be successful at reducing health service use in asthmatics, SMIs for arthritis and diabetes had a less immediate effect on the use of health care, since control of symptoms to restrict emergency visits was not the focus of these interventions (4). Nevertheless, behaviour change, irrespective of the disease focus was still found to be the most successful outcome assessed in the studies reviewed.

From a recent review (4) conducted on the background, content and efficacy of SMIs for asthma, type 2 diabetes and arthritis that was described in the current literature, several key recommendations were made:

1. The alternative approach to the disease-specific SMIs is to adopt a generic approach based on the premise that a core generic set of skills for example, problem solving and goal setting - might be sufficient to improve self-management (and hence health outcomes). However, the extent to which these generic rather than disease-specific skills are sufficient for the desired change in any illness has yet to be established and in doing so would be an important step in further developing the field of self-management.
2. To assist integration of SMIs into the health system, there needs to be recognition of the need for such interventions within national standards of care, as is beginning to occur in the UK (with asthma) and diabetes (with asthma and diabetes). In addition, if SMIs are to be more widely adopted in health care, skills such as group facilitation, problem solving, goal setting, and cognitive-behavioural techniques need to be enhanced and included as part of most HSPs' training.
3. In order to effectively target resources, there needs to be further investigation into which groups of clients benefit most from which interventions as well as considering how and when they are offered to clients.

All of the above recommendations are of relevance to the aims of the SHCI and are considered in more depth in Section 2.

1.2.4 Measures of self-management

Consistent with the predominantly disease-specific focus of chronic conditions, SMIs have historically been evaluated using disease-specific measures (12, 17). However, in recent times there has been a shift away from these disease-specific outcome measures (for example, through clinical assessments) to those which assess the development of self efficacy and self-management skills (see Box 2) in people with a wide range of chronic conditions (3, 7, 8, 18, 19).

Box 2 Definitions for Self Efficacy and Self-management Skills

Self efficacy: is the belief in one's own ability to successfully perform a health behaviour. Self efficacy is proposed as the most important prerequisite for behaviour change and will affect how much effort is put into a task and the outcome of that task. The promotion of self efficacy is thus an important aspect in the achievement of behaviour change, which in this case is improved self-management (20) (see self-management skills below).

Self-management skills: enable clients to be better equipped to live with and manage their chronic condition through:

- Adopting self-management behaviour (for example, regularly exercising);

- Managing the effect of chronic conditions on lifestyle (for example, on social activities);
- Achieving health-related outcomes (for example, managing symptoms); and
- The development of collaborative relationships with HSPs.

The prevalence of self-efficacy and related constructs as a measurement domain in the self-management literature reflects that most approaches share the premise that success reflects a development among clients of enhanced self-efficacy related to management of their chronic condition(s).

Accordingly, scales have been developed to specifically measure self-efficacy in relation to chronic conditions. Some of these are disease specific measures of self-efficacy (17). However, approaches to assessing the development of self-efficacy in relation to chronic conditions in general have also been developed. A well documented exemplar of a more generic instrument comes from Lorig and colleagues (18, 19). This instrument, field tested in several studies, is a composite of measures around self efficacy and self-management skills (18).

Outcome measurement of self-management programs has focused on health status, both physical and mental health, and health service utilisation. This focus reflects the view that, by delaying disability and reducing the toll of suffering associated with chronic conditions, self-management programs have the potential to improve health status, health related quality of life and to reduce reliance on health services. Again, condition-specific measures have been reported extensively in the self-management literature (7). They have the advantage of having been designed for the chronic condition in question and being able to provide detailed health measurement. However they do not allow comparison across conditions, including comparisons with normative data. Use of generic multi-dimension health status measures are also common in the self-management literature (21) for instance self rated health (for example, SF-1) (22). The question of course arises as to how sensitive generic health status measures might be to the more subtle influence of learning to better manage an ongoing chronic condition. Accordingly, standard health status measures are often augmented by more sensitive measures such as functional status and psychological distress measures, which might more readily be able to detect change over time in health related quality of life due to improved management of an ongoing condition (4, 23).

Reduced health service utilisation has consistently been reported as an outcome of self-management programs, both condition specific programs (5) as well as generic self-management programs (for example, (7)). These measures relate to the extent of physician visits, emergency room presentations, hospital admissions and hospital stays. While many studies have collected self reported measures of health service use, there have been concerns around the reliability of self reported utilisation. Recently self reported utilisation during a self-management program was validated against

computerised medical records and charts (21). With a six month recall period, self reported outpatient visits, including physician and emergency room visits, and hospital days were well correlated with the computerised medical records. Importantly reporting discrepancies were similar over time, which lessens concern when the measure of interest is change over time.

Section 3 outlines the measures which have been used as part of the National Evaluation of the SHCI

1.3 Purpose of the SHCI

Ultimately, the SHCI is about the implementation of the self-management approach in the wider Australian context with a view to understanding the potential population-based impact of widespread dissemination of such a public health innovation i.e. effectiveness. In order to achieve this, eight DPs were funded by DoHA to explore a variety of local generic approaches to the self-management of chronic conditions. As indicated in Section 1.2.3, there is a range of evidence to support the efficacy of SMIs, but not their effectiveness, hence the local self-management programs were DPs rather than trials.

As previously stated, the broad aims of the SHCI were to:

- Improve the health-related quality of life for people with chronic conditions, particularly those with co-morbidities;
- Improve the use of the health care system by people with chronic conditions; and
- Encourage collaboration between clients, their families and HSPs in the management of chronic conditions.

Trying to achieve these objectives raises a range of particular issues around implementation in the Australian context, for example:

- Roll-out as a community based health intervention;
- Engagement of HSPs;
- Cultural appropriateness of the approach; and
- Stakeholder involvement.

It was the DPs responsibility to consider these issues as part of their implementation strategies to operationalise self-management in their chosen contexts. Their focus and approach are described in more detail below.

1.4 The Demonstration Projects

The eight DPs, (one in each State and Territory covering a range of locations from metropolitan to remote) were funded to develop locally based DPs to demonstrate a variety of self-management service delivery approaches covering a range of chronic conditions. These DPs were generic across a range of chronic conditions and incorporated a variety of interventions, as there were no specified interventions that the DPs were required to undertake. The DPs also covered a range of culturally and linguistically diverse (CALD) and Indigenous populations. Within each self-defined context, the focus of the DPs was to:

- Develop and refine solutions to bring about change and improvement to identified systemic problem(s);
- Develop and strengthen partnerships between relevant stakeholders; and
- Be responsive and appropriate to their environmental and social context.

As a consequence, the DPs were not efficacy trials (for example, randomised controlled trials) of the self-management intervention. Rather the purpose of the DPs was to improve understanding about how to most effectively deliver self-management programs in the Australian context and to provide Australian-specific information for future policy options for better management of chronic conditions.

Each DP appointed a local evaluator whose main role was to provide data for the National Evaluation, and undertake a DP specific evaluation incorporating local objectives and contextual information. The findings of these local evaluations have been reported separately.

1.4.1 Demonstration Projects

The following is a brief description of each of the eight DPs, which includes the focus of the DP, an approximate timeline of DP activities, the target population and client interventions.

1.4.1.1 Australian Capital Territory (ACT)

DP name: Health Partners ACT.

Sponsor: The ACT Division of General Practice.

Location: Canberra (metropolitan location), ACT.

Focus: Health Partners ACT involved formal partnerships between four organisations: ACT Division of General Practice, ACT Community Health, Arthritis ACT and Health Care Consumers Association of the ACT. The aim of the DP was to improve the capacity of consumers to engage in self-management principles towards an improved quality of life, while developing the capacity of health care providers and Non-Government Organisations (NGOs) to support the process.

Timing: the approximate timing of the pre-implementation and implementation stages, along with the period of client recruitment is shown in Table 1.

Table 1 ACT timeline

2001		2002				2003				2004			
Jul - Sep	Oct - Dec	Jan - Mar	Apr - Jun	Jul - Sep	Oct - Dec	Jan - Mar	Apr - Jun	Jul - Sep	Oct - Dec	Jan - Mar	Apr - Jun	Jul - Sep	Oct - Dec
Pre-implementation		Implementation											
		Client recruitment											

Target population/recruitment: the DP aimed to recruit 256 clients aged over 50 years with at least two chronic conditions. The DP ended up recruiting 271 clients, in addition to working with another 14 participants in a younger age pilot and the Spanish community.

It was originally intended that GPs would be the primary source of referrals, however after four months the self-referral pathway was opened up to allow equal access to consumers who were not connected to the recruited GPs.

Client interventions: there were three key interventions offered to clients:

- Self-management planning: the DP intended to undertake care planning, however many of the participating GPs chose not to utilise a formal care planning process. Self-management planning was a primary intervention that involved goal setting, action planning and problem solving (from the Partners in Health (PIH) Scale (2)).
- Education and training: client education for self-management was based on the Chronic Disease Self-Management (CDSM) course developed by Stanford University ('Stanford Model'). The course ran over a period of six weeks in a group setting. A total of 243 clients (including 17 carers) enrolled in a self-management course, of these 215 completed the course. The course was also offered to the Spanish speaking clients in Spanish.
- Support: support was provided to clients via the DPs project officer and linkage to HSPs, however, the main pathway for client support was via self-help groups and organisations.

1.4.1.2 New South Wales (NSW)

DP name: South Western Sydney Chronic Disease Self-management Demonstration Project.

Sponsor: South Western Sydney Area Health Service, NSW.

Location: South-western Sydney (metropolitan location). The DP was located in four sites: Liverpool, Bankstown, Fairfield and Macarthur. A fifth site was to be located in the Southern Highlands as a sub-region of Macarthur, however the site remained inactive throughout the DP self-management program.

Focus: the aim of the DP was to better inform individuals with chronic conditions to better manage their conditions on a day to day basis so as to improve their health related quality of life. It also focused on Arabic speaking people in order to see if the Chronic Condition Self-Management (CCSM) intervention offered to English speaking clients was useful to Arabic speaking clients.

Timing: the approximate timing of the pre-implementation and implementation stages, client recruitment and the timing of the intervention for non-project participants is shown in Table 2.

Table 2 NSW timeline

2001		2002				2003				2004			
Jul - Sep	Oct - Dec	Jan - Mar	Apr - Jun	Jul - Sep	Oct - Dec	Jan - Mar	Apr - Jun	Jul - Sep	Oct - Dec	Jan - Mar	Apr - Jun	Jul - Sep	Oct - Dec
Pre-implementation													
		Implementation											
		Client recruitment						Intervention for non-DP clients					

Target population/recruitment: the DP planned to recruit 300 participants over the age of 50 years with at least one primary and one secondary chronic condition (or two primary diseases). The DP ended up recruiting approximately 320 clients, including 57 Arabic speaking clients.

Client interventions: the DP offered a 12 month intervention to clients which included the following elements:

- Care/self-management planning: the self-management interview/plan included the completion of the cue and response questions and problem and goal setting (from the PIH scale). This was followed by the development of an EPC care plan which a Primary Health Nurse completed with the client prior to being sent to the GP to provide input and sign-off.
- Education and training: client education for self-management was based on the Stanford model, which was offered in both the group and

one-on-one setting. The course was also translated into Arabic for the Arabic clients. Disease specific education and training was also offered to clients, however it was based upon client need and the availability of training.

- Support: support was generally DP based (for example, telephone calls, newsletters) along with referral to other HSPs.

1.4.1.3 Northern Territory (NT)

DP name: Katherine West Health Board Chronic Disease Self-management Project.

Sponsor: Katherine West Health Board.

Location: Katherine West region, NT. The DP operated out of four remote and isolated Indigenous communities at Lajamanu, Kalkaringi, Daguragu and Yarralin. The main DP office was located in Katherine.

Focus: the aim of the DP was to introduce CCSM to the four remote and isolated Indigenous communities by drawing on community development, self-management and health promotion techniques and skills. The DP focussed entirely on an Indigenous population.

Timing: the approximate timing of the pre-implementation, pilot implementation and full implementation stages along with client recruitment are shown in Table 3.

Table 3 NT timeline

2001		2002				2003				2004			
Jul - Sep	Oct - Dec	Jan - Mar	Apr - Jun	Jul - Sep	Oct - Dec	Jan - Mar	Apr - Jun	Jul - Sep	Oct - Dec	Jan - Mar	Apr - Jun	Jul - Sep	Oct - Dec
Pre-implementation													
					Pilot implementation								
					Full implementation								
					Client recruitment								

Target population/recruitment: the DP aimed to recruit 162 clients from a target group of 208 over the age of 35 years. The first disease the DP was targeting was diabetes, followed by high blood pressure (with or without diabetes) and then renal disease (with or without diabetes and/or high blood pressure). The DP recruited approximately 147 clients.

Client interventions: the primary interventions offered to clients included:

- Health promotion: community development was the core principle behind all CCSM health promotion activities (for example, walking groups and health eating video) and was driven by the communities' needs. In order to create community ownership of the activities, the health promotion activities were implemented by the Community

Support Workers (CSWs). Health promotion activities included videos and pamphlets.

- Care/self-management planning: self-management planning/interview included problem identification and goal setting. Care planning took place during a CCSM clinic and typically involved the client, GP, CSWs and a nurse. The care plan included EPC items and used graphics to help explain items to the client.
- Education and training: client education for self-management was based on the Stanford model and was introduced in the later stages of the DP. The course was modified to be more culturally appropriate, and changes to the course were community based. The course was offered in the group setting and in some cases, separate groups were run for males and females.

1.4.1.4 Queensland (QLD)

DP name: Sharing Healthcare.

Sponsor: The Arthritis Foundation of QLD.

Location: the main DP office (the metropolitan site) was located in Brisbane North, and the rural site was located in Warwick (Southern Downs District) QLD.

Focus: the DP aimed to create social, cultural and environmental conditions to enable self-management and change attitudes of health professionals and improve public awareness, in both the metropolitan and rural settings.

Timing: the approximate timing of the pre-implementation and implementation stages (including the pilot) along with client recruitment are shown in Table 4.

Table 4 QLD timeline

2001		2002				2003				2004			
Jul - Sep	Oct - Dec	Jan - Mar	Apr - Jun	Jul - Sep	Oct - Dec	Jan - Mar	Apr - Jun	Jul - Sep	Oct - Dec	Jan - Mar	Apr - Jun	Jul - Sep	Oct - Dec
Pre-implementation													
Implementation (including pilot)													
Client recruitment													

Target population/recruitment: the DP aimed to recruit 500 clients over the age of 50 years with any of the following chronic conditions and two co morbidities: diabetes, arthritis, osteoporosis, respiratory disorders and depression (co-morbidity). The DP recruited approximately 304 clients to their self-management program.

Client interventions: interventions offered to clients included:

- Education and training: client education for self-management was based on the Stanford model and was offered to clients in the group setting in both the metropolitan and rural locations.
- Support: support to clients was not an original feature of the DPs self-management program, however the need for support was identified during the self-management program. As a result, the DP offered all clients the opportunity to attend forums to discuss their need and provide input into the development of a self-sustaining framework for the establishment and growth of the support groups.

1.4.1.5 South Australia (SA)

DP name: Our Health in Our Hands in Our Region.

Sponsor: The South Australian Centre for Rural and Remote Health and the Spencer Gulf Rural Health School.

Location: the DP operated across three rural sites: Whyalla, Pika Wiya and Port Lincoln. The emphasis was placed on Whyalla as the DP centre, with Pika Wiya and Port Lincoln being viewed as smaller outreach sites. The site at Pika Wiya had a specific Indigenous focus and operated out of the local Aboriginal health service, within the context of the broader DP, which involved predominately non-Indigenous participants.

Focus: the DP aimed to explore ways in which to encourage participating clients to learn more about their illness and to understand how to manage their symptoms better. The DP also sought to encourage and actively promote more effective information sharing and collaboration between HSPs. Additionally, the DP looked to involve carers in the education and service access process, and promote community ownership and control of resources and information towards improved health and wellbeing.

Timing: the approximate timing of the pre-implementation and implementation stages and client recruitment is shown in Table 5.

Table 5 SA timeline

2001		2002				2003				2004			
Jul - Sep	Oct - Dec	Jan - Mar	Apr - Jun	Jul - Sep	Oct - Dec	Jan - Mar	Apr - Jun	Jul - Sep	Oct - Dec	Jan - Mar	Apr - Jun	Jul - Sep	Oct - Dec
Pre-implementation		Implementation											
		Client recruitment											

Target population/recruitment: the DP planned to recruit 750 clients aged 50 years and over for non-Indigenous clients and 35 years and over for Indigenous clients. Clients with one of the following chronic conditions were eligible to participate: asthma, arthritis, diabetes, osteoporosis, cardiovascular disease and depression (co-morbidity). The DP formally recruited

approximately 373 clients (258 in Whyalla, 46 in Pika Wiya, 69 in Port Lincoln).

Client interventions: interventions offered to clients included:

- **Care/self-management planning:** the self-management planning process for Indigenous and non-Indigenous clients involves cue and response questions and problems and goal setting (from the PIH scale). The self-management planning process led into the care planning process for both the Indigenous and non-Indigenous. The non-Indigenous EPC care plan was developed by a chronic condition management nurse, and required three HSP signatories in order to qualify for the Medicare Benefits Scheme (MBS) payment. The Indigenous EPC care plan was an integrated social, emotional and physical care plan that undertook a holistic approach to health.
- **Education and training:** client education for self-management was based on the Stanford model and offered to clients in the group setting for both the Indigenous and non-Indigenous participants. The course was adapted to be made more culturally appropriate for Indigenous clients. In addition, disease specific education and training was offered to clients through classes such as Tai Chi and exercise for arthritis.
- **Support:** support was DP based (for example, newsletters) as well as including a self-help element (for example, self-help groups, volunteers network and health resource centre).

1.4.1.6 Tasmania (TAS)

DP name: Whose Health is it Anyway?

Sponsor: The University Department of Rural Health, TAS.

Location: the DP operated out of three sites: Glenorchy/Glenview Homes (metropolitan); Break O’Day Local Government Area (incorporating St Helens, St Mary’s and Fingal) and the Mersey-Leven area (with outreach to Ulverstone and Sheffield) – both of which are rural locations.

Focus: the DP provided education, training and support to clients and HSPs in the three pilot sites. The DP aimed to increase the level of self-management among people with co-morbid chronic condition and to increase the level of knowledge and support for self-management in the health system.

Timing: the approximate timing of the pre-implementation and implementation stages and client recruitment is shown in Table 6.

Table 6 TAS timeline

2001		2002				2003				2004			
Jul - Sep	Oct - Dec	Jan - Mar	Apr - Jun	Jul - Sep	Oct - Dec	Jan - Mar	Apr - Jun	Jul - Sep	Oct - Dec	Jan - Mar	Apr - Jun	Jul - Sep	Oct - Dec
Pre-implementation													
Implementation													
Client recruitment													

Target population/recruitment: the Tasmanian DP planned to recruit 600 clients aged 50 years and over with one of the following chronic conditions: cardiovascular disease, diabetes, arthritis, osteoporosis, respiratory disorders and depression (co-morbidity). The DP also aimed to provide reach into the Polish community. The DP formally enrolled 264 clients into its self-management program, including 23 Polish clients.

Client interventions: interventions offered to clients included:

- Education and training: client education for self-management was based on the Stanford model and offered to clients in a group setting. The course was also provided to the Polish clients in their own language by someone from their own culture.
- Community development/support: the DP had a community development fund from which the site managers were able to delegate amounts up to \$1000 to community groups to undertake activities that supported the DP's aims and objectives. The DP was involved in a number of community development/support activities (for example, Tai Chi, cooking for diabetes, on-line guide to accessing health information, and a number of workshops, seminars and expos addressing health related issues such as grief, falls prevention, medicine usage, osteoarthritis and osteoporosis).

1.4.1.7 Victoria (VIC)

DP name: The Good Life Club.

Sponsor: Whitehorse Division of General Practice.

Location: the eastern suburbs of Melbourne, encompassing the Whitehorse Municipality (metropolitan location).

Focus: the DP was based on a Stages of Change Model of behaviour change and telephone coaching. The DP aimed to improve the health related quality of life for clients with diabetes and cardiovascular disease, improve the use of the health system by clients with those diseases, and to encourage collaboration between individuals, their families and HSPs in the management of their chronic conditions.

Timing: the approximate timing of the pre-implementation and implementation stages and client recruitment is shown in Table 7.

Table 7 VIC timeline

2001		2002				2003				2004			
Jul - Sep	Oct - Dec	Jan - Mar	Apr - Jun	Jul - Sep	Oct - Dec	Jan - Mar	Apr - Jun	Jul - Sep	Oct - Dec	Jan - Mar	Apr - Jun	Jul - Sep	Oct - Dec
Pre-implementation													
Implementation													
Client recruitment													

Target population/recruitment: the Victorian DP planned to recruit 1000 clients aged 50 years and over with diabetes and cardiovascular disease, a sub-target of the DP was older males and the Chinese community. The DP recruited a total of 350 clients.

Client interventions: intervention offered to clients included:

- Care/self-management planning: the self-management planning process involved the development of a self-management plan (including problem and goal setting) and a medical management plan (which involved GP sign-off on the client’s goals and allowed for the opportunity for medical targets to be added). Clients were ideally referred to the DP by a GP with a partially completed care plan, which was then fully completed by the DP. Due to the rate of GP participation in care planning falling as the DP progressed, it was envisaged that the medical management plan would be a process through which to engage the GP.
- Support: each client was allocated a coach after which the coaching process began. The coaching was based upon the stages of change model (24), with a CCSM focus in order to build the clients self-management capacity over time. A number of support/education activities were developed over the course of the DP self-management program (for example, workshops, computer/internet training, supermarket tours and resistance training).

1.4.1.8 Western Australia (WA)

DP name: HealthPartners.

Sponsor: Canning Division of General Practice.

Location: South-East region of Perth (metropolitan location), WA.

Focus: the DP aimed to build capacity in clients, GP practices and health and social service providers within the Canning Region to support the principles of self-management through the promotion of awareness, understanding and the integration of a self-management model of care into the primary care setting.

Timing: the approximate timing of the pre-implementation, pilot and implementation stages, along with client recruitment is shown in Table 8.

Table 8 WA timeline

2001		2002				2003				2004			
Jul - Sep	Oct - Dec	Jan - Mar	Apr - Jun	Jul - Sep	Oct - Dec	Jan - Mar	Apr - Jun	Jul - Sep	Oct - Dec	Jan - Mar	Apr - Jun	Jul - Sep	Oct - Dec
		Pre-implementation				Pilot implementation				Full implementation			
						Client recruitment							

Target population/recruitment: the DP planned to recruit 400 clients aged 50 years and older with cardiovascular conditions and/or diabetes with other co-morbidities including depression. The DP aimed to target clients whose social circumstances may be a barrier to their capacity to self-manage. The DP had a total of 605 clients participating in the self-management program, of these clients 200 agreed to be part of the National Evaluation. A financial incentive was paid to GPs for referral of clients to the DP who partook in the evaluation.

Client interventions: intervention offered to clients included:

- Care/self-management planning: the DP originally intended to recruit GPs who would refer clients and be an active participant in the client’s self-management planning (incorporating the PIH and stages of change) and care planning. The care plans would be eligible for EPC payments and they would be based on documentation already utilised by the Canning Division of General Practice. However due to difficulties in recruiting GPs and the pressure this put on the DP’s timetable, the active involvement of GPs in the self-management/care planning process did not evolve.

Instead, action plans replaced care plans. The action plan was developed by the DP facilitator and was based upon the stages of change model, which allowed for the identification of where the client was at in terms of readiness for change (24), client goals and referrals. Developing the action plan with the client became a barrier to engaging the client, so it became a tool for recording the client’s progress. As there was no sign off on the plan by the clients, the GP did not see the action plan.

- Education and training: client education for self-management was based on the Stanford model and offered to clients in a group setting. Disease specific education and training occurred via the Live Life Club, which aimed to increase the client’s knowledge of a variety of lifestyle issues in a supportive environment and operated out of two locations. Walking groups and nutrition courses were also provided to clients.
- Support: whilst some support was DP based (for example, contact with the DP facilitators) support to clients generally occurred via the Live Life Club (run by DP personnel), and walking and nutrition groups.

1.5 Purpose of the report

This is the final report of the National Evaluation of the Sharing Health Care Initiative (SHCI). The final report comprises: the *Executive Summary*, the *Discussion*, the *Technical Report (this report)* and *Appendices (attached to this report)*.

The primary purpose of the Technical Report is to present the results from the process, impact and outcome evaluation components of the National Evaluation of the SHCI. All of the analyses presented here is in aggregated, de-identified form and covers the period from DP ‘go-live’ in June 2002 through to their completion in June 2004.

Presentation of findings

In accordance with discussion at the August 2004 Indigenous National Evaluation workshop, the results for the non-Indigenous DPs and Indigenous DPs have been reported separately in Section 4 and Section 5 respectively.

1.5.1 Roadmap to the report

The purpose of the National Evaluation was to address each of the nine evaluation questions (set out in Table 11, Section 2). However, whilst aspects of these evaluation questions are considered throughout this Technical Report, it is the purpose of the full Discussion in the final section of this report to pull together all of the findings described here and to explicitly address each of these questions. For reference purposes, the following table provides a roadmap of the components of the National Evaluation to the evaluation questions and data sources which are set out in this Technical Report.

Table 9 Final Report Roadmap

	Evaluation Questions	Key Source Data	Report Section Non-Indigenous; Indigenous
Demographics	1, 2 (<i>Who participated?</i>)	<ul style="list-style-type: none"> Client Information Questionnaire (CIQ) 	<ul style="list-style-type: none"> Methods 3.1 Results 4.2; 5.3 Discussion 6
Process	1, 2, 3, 4 6, 8 (<i>What happened?</i>)	<ul style="list-style-type: none"> Process Maps Project Reports 	<ul style="list-style-type: none"> Methods 3.2.1; 3.2.2 Results 4.3.1; 4.3.2; 5.4.1 Discussion 6
Impact	4, 6, 7, 8, 9 (<i>What barriers & facilitators were experienced?</i>)	<ul style="list-style-type: none"> Focus Groups Key Informant Interviews Client Health Questionnaire (CHQ) 	<ul style="list-style-type: none"> Method 3.3.1; 3.3.3 Results 4.4.1;4.6; 5.5.1; 5.7 Discussion 6
Outcome	4, 5,6 (<i>Who benefits?</i>)	<ul style="list-style-type: none"> CIQ CHQ Client Service Use Questionnaire (CSUQ) Intervention Schedule 	<ul style="list-style-type: none"> Method 3.4; Results 4.4.2 to 4.5.5; 5.6 Discussion 6