5 Results for the Indigenous Demonstration Projects

5.1 Results for the Indigenous Demonstration Projects

As discussed at the August 2004 Indigenous National Evaluation workshop, the results from the Indigenous DPs (Katherine West Health Board [NT] and Pika Wiya Aboriginal Health Service [SA]), have been described separately to the non-Indigenous DPs. The results of the non-Indigenous DPs are set out in Section four and those of the Indigenous DPs are set out below.

The context within which the both of the Indigenous DPs sit differs somewhat, in that one Indigenous DP focused entirely on an Indigenous population that involved remote sites, while the other Indigenous DP was a specific Indigenous site within a broader DP that involved predominately non-Indigenous participants. The questionnaire data presented in this Section also includes 2% of clients from the non-Indigenous DPs who identified themselves as being of an Indigenous background.

5.2 Sample Characteristics and analysis

5.2.1 Number of respondents

Table 106 shows the number of clients who completed questionnaires at each of the measurement points.

Table 106 Client questionnaire completion over time

	Baseline	Middle	Last
CIQ	210	n/a	72
CHQ	203	142	71
CSUQ	210	143	67

From the table it can be seen that clients provided various combinations of data over the course of the DP ((baseline, middle and last). This is described in more detail below.

Two hundred and ten (210) clients were recruited into the Indigenous DPs at baseline and the CIQ was completed for all these clients. From this point forward, not all clients provided information at each measurement point. Even at baseline, 7 (3%) of the 210 clients recruited were missing the CHQ, whilst 210 clients completed the CSUQ.

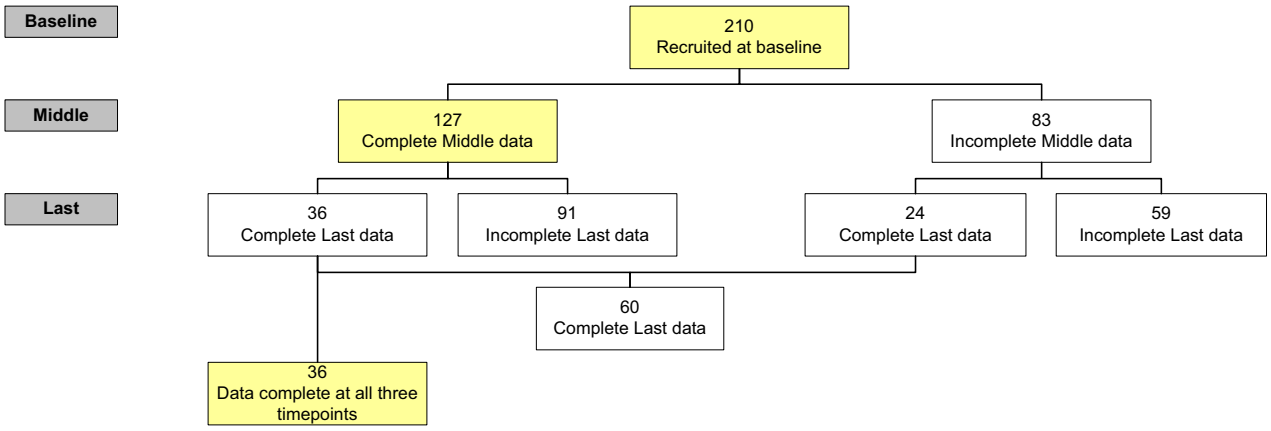
At the middle point, 142 clients completed the CHQ. However, 15 of these clients did not have any matching baseline information and were not eligible for further analysis. At the middle measurement point, 127 clients had baseline data (CIQ and CHQ or CSUQ) and complete middle data (CHQ, CSUQ), representing

60% of the total number of clients recruited. Eighty three of the 210 clients (40%) recruited at baseline had missing data at the middle point.

At the last measurement point, 60 clients had complete data, 24 of these clients had previously missed the middle data measurement point. Only 36 of the 210 clients had complete information at all three measurement points. Therefore, the analysis plan developed for the Indigenous DPs was to attempt to conduct statistical comparisons between 1) baseline and middle points (n=127) and 2) baseline and last points (n=60). This strategy utilised all the data received in the most efficient way.

The shaded boxes in Figure 47 represent the information used for different analysis purposes.

Figure 47 Number of clients who provided information at each measurement point



Additional information from the Indigenous DPs received at the conclusion of the DPs revealed that 504 clients had withdrawn from the SHCI over the life of the Indigenous DPs for a variety of reasons. The reasons for drop out are not known as this was not provided to the national evaluator.

5.2.2 Rationale for selection of variables used in analysis

The range and type of health outcome variables available for analysis was severely restricted by the disparity of the questions posed in each Indigenous questionnaire. To obtain a common dataset across all Indigenous DPs, sets of variables from the two Indigenous questionnaires were collapsed into a categorical form and then merged together. Hence, in addition to the core demographic variables, sixteen categorical health outcome variables were identified for analysis between measurement points (see Table 107).

It is important to recognise that this is the first time that self-management questionnaire data have been collected from Indigenous communities in

Australia, therefore with minimal testing of the survey instrument, it is not known whether the results from these data will be valid and/or reliable.

Also, the substantial variation between the two sets of Indigenous questionnaires has had a considerable impact on the extent of analysis that can be undertaken at an aggregated national level. In particular, only a limited number of questions can now be directly compared either nationally or against international findings. Table 107 outlines the variable used in the analysis and the categorical response options.

Table 107 Variables included in analysis of Indigenous DPs

Variable/Questions	Categorical Response Options
How is your general health now?	Very good/Fair/Poor
Do you get tired?	Not at all/Sometimes/All the time
Do you get short breath?	Not at all/Sometimes/All the time
Do you get pain sometimes?	Not at all/Sometimes/All the time
Does your illness affect things you can eat or drink?	Not at all/Sometimes/All the time
Does your illness affect looking after your family?	Not at all/Sometimes/All the time
Does your illness affect you playing sport?	Not at all/Sometimes/All the time
Does your illness affect you when you are relaxing like watching TV?	Not at all/Sometimes/All the time
Does your illness affect your financial situation?	Not at all/Sometimes/All the time
Does your illness affect your relationship with your husband/wife?	Not at all/Sometimes/All the time
Does your illness affect your relationship with your family?	Not at all/Sometimes/All the time
Does your illness affect your relationship with your neighbours?	Not at all/Sometimes/All the time
How confident are you that you can stop tiredness keeping you from the things you want to do?	Not at all confident/Sometimes confident/Totally confident
How confident are you that you can keep physically active when you want to?	Not at all confident/Sometimes confident/Totally confident
How confident are you that you can stop your illness from making you feel down?	Not at all confident/Sometimes confident/Totally confident
How confident are you that you can do the different things you need to manage your illness?	Not at all confident/Sometimes confident/Totally confident

The results presented in this report relate to demographic characteristics, and some indicative health status and behaviour information. Data are summarised in either table form or as a series of cross-tabulations with chi-squared tests, where appropriate. The use of statistical tests was limited due the small sample sizes. Categorical data at each measurement point are displayed visually using bar charts.

Spearman's correlation co-efficient was used to examine relationships between the health status and behaviour variables at baseline. Comparisons were made between baseline and middle measurement points and baseline and last measurement points. Analysis across three measurement points was not possible due to the small sample size (n=36). Significant differences were reported using a non-parametric Wilcoxon's Matched Pairs Signed ranks test.

5.2.3 Changes in the demographic profile due to loss to follow-up

Table 108 and Table 109 shows the demographic characteristics of clients lost to follow-up at the middle and last measurement points. It is evident from these tables that the clients lost to follow-up at both measurement points were not significantly ($p>0.0005$) different from those who continued to participate in the study.

The impact of loss to follow-up on client health status profile was also reviewed and no significant differences in any of the health outcome variables or health service utilisation were observed.

Table 108 Demographic characteristics of participants lost to follow-up at middle

		Lost at Middle (n=83)		Middle (n=127)		
Characteristics		**n**	**%**	**n**	**%**	**p**
Schooling						
	None	28	36.4	38	32.5	
	Year 8 or below	31	40.3	47	40.2	
	Year 9 to Year 12	18	23.4	32	27.4	0.78
Sex						
	Male	32	38.6	44	34.6	
	Female	51	61.4	83	65.4	0.67
Age						
	<35 years	13	16.5	18	15.3	
	35-44 years	15	19.0	24	20.3	
	45-54 years	20	25.3	25	21.2	
	55-64 years	21	26.6	22	18.6	
	65+ years	10	12.7	29	24.6	0.27
Disease group						
	Diabetes	46	82.1	91	89.2	0.32
	Cardiovascular	51	79.7	73	89.0	0.18
	Renal	5	20.0	13	31.0	0.49

Table 109 Demographic characteristics of participants lost to follow-up at last

		Lost at Last (n=150)		Last (n=60)		
Characteristics		**n**	**%**	**n**	**%**	**p**
Schooling						
	None	44	31.7	22	40.0	
	Year 8 or below	52	37.4	26	47.3	
	Year 9 to Year 12	43	30.9	7	12.7	0.033
Sex						
	Male	51	34.0	25	41.7	
	Female	99	66.0	35	58.3	0.376
Age						
	<35 years	25	17.7	6	10.7	
	35-44 years	25	17.7	14	25.0	
	45-54 years	34	24.1	11	19.6	
	55-64 years	29	20.6	14	25.0	
	65+ years	28	19.9	11	19.6	0.552
Disease group						
	Diabetes	102	86.4	35	87.5	1
	Cardiovascular	92	82.9	32	91.4	0.336
	Renal	13	23.6	5	41.7	0.359

5.3 Description of the sample

In this Section, the demographic characteristics and health related circumstances of DP participants are described including how the participant profile changed over time taking into account the impact of loss to follow-up/drop out from the SHCI.

5.3.1 Demographic characteristics

Table 110 shows the demographic characteristics of participants in the Indigenous DPs at the baseline and last measurement points.

The majority of participants in the Indigenous DPs were female. The level of schooling that respondents had obtained was reasonably well spread, however, there were slightly more respondents who reported that they had completed schooling at a level equivalent to year 8 or below. Participants were distributed relatively evenly among age categories from less than 35 years to 65 years plus, however, there were slightly fewer participants in the younger than 35 age category. Over 90% of respondents reported that they spoke a language other than English at home.

Table 110 Demographic characteristics of participants in Indigenous DPs at baseline and last measurement points

		Baseline (n=210)		Last (n=60)	
Characteristics		**n**	**%**	**n**	**%**
Schooling					
	None	66	31.4	22	40.0
	Year 8 or below	78	37.1	26	47.3
	Year 9 to Year 12	50	23.8	7	12.7
Sex					
	Male	76	36.2	25	41.7
	Female	134	63.8	35	58.3
Age					
	<35 years	31	14.8	6	10.7
	35-44 years	39	18.6	14	25.0
	45-54 years	45	21.4	11	19.6
	55-64 years	43	20.5	14	25.0
	65+ years	39	18.6	11	19.6
Language spoken at home					
	Language other than English	192	91.4	58	96.7
	English	18	8.6	2	3.3

5.3.2 Health-related circumstances

Table 111 shows that the majority of participants reported living with their families or others rather than living alone, although only around one fifth reported that they had a 'carer'. Respondents reported diabetes and cardiovascular disease to be the most common conditions that they currently had. The proportion of participants who reported that they never smoked increased from baseline to last as did the proportion who stated that they were a smoker or ex smoker. Alcohol consumption remained relatively stable over time with most participants stating that they never drank.

Table 111 Health-related circumstances of participants in Indigenous DPs at baseline and last measurement points

	Baseline (n=210)		Last (n=60)	
Characteristics	**n**	**%**	**n**	**%**
Living Arrangements				
Live alone	20	9.5	3	5.0
Live with family / friends	189	90.0	57	95.0
Has a Carer				
Yes	34	16.2	14	23.3
No	168	80.0	46	76.7
Present condition (can have more than one)				
Diabetes	137	65.2	35	58.3
Cardiovascular Disease	124	59.0	32	53.3
Renal Disease	18	9.0	5	8.3
Smoking Status				
Never smoked	117	55.7	42	72.4
Smoker / ex smoker	84	40.0	16	26.7
Alcohol Consumption				
Never drink	124	59.0	39	65
Sometimes drink/drink daily	78	37.1	20	33.3

Some occasional missing data - percentages may not total to 100%

The relationships between the demographic variables at baseline are outlined in Appendix 32. In this small group of participants from the Indigenous DPs, the following inter-relationships between the demographic characteristics were noticeable and statistically significant and may have an effect on participant health status which is considered in Section 5.6:

- Older clients reported less schooling and were less likely to drink alcohol;
- Male clients were more likely to drink alcohol and smoke;
- In general, clients who reported that they were smokers were more likely to report that they drank alcohol;

- Clients who live alone were more likely to speak English; and
- Clients with diabetes were more likely to live with their family and also have cardiovascular disease.

5.4 Process evaluation results – what processes were undertaken during Demonstration Project implementation and how they changed over time

This Section describes how, over the life of the SHCI, the Indigenous DPs sought to reach potential participants and what processes were undertaken during the implementation phase.

5.4.1 Process maps of the Indigenous self-management Demonstration Projects in the SHCI

5.4.1.1 Client

5.4.1.1.1 Baseline

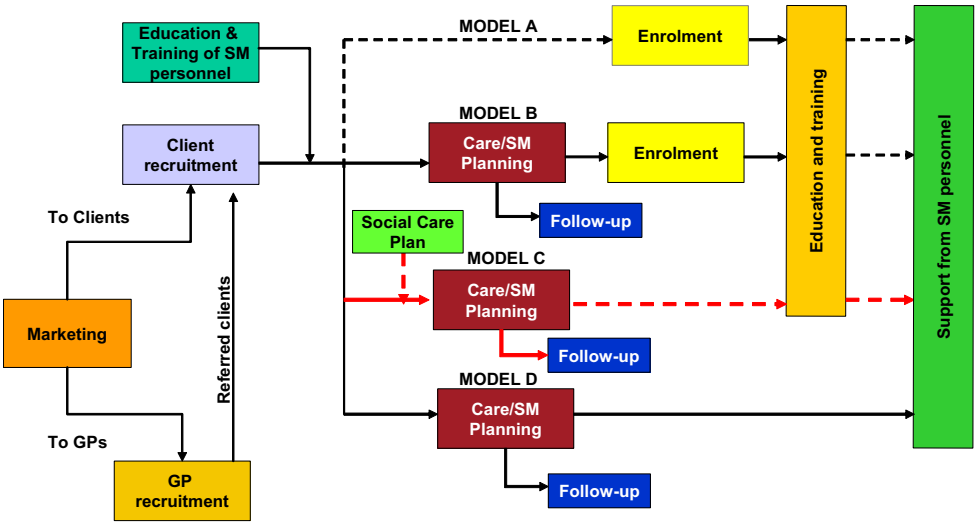
Description of the client overview process map

The overview process map at baseline for the client domain, including Indigenous clients is shown in Figure 48.

From the baseline client overview process map, it is possible to see that all of the DPs did some form of marketing to clients and client recruitment. This was achieved through the recruitment of GPs, who then undertook the marketing to clients or for the DPs to market directly to the clients.

After the marketing and recruitment of clients, there was some diversion in the Process Models adopted by the DPs. This resulted in four distinct Process Models at baseline, each of which is described in Section 4.3.1.1.1. The Indigenous DPs were in Process Model C. Described below are the elements that are unique to the Indigenous DPs, and highlighting any points of variation between the two Indigenous DPs.

Figure 48 Indigenous overview process map for the client domain at baseline



Description of the client Process Model for Indigenous DPs

A description of Process Model C is provided below. For a description of Process Models A, B and D at baseline see Section 4.4.1.1.1.

Process Model C

The education and training of self-management personnel for Indigenous DPs was on an ongoing basis.

The marketing process for the Indigenous DPs was based upon on a broader community health approach that focused not only on client recruitment, but also incorporated health promotion. This was then followed by the client recruitment process. To assist with this, one DP undertook a targeted approach to client recruitment, identifying those clients who fit the selection criteria, whilst the other achieved client recruitment via community engagement.

The first key step for clients following recruitment into the DP was a care/self-management planning process. One of the Indigenous DPs developed a distinct social care plan. The social care plan took a holistic approach to health care, taking into consideration non-health related factors. The care/self-management process involved some degree of follow-up.

Education and training options for Indigenous DPs at baseline were informal education sessions. All clients received varying degrees of support from self-management personnel, primarily the CSWs and Aboriginal Health Workers (AHWs) who were involved with the DP.

Variation in process for the Indigenous DPs in Process Model C existed for the theme: *timing of education and training of self-management personnel*. The reason being one Indigenous DP undertook education and training of self-management personnel prior to the recruitment of clients, whilst the other DP undertook the majority of training on an ongoing basis, with some occurring prior to client recruitment.

An example of similarity in process was for the theme: *nature of marketing*, as both DPs focused on marketing directly to clients. See the thematic analysis in Appendix 30 for more detail on variations and similarities.

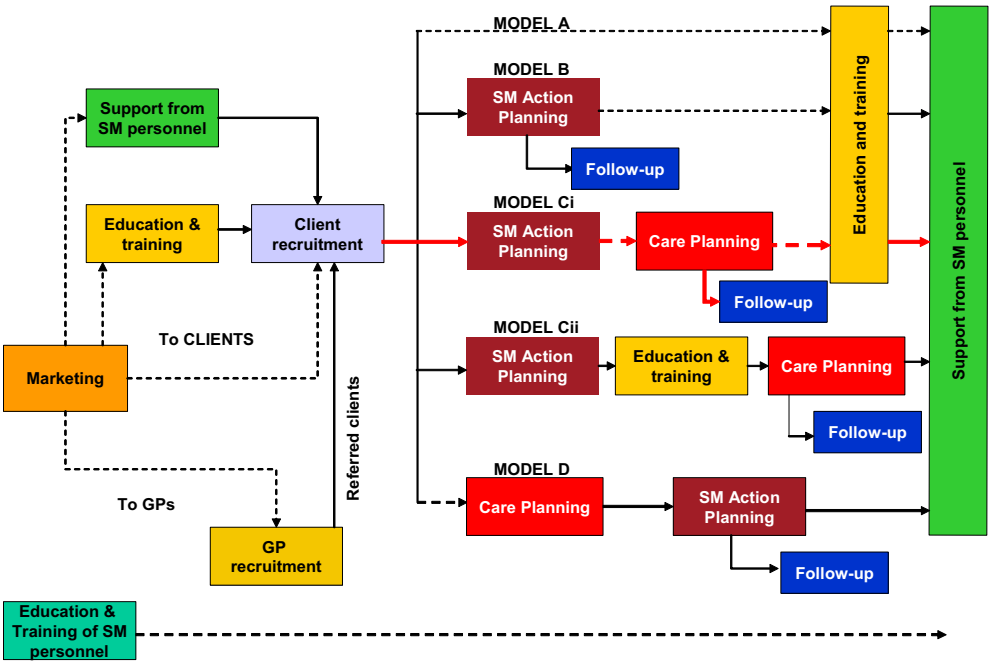
5.4.1.1.2 Middle measurement point

Description of the client overview process map

The overview process map for the client domain including Indigenous DPs, at the middle of the DP is shown in Figure 49.

The middle of DP overview process map identifies that whilst many of the same processes were still in place, refinements to the processes in order to meet their recruitment targets were made, resulting in the points of diversion (Process Models) increasing to five, however both Indigenous DPs remained in Process Model Ci.

Figure 49 Indigenous overview process map for the client domain at the middle measurement point



Changes from baseline to the middle measurement point for Indigenous DPs

When comparing the processes in place for the Indigenous DPs at the middle measurement point (Figure 50) with those at baseline (Figure 49), a number of clear themes emerged:

- **Client marketing and recruitment:** between baseline and the 6 month measurement point, many of the non-Indigenous and Indigenous DPs had explored more diverse ways of reaching their client base in order to increase the number of clients recruited into the DPs. This included one of the Indigenous DPs, who sought to recruit community members attending informal education and training sessions held by the DP, resulting in those participants receiving education and training prior to formal recruitment into the DP self-management program. To reflect this change education and training has been included in the front end of the process map.

- **GP recruitment:** whilst many of the non-Indigenous DPs experienced difficulties in recruiting GPs into their self-management programs for the purpose of client recruitment and to partake in the care/self-management process, the Indigenous DPs had some success in engaging GPs via the care planning process, which could be due in part to the fact that the GPs are employed by the Aboriginal health services, along with the engagement and support of the respective Aboriginal health service board.

- **Education and training of self-management personnel:** the ongoing nature of education and training in the Indigenous DPs resulted in the development of various DP specific training options, reflecting the individual DPs commitment to continuing staff development and/or the DP self-management program needs. To reflect this, the process now runs alongside the overview client process map instead of being an integral part of the overall client process which was the case for baseline.

- **Care/self-management planning:** the distinction between self-management planning and care planning became evident at the middle process mapping visit. This was due to the DPs being able to more easily define the scope of their client self-management planning processes. This was due, in part, to the DPs success or otherwise in engaging HSPs into the process and the extent to which they would be involved in the care/self-management planning process. At the middle measurement point, it was clear that both Indigenous DPs undertook a self-management planning process. The social care planning that was undertaken by one of the Indigenous DPs at baseline had been incorporated into the self-management planning process by the middle measurement point.

However, social issues and non-health related problems continued to be identified through the problem identification and goal setting processes in the self-management plan for both Indigenous DPs.

Following the self-management planning, both Indigenous DPs had a formal care planning process underway by mid DP that included the involvement of a GP. For one of the Indigenous DPs the care plan was developed in a DP specific CCSM clinic. Ideally, in attendance at this clinic were the client, GP, a nurse and CSW(s), who worked together to develop the care plan through a multi-disciplinary approach. For both Indigenous DPs, the care planning tool evolved over the life of the DP self-management program, both in terms of being culturally appropriate and self-management appropriate.

- **Education and training of clients:** in order to increase recruitment numbers, one of the Indigenous DPs began to recruit DP participants through DP led initiatives, such as informal health information sessions on a range of health issues, resulting in some clients receiving education and training prior to formal recruitment into the DP.

Description of the client Process Model for the Indigenous DPs

The changes that had evolved from baseline to the middle measurement point for the Indigenous DPs resulted in some changes to the Process Model C described at baseline. Process Model C is described below, the other four Process Models that had evolved at the middle measurement point are described in the middle client overview process map in Section 4.3.1.1.2.

Process Model C

The first key step for clients following recruitment into the DP was a self-management planning process, incorporating social and non-health related factors, this was then followed by a formal care planning process involving a GP. The care and self-management planning process involved some degree of follow-up for all clients. The clients in one of the Indigenous DPs then had the option of participating in informal education and training. All clients received varying degrees of support from self-management personnel.

An example of variation in process between the DPs in Process Model C was for the theme: *referral of clients for recruitment*. The reason being one of the DPs had clients who self-referred to the self-management program only, whilst the other DP utilised all avenues of referral (for example, self-referral, GP and other HSP).

An example of similarity in process was for the theme: *driver of self-management planning, as the DP personnel*, AHW or CSW originated and

completed the self-management plan. See the thematic analysis in Appendix 30 for more detail on variations and similarities.

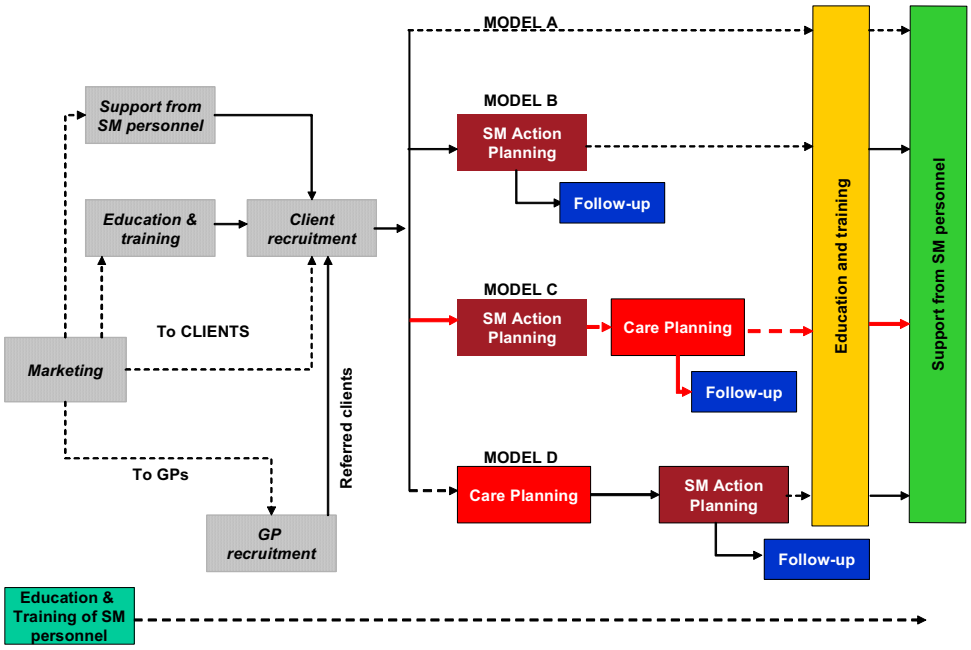
5.4.1.1.3 Last measurement point

Description of the client overview process map

The last overview process map for the client domain is shown in Figure 50.

The last overview process map signals the changing focus of the DPs, as the self-management programs came to a close, as many of the Indigenous DPs were no longer actively recruiting participants to the self-management programs, and were concentrating on the back end processes such as care/self-management planning, education and training and support.

Figure 50 Indigenous overview process map for the client domain at the last measurement point



Changes from the middle measurement point to the last measurement point

When comparing the process that were in place at the middle measurement point (Figure 49) and the last measurement point (Figure 50), some clear themes emerged:

- **Marketing and recruitment:** reflecting the fact that the Indigenous DPs were coming to the closing stages of their self-management programs, they had ceased actively trying to recruit new clients.

- **Education and training of self-management personnel:** by the closing stages of the DP self-management programs, the core education and training of self-management personnel that was generally standard across the DPs was still ongoing for one of the Indigenous DPs as a result of the high level of turnover in DP personnel and the constant need to train the new staff. DP personnel from one of the Indigenous DPs attended the Master training for the Stanford course, resulting in that DP potentially having the only Indigenous Master Trainer in the world. After the middle measurement point, DP specific education and training with a broader health focus was also continuously being implemented in the Indigenous DPs.

- **Care/self-management planning process:** the care planning tools used by the Indigenous DPs continued to evolve over the later stages of the DP self-management program. Whilst many of the non Indigenous DPs were focussing on care plan review and follow-up at the last measurement point, the focus of the Indigenous DPs was still on care plan development.

- **Education and training of clients:** whilst one of the Indigenous DPs had been offering informal education and training to participants at both baseline and the middle of the DP, by the last measurement point both Indigenous DPs had implemented the Stanford course. In order to make the course more culturally appropriate, both Indigenous DPs adapted the course depending on the community in which the course would be held.

Description of client Process Model for Indigenous DPs

The changes that had evolved from the middle to the last measurement point resulted in the number of Process Models decreasing from five to four Process Models, the four Process Models at the last measurement point are described in Section 4.3.1.1.3. Process Model C at the last measurement point is described below.

Process Model C

The first key step for clients following recruitment into the DP was a self-management planning process, this was then followed by care planning. The care/self-management planning process involved some degree of follow-up for all clients. The clients in Process Model C then had the option of participating in a Stanford course, and/or other informal education and training for one of the DPs. All clients received varying degrees of support from self-management personnel (for example, talking with self-management personnel, self-help groups and information sessions).

Examples of variation in process at the last measurement point remained unchanged from those described at the middle measurement point.

Within Process Model C at the last measurement point, an example of similarity in process was for the theme: *determinants of client education and training*. The reason being the education and training of clients was based upon client need for both Indigenous DPs, and in some cases, there was a range of education /training options available (for example, information sessions). See the thematic analysis in Appendix 30 for more detail on variations and similarities.

5.4.1.2 Community domain

5.4.1.2.1 Baseline

At baseline, despite the Indigenous DPs having a clear idea of who their community was, their general approach to community engagement and what goals they wanted to achieve, they had had less clarity around how to achieve those goals. This was not surprising, as the DPs were still in the very early stages of implementation, and for this reason it was not possible to develop an "overview process map" for the Indigenous DPs at baseline.

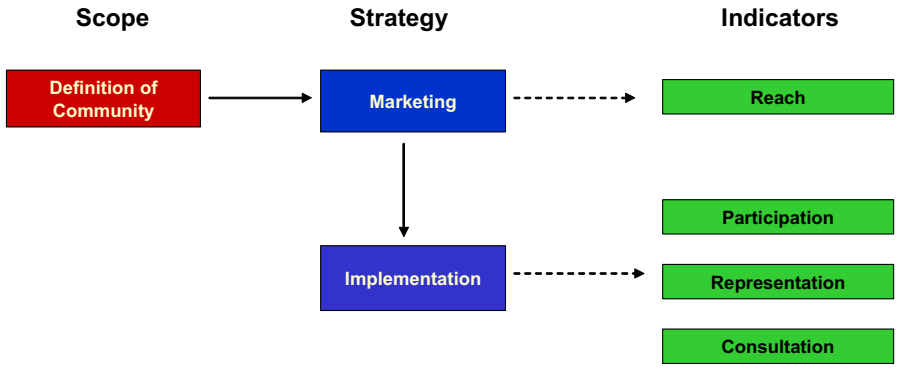
It was possible however to map the four processes describing community involvement in self-management identified in the NEF (reach, health promotion, health planning, and support from the DPs).

Description of the processes of community involvement

Taking this approach to the community domain, Figure 51 was developed in order to capture the following processes of community engagement:

- A DP specific description of how community was defined;
- The nature of the marketing strategies that were used to engage the community;
- The subsequent implementation strategies; and
- A description of the indicators of success of these strategies, which are reach, participation, representation and consultation.

Figure 51 Indigenous processes of community involvement at baseline



A feature of the Indigenous DPs was that they undertook a whole of community approach. This approach was characterised by:

- Community ownership and control;
- Designing the DP to suit the diverse needs of the community, and requiring a number of different strategies in order to achieve this (for example, large health promotion focus in addition to client interventions in a culturally appropriate way);
- Engagement of the entire community, not just clients/potential clients; and
- Community wide resourcing and skill development to support the DP.

Based upon the processes utilised by the Indigenous DPs at baseline in their approach to community engagement, variations and similarity were highlighted by the thematic analysis.

An example of variation in process between the DPs in the community Process Model was around the theme: *consultation with the community*. One of the DPs undertook reasonably extensive consultation with the community. This involved consultation on a repeated basis, consultation with a number of community groups via a number of methods, and there was a rather wide focus of discussion. While the other DP undertook less extensive consultation with the community. This involved one off consultations, a limited number of community groups being consulted, a very limited number of avenues of consultation were used, and there was a narrow focus of discussion.

For all other themes, the DPs were classified similarly. See the thematic analysis in Appendix 30 for more detail on variation.

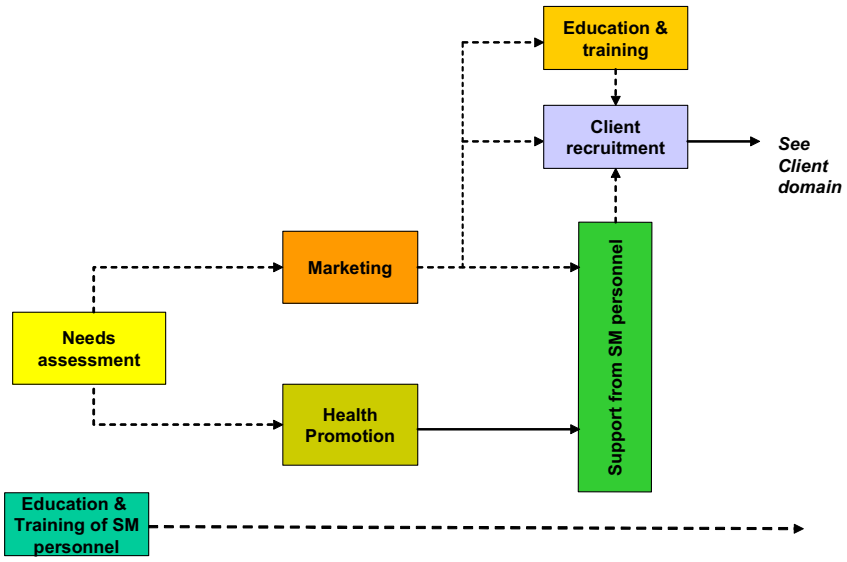
5.4.1.2.2 Middle measurement point

Description of the community overview process map

The middle of DP overview process map for the community domain is shown in Figure 52.

At the middle data measurement point, it was possible to take the broad areas described at baseline and develop an "overview process map", which reflected the 'whole of community' approach being undertaken by the Indigenous DPs. Community engagement (to a greater or lesser degree) was the key way of recruiting clients into the self-management program for both DPs.

Figure 52 Indigenous overview process map for the community domain at the middle measurement point



Changes from baseline to the middle measurement point

When comparing the processes in place for the community at the middle measurement point (Figure 52) with those at baseline (Figure 51), a number of clear themes emerged:

- **Needs assessment:** the Indigenous DPs had undertaken some analysis of the community's needs or 'interest' in the concept of self-management either via a formal needs assessment or through consultation with the community. This was an important part of getting community buy in to the DP self-management program and building trust with the community members.

- **Marketing and health promotion:** the Indigenous DPs pursued a dual strategy, which included recruiting clients to the DP in conjunction with running health promotion activities, such as videos, pamphlets, self-management camps and information sessions on health issues. The health promotion activities aimed to raise the awareness and importance of self-management at the wider community level and to empower the community to take ownership of their health. The use of CSWs and AHWs in the marketing and health promotion processes provided a trusted link to the community and ensured that information was delivered in a culturally appropriate way. One way in which the Indigenous DPs were able to maintain community engagement was through the pursuit of community activities that had been initiatives of the community members, for example, women's walking groups.

- **Support from self-management personnel:** both Indigenous DPs at this stage provided support to the community on an ongoing basis, for example, education and skill development, walking groups and continuous community consultation. The use of CSWs in one of the Indigenous DPs was a means through which support was provided to the community. The role of the CSWs was to implement and sustain health promotion activities, and to encourage and support community members to make positive lifestyle changes through the creation of supportive environments.

Description of the community Process Model

An analysis of the need or interest of the community in self-management was undertaken by both DPs (either formally or informally). The DPs then marketed to the community for the purpose of raising the awareness of both the DP and self-management. Both DP pursued a dual marketing/health promotion strategy, and provided support from the self-management personnel to the community. The education and training of self-management personnel was ongoing. The overview also shows the linkage with the client recruitment and education and training processes.

An example of the variation in process between the DPs in the Process Model, was around the theme: *consultation with the community*. The DPs undertook very extensive consultation with the community (for example, ongoing and regular consultation, a range of community groups were consulted, many avenues of consultation were used, and had a wide focus of discussion), while the other DP undertook reasonably extensive consultation with the community (for example, consultation was on a repeated [but limited and not ongoing] basis, quite a number of community groups were consulted, quite a few of avenues of consultation were used, and there was a rather wide focus of discussion). See the

thematic analysis in Appendix 30 for more detail on variations, for all other themes, the DPs were classified similarly.

5.4.1.2.3 Last measurement point

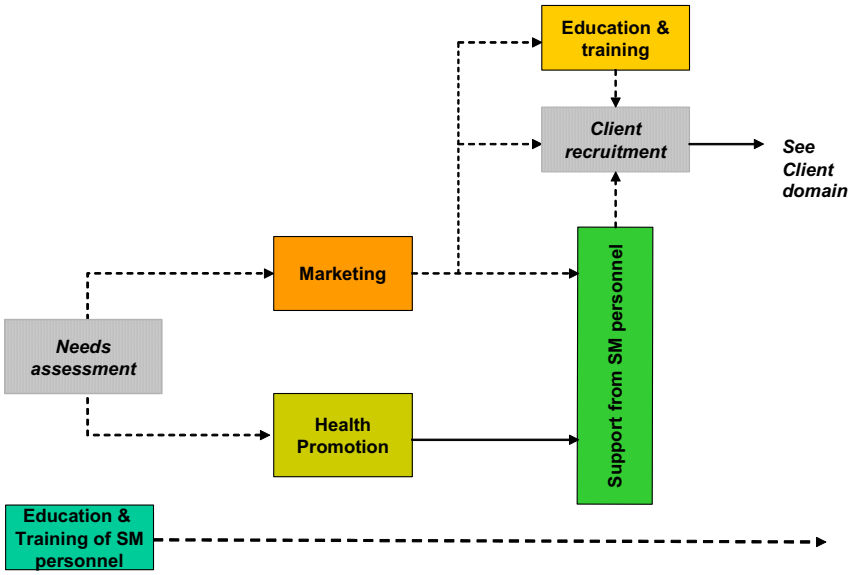
Description of the community overview process map

The last overview process map for the community domain is shown in Figure 53.

The last process map for the community domain remains predominately unchanged from that described at the middle measurement point.

The needs of the community were still being assessed, but instead of assessment taking place at the community wide level, needs were being assessed through ongoing consultation with the community or through the Aboriginal Health boards or Aboriginal health services. This was followed by the education and training of self-management personnel. The DPs were no longer recruiting clients, however health promotion activities were ongoing.

Figure 53 Indigenous overview process map for the community domain at the last measurement point



Changes from the middle measurement point to the last measurement point

When comparing the processes in place for the community at the middle measurement point (Figure 52) with those at the last measurement point (Figure 53) a number of clear themes emerged.

- **Needs assessment:** assessments of community wide need were no longer taking place, rather, ongoing consultation with the community and Aboriginal Health Boards addressed issues as they arose and ensured the DPs were addressing the need in the community.

- **Education and training of self-management personnel:** the constant turnover of Indigenous DP personnel in the Indigenous communities meant that the core education and training process for the Indigenous DPs needed to be held on an ongoing basis.

- **Client recruitment:** reflecting the fact that the DPs were coming to the closing stages of their self-management programs, client recruitment had ceased. See changes for the last measurement point in the client domain in Section 5.4.1.1.3.

- **Education and training of clients:** by the last measurement point both Indigenous DPs had implemented the Stanford course. In order to make the course more culturally appropriate, both Indigenous DPs adapted the course depending on the community in which the course would be held.

Description of the community Process Model

Community wide needs assessments were no longer taking place in either of the Indigenous DPs. Both DPs undertook marketing to the community primarily for the purpose of raising the awareness of self-management, and in some cases, for the purpose of recruitment. Health promotion activities were ongoing (for example, videos, pamphlets, self-management camps and information sessions), and the DPs then provided some support from the self-management personnel to the community. The education and training of self-management personnel was ongoing. The overview also shows the linkage with the client recruitment and education and training processes.

The variation and similarity in process remain unchanged from those described at the middle measurement point. See the thematic analysis in Appendix 30 for more detail on variation and similarity.

5.4.1.3 Health Service Providers

5.4.1.3.1 Baseline

Description of HSP overview process map

The baseline overview process map for the HSP domain is shown in Figure 54.

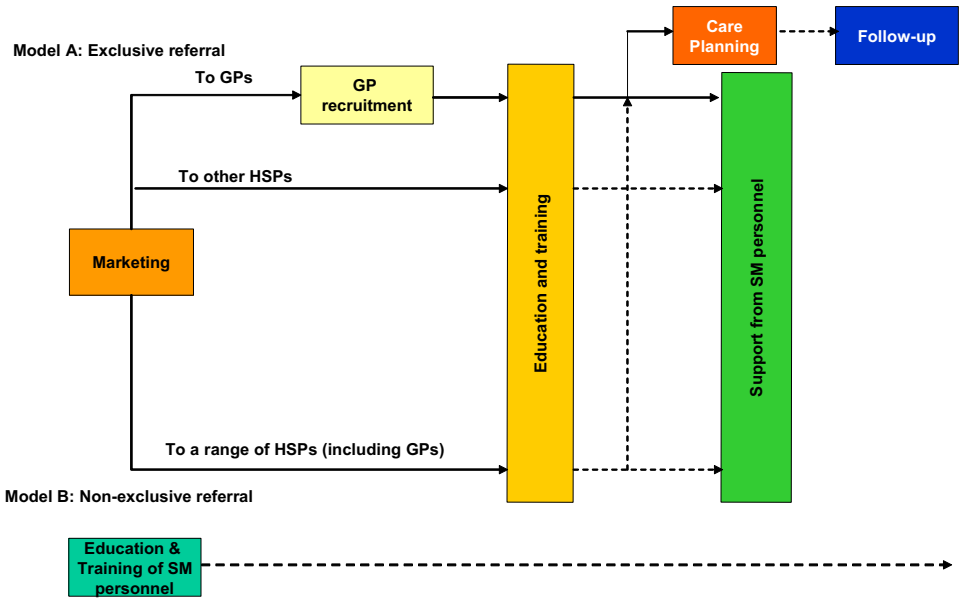
For HSPs at baseline there were in essence two Process Models, with the main distinction between the two being whether the DP was seeking to recruit their clients exclusively through GPs or not. At baseline, one Indigenous DP was

seeking to recruit clients exclusively through GPs, whilst the other DPs approach was to undertake marketing to a range of HSPs (including GPs) for purposes other than client recruitment.

The initial GPs engaged to participate in both Indigenous DPs were all employees of the local Aboriginal health service from which the DPs were operating, which in some regards may have been a facilitator to GP engagement for these DPs, however they faced many of the same pressures on their time as GPs in the 'mainstream' system.

Both Process Models provided some degree of education and training for HSPs (including GPs) together with a level support, and link in with the client care/self-management planning and follow-up processes.

Figure 54 Indigenous overview process map for the HSP domain at baseline



Description of the HSP Process Model

Process Model A

The DP who was in Process Model A was seeking to recruit clients through exclusive GP referral. For this DP there were two complementary process pathways. Firstly, the DP needed to market to GPs in order to recruit the GPs, whilst they also marketed to a range of other HSPs in order to raise awareness about the benefits of self-management and the DP self-management program itself. Following the marketing process and the recruitment of GPs, the HSPs and recruited GPs received education and training, they may or may not have been

involved in the care/self-management planning process and received some degree of support from the DP personnel.

Process Model B

The marketing by this DP was much broader and could cover both a recruitment focus and/or an awareness raising focus. Marketing was then followed by education and training and a degree of support from the DP personnel. The HSPs in Process Model B may or may not have been involved in the care/self-management planning process for clients.

As the Indigenous DPs were in different Process Models at baseline, the identification of variation and similarity in process within a Process Model was not applicable. See the thematic analysis in Appendix 30 for more detail on variations and similarities.

5.4.1.3.2 Middle measurement point

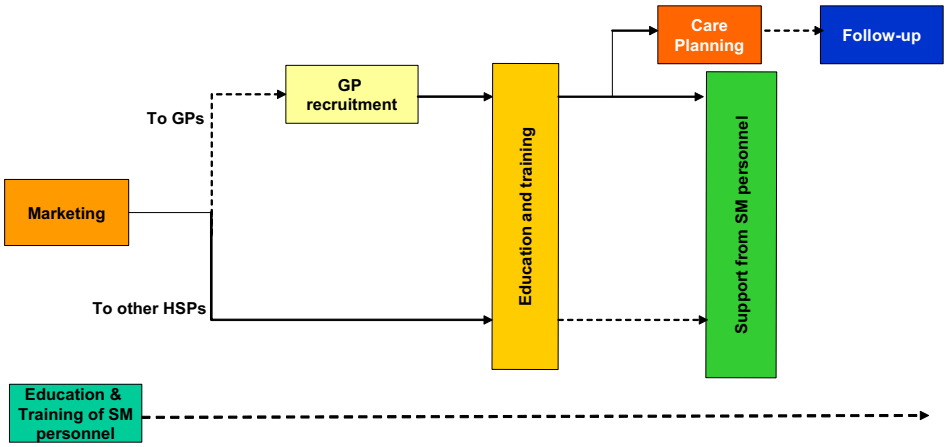
Description of the HSP overview process map

The overview process map for the HSP domain at the middle of the DP is shown in Figure 55.

At the middle measurement point, there was essentially one Process Model for the HSP domain. This was due to the fact that the DPs were no longer actively trying to recruit GPs for the purpose of client recruitment.

For this reason, the Indigenous DPs were able to be grouped into the one Process Model whereby, marketing was to a broad range of HSPs, for the purposes of participation in the DP self-management program and awareness raising. The recruitment of GPs occurred on the basis of GP interest. The Process Model also included elements of education and training, support from self-management personnel and linked into the care/self-management planning and follow-up processes.

Figure 55 Indigenous overview process map for the HSP domain at the middle measurement point



Change from baseline to the middle measurement point

When comparing the processes in place for the HSPs at the middle measurement point (Figure 55) with those at baseline (Figure 56), the emerging themes were:

- **GP recruitment:** at the middle measurement point, neither of the Indigenous DPs were trying to recruit clients exclusively through recruited GPs. This reflected the difficulty that the Indigenous DPs experienced in building a solid client base exclusively through recruited GPs. The Indigenous DPs also experienced a high level of HSP staff turnover (including GPs). This meant that the engagement, orientation and education and training effort undertaken by the DP with those HSPs was often lost.

- **Education and training:** the high turnover of a broad range of HSPs in the Indigenous communities meant that the core education and training process for the Indigenous DPs needed to be held on an ongoing basis. This was to ensure that the new HSPs (including GPs) in the community had the skills and knowledge to participate in the DP self-management programs and to continue to assist in the development of self-management skills in the participants.

Description of the HSP Process Model

Marketing in the middle HSP Process Model was to a broad range of HSPs, for the purposes of recruitment and awareness raising, with GP recruitment occurring on an ad hoc basis. Following on from the marketing and recruitment processes, the DPs then provided some degree of education and training for HSPs, together with a level of support from DP personnel. The overview also

shows the linkage with the client care/self-management planning and follow-up processes.

An example of variation in process between the DPs in the Process Model, was around the theme: *focus of marketing*. The focus of marketing for one DP was to a select group of GPs only, whereas the other DP undertook a marketing strategy that focused on a whole of community approach.

An example of similarity in process was around the theme: *type of education and training*. Only the core education and training was offered to HSPs (for example, Stanford, Flinders and RACGP) in both DPs. See the thematic analysis in Appendix 30 for more detail on variations and similarities.

5.4.1.3.3 Last measurement point

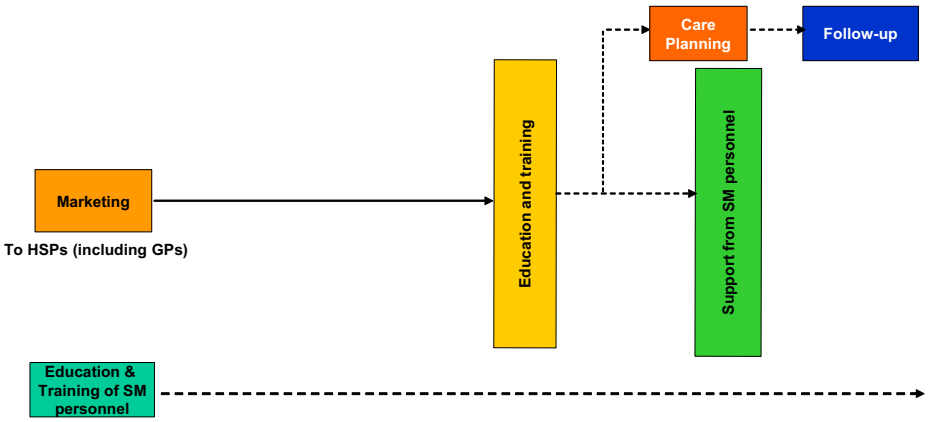
Description of the HSP overview process map

The last overview process map for the HSP domain is shown in Figure 56.

The HSP overview process map for the last measurement point, remained predominantly unchanged from that described at the middle measurement point, the key difference being that no Indigenous DPs were recruiting GPs for client recruitment purposes.

The last measurement point Process Model outlines that marketing was to a broad range of HSPs (including GPs), primarily for the purpose of awareness raising. All of the DPs then provided some degree of education and training for a broad range of HSPs, together with a level of support from DP personnel. The overview also shows the linkage with the client care/self-management planning and follow-up processes.

Figure 56 Indigenous overview process map for the HSP domain at the last measurement point



Changes from the middle measurement point to the last measurement point

When comparing the processes in place for the HSPs (including GPs) at the middle measurement point (Figure 55) with those at the last measurement point (Figure 56) the themes emerging are:

- **Marketing:** the focus of the marketing strategy for both DPs had shifted away from client recruitment and was largely directed at raising the awareness of the benefits of self-management, building the profile of the DP in the HSP (including GPs) domain and to encourage those HSPs to participate in education and training.

- **GP recruitment:** at the last measurement point no DPs were actively seeking to recruit GPs for the purpose of client recruitment. However, GPs were still being engaged in the DPs for education and training purposes and to partake in the care/self-management planning process.

- **Education and training:** the core education and training of HSPs (including GPs) was ongoing in the Indigenous DPs, due to the high turnover of HSP personnel. However, one Indigenous DP was no longer actively seeking GP participation in education and training sessions as it was difficult to encourage the GPs to participate. A broader range of education and training options were also being offered to all HSPs in the later stages of the DP self-management programs, such as Tai Chi training.

Description of the HSP Process Model

Marketing was to a broad range of HSPs (including GPs), primarily for the purpose of awareness raising, for both the DP self-management programs and the benefits of self-management. In addition, there was less focus on marketing for recruitment purposes, as the DPs generally were no longer actively seeking client recruitment. The DPs then provided some degree of education and training for HSPs, together with a level of support from DP personnel. The overview also shows the linkage with the client care/self-management planning and follow-up processes.

An example of variation in process between the DPs in the Process Model, was for the theme: *the extent of education and training for other HSP*s. The reason being one of the DPs provided training that was comprehensive (for example, Flinders two day workshop), while the other DP provided less comprehensive training (for example, Flinders three hour overview).

An example of similarity in process was for the theme: *support from self-management personnel*, as both DPs offered quite informal support to HSPs, in

that it had some regularity, but could also be impromptu. See the thematic analysis in Appendix 30 for more detail on variations and similarities.

5.4.1.3.4 Summary of the Indigenous process mapping

The key themes that arose from the Indigenous process mapping across all domains (client, HSP and community) at the baseline, middle and last measurement points were:

- **Development of innovative strategies to engage the community:** in order to build community trust and support in the DPs, the DPs were required to be innovative in their effort to engage the community. One element of this innovation was the development of successful health promotion and marketing strategies which involved healthy eating videos, community groups (women's and men's health groups), word of mouth and building trust. The second element was the use of AHWs and the newly created role of the CSWs. These roles allowed the Workers to approach, and discuss the DPs in a culturally appropriate way, and proved to be very successful method in which to engage the community.

- **Engagement of HSPs:** the constant turnover of HSP staff in the communities was a major problem for both DPs. As a result, the engagement, orientation and education/training effort the DPs undertook at the beginning of their self-management program with HPS was often lost. This meant that the DPs were required to maintain their HSP education and training program over the course of the DP. The use of GP champions was another method through which GPs were engaged.

- **Variation in the DPs approach to community:** initially, the approaches undertaken by the DPs were not the same, as indicated by the comparatively differing initial amount of consultation undertaken with the communities by the two DPs. However, as the DPs progressed, the amount of consultation undertaken with the communities and their respective Aboriginal health services became more similar and both DPs were undertaking informal, ad hoc needs assessments – which in turn built community ownership of the DP self-management programs and allowed for greater penetration into the communities.

- **Evolution of DP specific training:** in order to meet the diverse needs of the community, the need for culturally appropriate training for community members was predominant, and meant that both DPs needed to adapt training in order to make it more specific to the Indigenous context. One example of this was the Stanford education and training, whereby the adaptation of the training evolved as the courses were conducted.

5.4.2 Project Reports

As it was difficult to disaggregate the information provided by the SA DP for Pika Wiya, in addition to the NT DP not using the project report template for reporting purposes to DoHA, project report information has not been reported for the Indigenous DPs.

5.5 Impact and outcome evaluation results

This Section sets out the responses to DP self-management program implementation from those primarily affected: clients; carers; HSPs; and the community. These responses can be measured in terms of impacts and outcomes. Impacts relate to such medium term effects as perceptions and experiences of the DP self-management program, health behaviour and attitudes regarding self-management. Outcomes relate to the longer-term health and wellbeing reported by participants. The data sources for the impact and outcome evaluations are set out in Table 112.

Table 112 Impact and outcome evaluation data sources

Evaluation component	Data source
Impact	• Focus groups
	• CIQ
	• CHQ
Outcome	• CHQ
	• CSUQ

The key informant interviews which are also an aspect of the Impact evaluation are discussed in the context of sustainability (see Section 5.7)

5.5.1 Satisfaction, perceptions and experiences of participants, carers, HSPs and communities in the DPs

The impact evaluation results for the Indigenous DPs' focus groups are described below by domain - client, carer, HSP and community. For each domain, the overall themes of the focus groups and any changes over time from the baseline and middle to the last measurement points are outlined. These are described for each dimension heading identified in the NEF.

These results have been produced for the Indigenous DPs focus groups by conducting a thematic analysis of information provided by each DP, followed by an aggregation of DP information to the national level. Results from non-Indigenous DPs are reported in Section 4.4.1.

The numbers of focus group participants nationally are listed in Table 113.

Table 113 Number of Indigenous DP focus group participants nationally, by domain and measurement point

	Measurement Point		
Domain	**Baseline**	**Middle**	**Last**
Client (n)	4**	2**	10**
Carer (n)	3**	2**	1**
HSP (n)	7	3**	1**
Community (n)	3**	unknown*	unknown*

* Domains/measurement points that certain DPs did not provide information for

** For each domain at each measurement point, there were some DPs who provided focus group information but did not state how many participants there were. Therefore, the totals for these cells are a minimum and will be larger than reported.

5.5.1.1 Client

5.5.1.1.1 Baseline

Overall satisfaction with the DP self-management program

At baseline, clients were generally satisfied with their DPs.

Perceptions and experiences with self-management orientation/education and training

Even at this early stage, clients reported changes in health behaviours such as increased walking, healthy eating and greater awareness of health management.

Clients reported being informed about the DP to varying degrees. Some felt they had been adequately informed, while others stated that they were poorly informed which led to their confusion around the different activities and the timing of the DPs.

Regarding relationships with staff, clients at one DP site felt staff were readily available while those in the other site reported that staff were less accessible due to problems associated with lack of transportation. Despite these different experiences, all clients reported that they felt as though they were listened to during care planning and that staff were good to talk with and took an interest in health issues for which clients were grateful. They added that they had been given adequate information about their health and medication. Respondents noted that they preferred to discuss their health with AHWs and CSWs than with "white fellas" and they reported that they found stories portrayed in videos and pamphlets very useful.

Perceptions and experiences of care and relationships with HSPs

It was generally felt that HSPs provided adequate information, although some reported that HSPs did not always listen to them or answer their questions. Several clients within one of the DPs felt that this was a result of high staff turnover that did not allow clients to form close relationships with their HSP. It was suggested that HSPs needed to focus more on Aboriginal healing and integrate such methods into the DPs, as well as their work in general.

Barriers

As with the non-Indigenous clients, some Indigenous clients reported difficulties with transportation to clinics, specialists and to pick up medication. They also reported that long waiting lists posed difficulties. For some, petrol vouchers and pharmacy closing times were reported to be common barriers to managing their health which is not surprising given the rural and remote settings.

5.5.1.1.2 Middle measurement point

Overall satisfaction with the DP self-management program

Clients continued to be satisfied with the DP self-management program at the middle measurement point and were anticipating benefits such as improved health outcomes and the development of better links between HSPs and Indigenous people in the area.

Perceptions and experiences with self-management orientation/education and training

Clients reported that they had already noticed an increase in knowledge about CCSM and the role that exercise and nutrition played. Clients expressed support for course leaders and encouraged the training of more leaders in the future.

As at baseline, there was continued support for videos that featured local people and positive feedback was received for education camps, walking groups and workshops, although it was suggested that information could be disseminated further. Similarly to baseline, the importance of recognising traditional knowledge (for example, bush tucker) was also discussed. Clients felt that the inclusion of such knowledge could have been increased by the DPs. It was also felt that it would be beneficial to increase resources to teach children about chronic conditions and influencing factors as a means of encouraging prevention.

Perceptions and experiences of care and relationships with HSPs

As was the case at baseline, clients felt that GPs were a good source of information regarding chronic conditions. Clients continued to suggest that the clinic could focus more on traditional Aboriginal healing.

Barriers

Barriers to the success of the DP self-management program were noted to be people's lack of motivation and interest in their health and difficulty accessing DP venues due to a lack of transportation. Some responded that waiting lists and access to services were again problematic for them at times.

5.5.1.1.3 Last measurement point

Overall satisfaction with the DP self-management program

As with baseline and middle, clients at the last measurement point responded that they were satisfied with the DP self-management program.

Perceptions and experiences with self-management orientation/education and training

Clients reported that they had: increased their knowledge about healthy living and chronic conditions; increased exercise; reduced alcohol consumption; and were more aware of medication management. Some clients added that they had lost weight or quit smoking. The majority of clients stated that they hoped to continue the activities and strategies they had learned throughout the DP self-management program although some expressed concern about their ability to remain motivated and sustain their learnings. This situation was exacerbated by the fact that only two clients (from the same DP) reported that they had received follow-up.

In contrast to opinions expressed at previous measurement points, clients now felt that the DP had been successful in disseminating information in a culturally appropriate way and the examples of bush trips and local art were mentioned. Although clients were positive about these aspects of the DP, they suggested that information could have been presented in a more gender appropriate manner and most stated that they did not understand at least some of the information that had been presented to them.

Relationships with course leaders were generally reported to be positive and constructive and leaders were described as easy to talk to. While DP staff were described as supportive, it was felt that they could be more supportive if they stayed in communities for a longer period of time.

Perceptions and experiences of care and relationships with HSPs

Similarly to relationships with DP staff, client's interactions with their GPs / main HSPs were generally reported to be positive and most clients felt that their HSPs listened to them. In addition, some clients felt that they had become more assertive in communication with HSPs.

Barriers

As with previous focus groups, clients reported that costs associated with frequent services and medication were a barrier, however, they felt that access to services was not a problem at this stage.

5.5.1.2 Carer

5.5.1.2.1 Baseline

Overall satisfaction with the DP self-management program

At the baseline measurement point, carers expressed stress in their role and satisfaction with DPs provision of new contacts for client care and the forum that the DP provided to meet other carers and obtain information.

Perceptions and experiences of the self-management orientation/education and training

Unlike the responses from clients, at baseline, most carers indicated that they were adequately informed about the DP self-management program. Contrary to the responses of non-Indigenous carers, carers in Indigenous DPs felt that the DP self-management program had provided them with sufficient guidance about how to care for themselves in their caring role. Where the carers felt the DP was not meeting their needs, was in the provision of information about how to look after the person they were caring for, which is not unreasonable given the early stage of the DPs.

While carers generally felt that staff were approachable, some reported that they had experienced situations in which staff took a considerable amount of time to answer questions.

Perceptions and experiences of care and relationships with HSPs

Relationships with HSPs were regarded positively.

Barriers

As identified by clients, carers also reported difficulties with waiting lists for services, although they did not report any problems with transportation.

5.5.1.2.2 Middle measurement point

Overall satisfaction with the DP self-management program

At the middle measurement point, carers reported that they were satisfied with the DP self-management program and they felt that it had better equipped them to promote a healthy lifestyle for the person they cared for (for example, reduced alcohol consumption and smoking).

Perceptions and experiences of the self-management orientation/education and training

Carers stated that this was through the courses that provided them with information about chronic conditions and through increasing their motivation to change the lifestyle of the person they cared for. Carers reported benefits for those in their care to include an increased understanding of their condition and a forum to meet others in similar situations.

Carers also expressed satisfaction with DP staff and described them as friendly, helpful and organised. It was generally felt that staff were respectful of culturally appropriate communication.

In terms of impacts on their roles as carers, respondents felt that they had been provided with strategies to cope with emotional stress associated with their role as well as medication management techniques for their clients. They stated that they were satisfied with the support and activities; however, they noted that they would like further carer training.

Perceptions and experiences of care and relationships with HSPs

Carers in one DP described HSPs as “helpful although sometimes forgetful” in their interactions.

Barriers

Despite the positive impacts of the DP, carers still reported emotional and physical stress, frustration, financial burden and isolation resulting from their role.

5.5.1.2.3 Last measurement point

Overall satisfaction with the DP self-management program

At the last measurement point, carers continued to express satisfaction with the DP self-management program and the forum and tools it provided to promote healthy lifestyles for carers and the person they cared for.

Perceptions and experiences of the self-management orientation/education and training

At the last occurrence of focus groups, carers in Indigenous DPs reported that the DP had increased their knowledge about the importance of maintaining a healthy lifestyle and they were pleased that bush tucker and bush medicine were referred to during the course. The only reservation about the DPs expressed at this stage was that they would have appreciated more carer-specific training.

In line with carers' comments at the two previous measurement points, they remained satisfied with the help provided by DP staff.

Perceptions and experiences of care and relationships with HSPs

Carers felt that HSPs listened to them and supported them in their caring role. These positive comments about relationships with HSPs were constant from the baseline to last measurement point for carers.

Barriers

Carers did not report any barriers to looking after the person in their care or promoting self-management for them.

5.5.1.3 Health Service Providers

5.5.1.3.1 Baseline

Perceptions/experiences/satisfaction with the DP self-management program

At baseline, the majority of HSPs (for example, AHWs, a GP and a Community Nurse) reported that they had noticed positive impacts of the DP self-management program as it had introduced the concept of self-management into the community and alerted people to the importance of healthy living and the relationship between lifestyle and health. Several felt that the pamphlets and videos had assisted with this. It was anticipated that the DPs would assist in increasing clients' knowledge about disease and subsequently, increase their confidence, making them better equipped to control their health and manage their medication.

Reservations about the DPs were around the fact that certain aspects of the self-management program were considered not to be culturally acceptable (for example, the response sheets). As most of the Indigenous clients moved throughout regions, it was suggested that it would be beneficial to have a protocol between HSPs that allowed for the care plans of such clients to be transferred, enabling them to have informed consultations regardless of their location.

Impact of the DP self-management program on HSP work practice

In terms of their roles as HSPs, it was reported that the DP self-management program had assisted in the decrease of the clinic workload and increased the network of HSPs. They felt that the DP supported HSPs in their role and DP staff were reported to be effective.

Reservations about the DP self-management program included the fact that some HSPs and staff had been hesitant to accept the self-management model as it was perceived as additional work. It was also discussed that the DPs were causing service duplication (for example, care planning).

5.5.1.3.2 Middle measurement point

Perceptions/experiences/satisfaction with the DP self-management program

At the middle measurement point, HSPs generally felt that clients and the community were more informed about chronic conditions. Despite this, it was suggested that the DPs could contribute more at the community level, such as improving the quality of food available at local stores, encouraging more sporting activities or increasing the focus on prevention through educating children about chronic conditions (as was suggested by clients in their focus groups). These recommendations stemmed from their concern about the 'top-down' implementation of the DP and they felt that the DPs would be more successful if they originated at the community level and were couched in a more culturally appropriate manner.

At this point in time, HSPs voiced several suggestions about how the DPs could improve. It was discussed that while videos and pamphlets were useful, DPs could have been more proactive in their dissemination. It was also suggested that the impact of such material could be evaluated. Majority of HSPs also felt that the SHCI could be integrated with existing disease specific programs to support them, rather than operating as a separate self-management program.

The role of the CSW was supported and appreciated, and it was generally felt that DP staff had lightened the workload in terms of dealing with chronic conditions. However, difficulties coordinating communication between HSPs and staff were evident.

Impact of DP self-management program on HSP work practice

HSPs reported that the DP self-management program had assisted them in increasing their knowledge about the aspects of chronic conditions that impact clients personally and they stated that they were now better equipped to appreciate the perspective of the client with the chronic condition. The use of AHWs in one DP was encouraged as it was felt they could incorporate

Indigenous knowledge, while the promotion of healthy lifestyles by CSW in the other DP was appreciated.

5.5.1.3.3 Last measurement point

Perceptions/experiences/satisfaction with the DP self-management program

During the last round of the Indigenous focus groups, all HSPs made positive comments about the DP self-management program. Several HSPs found the DP self-management program useful for client education and reported that clients had learnt a lot about healthy lifestyles, exercise, nutrition and medication. One DP reported that community attitudes were changing, for example, people were beginning to move from drinking full-strength beer to light beer. Regardless of the positive comments, there were several HSPs who stated that they had not found the DP self-management program as useful as they had expected as they had experienced difficulty explaining concepts to clients and it was reported that there were still some clients who did not understand care planning.

As with the previous measurement points, it was suggested that the DP engage in further marketing activities as many people in the community were unaware of the DP and its aims. It was proposed that this occur through increasing videos and pamphlets and taking a whole of community approach through involving schools and local councils.

Staff were described as motivated and their health promotion activities were valued, however, it was felt that most could benefit from further training. Increased support, collaboration and communication were also desired.

Impact of the DP self-management program on HSP work practice

It was stated that the DP had assisted in decreasing their workload as clients with a chronic condition(s) were having their consultations as part of the DP. However, there were also reports that HSPs in remote locations were only receiving limited information about the DP self-management program. Some again expressed frustration about the duplication of services that the DP was creating.

5.5.1.4 Community

5.5.1.4.1 Baseline

Perceptions and experiences of the DP self-management program in the context of the wider community

At the baseline measurement point, participants in the community focus groups had various opinions as to whether information about the DP had effectively reached themselves and their communities. Some participants knew little about

the DP self-management programs. In one of the DPs, some participants were aware of promotional videos and pamphlets and had discussed the DP with CSWs. It was generally reported across the Indigenous DPs that information was not effectively reaching all members of the community as it was being disseminated through existing relationships with HSPs, existing service delivery programs and existing personal relationships. It was suggested that community resources be used as a means of transferring information to communities (for example, local schools or local women's centres).

Participants agreed that information they had received was of a high quality and they were aware of the fact that the questionnaires had been reconstructed to be more culturally appropriate. It was felt that information was most effectively conveyed through videos and when it was available in local languages to accommodate the fact that some elderly community members did not speak English.

Even at this early stage, participants reported that the community was benefiting from the DP. It was reported that clients and other community members had increased their knowledge about chronic conditions, appropriate nutrition and medication management. Support was also expressed for the health management plans that enabled clients to pass their health information onto different HSPs they visited.

Overall, it was felt that the DPs were beneficial and should be continued. Concern was expressed regarding sustainability as it was generally felt that the 'top-down' approach to Aboriginal health would not be maintained by the community. Some participants hoped, however, that the DPs would assist in the development of stronger links between Aboriginal people and local medical staff.

5.5.1.4.2 Middle measurement point

Perceptions and experiences of the self-management program (DP interventions) in the context of the wider community

At the middle measurement point, participants reported that they were aware of the DPs and were familiar with some members of staff, however, they reported limited awareness of the details of the DPs. In terms of community awareness about the DPs, it was generally felt that this was lacking.

Community members recognised the need for such DPs and supported their continuation. It was reported that the community was becoming proactive in managing the health of its members, for example, it was stated that the local store of one of the communities was providing healthy food and the local club was promoting responsible drinking.

Suggested improvements to the DPs included:

- Targeting younger people as a means of prevention;
- Increasing the targeted dissemination of promotional DP information;
- Increasing links with community organisations to assist in this regard; and
- Increasing activities such as bush walking as a means of continuing in a culturally appropriate manner.

5.5.1.4.3 Last measurement point

Perceptions and experiences of the self-management program (DP interventions) in the context of the wider community

Unlike the previous measurement point, participants generally reported adequate knowledge about the DP. Many reported that they had been informed about the DPs from the DP Managers, through community consultations and advertisements. As was mentioned at the previous measurement point, it was felt that videos were an effective means of conveying information. Despite this, the majority of participants felt that the DP could benefit from wider dissemination of information and promotion of its objectives.

Participants continued to express satisfaction with the DP self-management program at this last measurement point. It was generally felt that the DP was well managed and that the leaders were competent. Benefits of the DP self-management program were reported to include: an increased awareness of chronic conditions; the healthy weight and walking groups; and the information provided regarding nutrition. As with the previous measurement point, one DP reported that their community was becoming involved as the local store was promoting healthy food and the club was encouraging responsible drinking. Some participants emphasised the importance of the DP for their Indigenous culture as it was reported that influential community members were dying from having a chronic condition.

Although satisfaction with the DP was expressed, several suggestions for improvement were made. These included increasing the number of bushwalks, including more elderly people and including more local organisations such as the school.

In general, it was felt that self-management programs were worthwhile and should be continued, however, some felt that their needed to be broader promotion of the DP and increased local support.

5.5.1.5 Summary of Indigenous Focus Groups

Table 114 lists the main themes to emerge from the Indigenous focus groups. These are categorised into those that refer to the positive impacts of the DP self-management program and those that refer to the barriers and reservations about the program. The table is divided by domain and includes information from the baseline, middle and last measurement points.

Table 114 Summary of Indigenous focus group impacts and barriers

Domain	Progression of focus group themes across measurement points
Client	**Overall satisfaction with the DP self-management program** • Clients reported that they were satisfied with the DPs at each measurement point and at the middle point, they were anticipating benefits. **Perceptions and experiences with self-management orientation/education and training** • At all measurement points, clients stated that the DP self-management program was having a positive impact on their lifestyle (for example, increased walking, healthy eating, and increased health knowledge and medication management). • While satisfaction with DP staff varied initially, relationships were later described as constructive and positive. • At baseline it was felt that information was not being effectively disseminated, while at later measurement points information was reported to be reaching those it needed to. **Perceptions and experiences of care and relationships with HSPs** • Relationships with HSPs were reported to improve over time. Clients felt HSPs listened to them more and they felt that they had become more assertive in communication with their HSP. **Barriers** • Clients reported similar barriers at each measurement point. These included lack of transportation, waiting lists for HSPs and costs associated with healthcare.
Carer	**Overall satisfaction** • Initially, carers reported satisfaction with the forum that the DPs offered to meet other carers. Over time, satisfaction was associated with the fact that the DPs had better equipped them to care for their clients and themselves. **Perceptions and experiences of self-management orientation/education and training** • Over time carers reported that benefits to clients were evident and they were being provided with strategies to cope in their caring role. It was felt at the last measurement point that more carer-specific training would be useful. • Satisfaction with relationships with DP staff increased over the life of the DP self-management programs with staff described as friendly, helpful and organised.

Domain	Progression of focus group themes across measurement points
	Perceptions and experiences of care and relationships with HSPs • Carers reported that their relationships with HSPs improved over time and carers felt listened to and supported in their roles by the last measurement point. **Barriers** • Barriers varied over time including waiting lists and stress in the caring role.
HSP	**Perceptions/experiences/satisfaction with the DP self-management program** • Satisfaction with pamphlets and videos used to disseminate DP information was reported at each measurement point. • At the last measurement point, positive impacts of the DP were reported for clients. • Staff were supported and appreciated early on in the DP self-management programs, while at later measurement points it was felt that staff could benefit from further training. **Impact on working life** • Impacts on working life remained consistent over time and included decreased workload, increased networks. It was felt however, that some services were being duplicated.
Community	**Perceptions and experienced of the DP self-management program in the context of the wider community** • Over time, community members felt that the DPs became more successful at disseminating information to the appropriate people within the community. However, even at the last measurement point, it was generally felt that the DPs could benefit from wider dissemination of DP information. At all measurement points it was felt that videos were the most effective means of conveying information. • At all measurement points community members felt that the community was benefiting from the DP, however, benefits became more apparent and solidified over time. These benefits included increased knowledge about chronic conditions, a greater awareness of the importance of healthy lifestyles and a proactive approach to managing conditions.

5.6 Outcome Evaluation Results

5.6.1 Relationship between demographic variables, health behaviour and health status at baseline

The inter-relationship between demographic variables, health behaviours and health status at baseline is of interest because it provides an insight into the potential reasons for change (or otherwise) in health status over time.

All available demographic variables were cross tabulated with the sixteen health outcome variables. Only a few health variables which showed significant differences related to the demographic characteristics of the Indigenous clients.

The following relationships were statistically significant:

- Clients with a lower level of schooling were more likely to report poorer health.
- Clients who live alone were more likely to report that their illness affected their relationship with their:
  - Family; and
  - Neighbours.
- Clients with cardiovascular disease were more likely to report that their illness affected:
  - Their ability to play sport; and
  - Their financial situation.
- Clients who never drank alcohol were less likely to report that their illness affected what they "ate or drank".

Although this analysis was severely limited due to the small sample size (making chi-square statistics invalid) it suggests that, as for the non-Indigenous DPs, important relationships are likely to exist on entry to self-management programs like the SHCI.

5.6.2 Correlations between health variables at baseline

Several significant correlations ($r>0.4$) were evident between health variables at baseline, again suggesting important interrelationships on entry to programs.

- The extent to which clients reported that they felt tired was positively correlated with the:
  - Degree to which they experienced shortness of breath ($r=0.509$);

- Degree to which they felt confident that they could remain physically active (r=0.662);
- Degree to which they reported experiencing pain (r=0.433); and
- Level of confidence that clients reported in their ability to prevent their illness from keeping them down (r=0.587).

- The extent to which clients reported that their illness affected their ability to look after their family was positively correlated with the:
  - Degree to which they felt that their illness affected their ability to play sport (r=0.446);
  - Degree to which they felt that their illness affected their relationship with their spouse (r=0.408); and
  - Degree to which they felt that their illness affected their relationship with their family (r=0.513).
- The extent to which clients felt that their illness affected their relationship with their family was positively correlated with the degree to which they felt that their illness affected their relationship with their spouse (r=0.549).
- The extent to which clients felt that their illness affected their relationship with their neighbours was positively correlated with the:
  - Degree to which they felt that their illness affected their ability to look after their family (r=0.561);
  - Degree to which they felt that their illness affected their ability to relax (r=0.434); and
  - Degree to which they felt that their illness affected their relationship with their spouse (r=0.415).
- The level of confidence that clients reported in their ability to prevent their illness from making them feel down was positively correlated with the degree to which clients felt that they were able to remain physically active (r=0.547).
- The level of confidence that clients reported in their ability to manage their illness was positively correlated with the:
  - Degree to which they reported feeling tired (r=0.543);
  - Degree to which they felt confident that they could remain physically active (r=0.488); and
  - Level of confidence that they reported in being able to prevent their illness from making them feel down (r=0.594).

Appendix 32 provides a summary of these significant correlations.

5.6.3 Significant changes from baseline to middle

While there were not many significant changes from the baseline to middle measurement points, there is evidence of a positive shift (i.e. an improvement in health status). Table 115 shows that between the baseline and middle measurement points, there was a significant reduction in the amount that participants felt their illness affected their eating and drinking habits ($p<0.0005$). A trend was also evident in the decrease for pain over this time period. ($p=0.066$).

Table 115 Change in self reported health from baseline to middle

Variable	Z*	Asymp. Sig (2-tailed)
General health	-0.246a	0.806
Do you get tired?	-0.865a	0.387
Do you get short of breath?	-0.140a	0.889
Do you experience pain?	-1.836b	0.066
Affect on eating and drinking	-3.598a	0.00
Affect on looking after family	-1.567a	0.117
Affect on playing sport	-0.666b	0.505
Affect on relaxation	-1.014b	0.31
Affect on financial situation	-1.136a	0.256
Affect on r'ship with spouse	-0.194a	0.847
Affect on r'ship with family	-0.493b	0.622
Affect on r'ship with neighbours	-0.659b	0.51
Confident prevent tiredness	-0.044b	0.965
Confident stay physically active	-1.424a	0.154
Confident wont feel down	-0.906a	0.365
Confident managing illness	-0.904a	0.366

a. Based on positive ranks

b. Based on negative ranks

c. Wilcoxon Signed Ranks Test

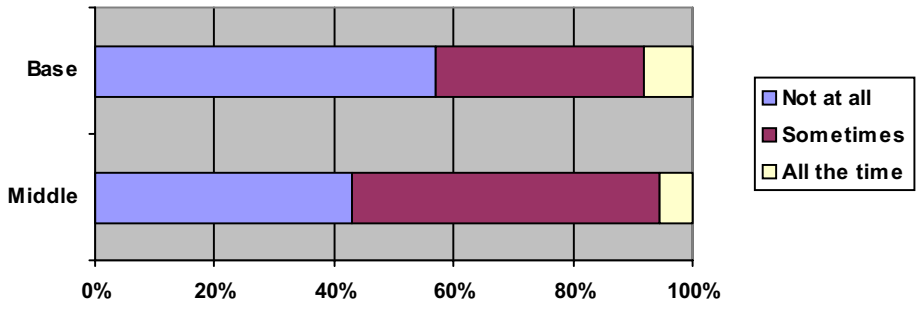
* Z score is a standardised normal variate and is a statistic which informs on the level of significance used to calculate the probability for significant difference

The changes highlighted in Table 115 from baseline to middle are displayed and described in the following bar charts. The bar charts for variables that had non-significant changes from baseline to middle can be found in Appendix 31.

5.6.4 Change in reported pain from baseline to middle

The majority of respondents at baseline stated that they did not experience pain at all (56.9%) which decreased to 42.9% at the middle measurement point, however, 35.0% of participants at baseline responded that they felt pain 'sometimes' which increased to 51.6% at middle (see Figure 57, where n=123). Approximately 8.1% of respondents stated that they experienced pain 'all the time' at baseline which decreased to 5.6% at middle. These differences from baseline to middle were not significant, although show a trend in a positive direction ($p=0.066$).

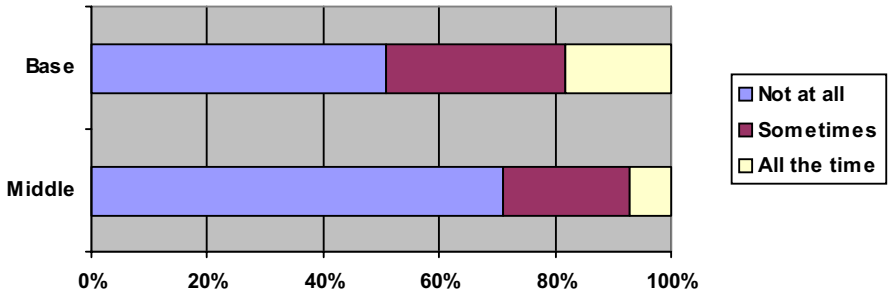
Figure 57 Do you get pain sometimes?



5.6.5 Change in reported things that you eat and drink from baseline to middle

There were significant shifts in the percentages of Indigenous participants indicating whether their illness affected the things they ate and drank ($p<0.005$). At the middle point, 70.7% of participants said their illness did not affect what they eat and drank compared to 51.3% at baseline (see Figure 58, where n=120).

Figure 58 Does your illness affect the things you eat and drink?



5.6.6 Significant changes from baseline to last

From the baseline to the last measurement points, there was a significant reduction in the amount that respondents felt that their illness affected their financial situation ($p=0.015$). There was also a trend in tiredness to decrease ($p=0.086$). This is outlined in Table 116.

Table 116 Changes in self reported health from baseline to last

Variable	Z*	Asymp. Sig (2-tailed)
General health	-0.704a	0.482
Do you get tired?	-1.715b	0.086
Do you get short of breath?	-1.573b	0.116
Do you experience pain?	-1.347b	0.178
Affect on eating and drinking	-0.316b	0.752
Affect on looking after family	-0.188b	0.851
Affect on playing sport	-0.270b	0.787
Affect on relaxation	-0.333a	0.739
Affect on financial situation	-2.443a	0.015
Affect on r'ship with spouse	-0.206a	0.837
Affect on r'ship with family	-0.538b	0.591
Affect on r'ship with neighbours	-0.881b	0.378
Confident prevent tiredness	-0.513b	0.608
Confident stay physically active	-0.557a	0.577
Confident wont feel down	-0.749b	0.454
Confident managing illness	-1.380b	0.167

a. Based on positive ranks

b. Based on negative ranks

c. Wilcoxon Signed Ranks Test

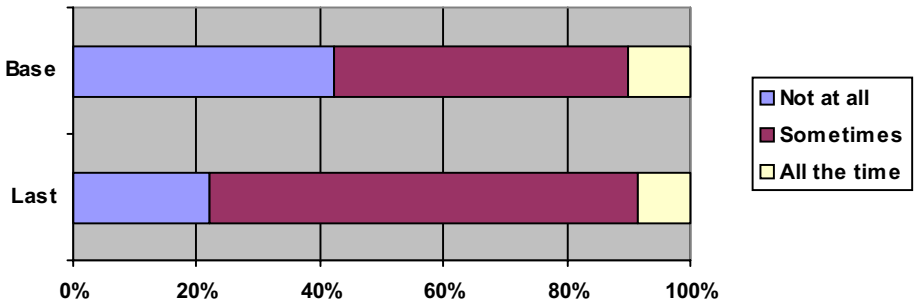
* Z score is a standardised normal variate and is a statistic which informs on the level of significance used to calculate the probability for significant difference

The significant changes highlighted in Table 116 from baseline to last are displayed and described in the following bar charts. Bar charts for variables that had non-significant changes from baseline to last can be found in Appendix 31.

5.6.7 Change in reported tiredness from baseline to middle

At baseline, 42.4% of participants responded that they did not get tired at all. This decreased to 22.0% at middle. However, there was an increase in the percentage who reported that they became tired 'sometimes' from 47.5% at baseline to 69.5% at middle (see Figure 59, where n=59). The number of participants who stated that they were tired 'all the time' did not alter over time (10.2% at baseline and 8.5% at middle). These changes were not significant although suggest a trend towards significance (p=0.086).

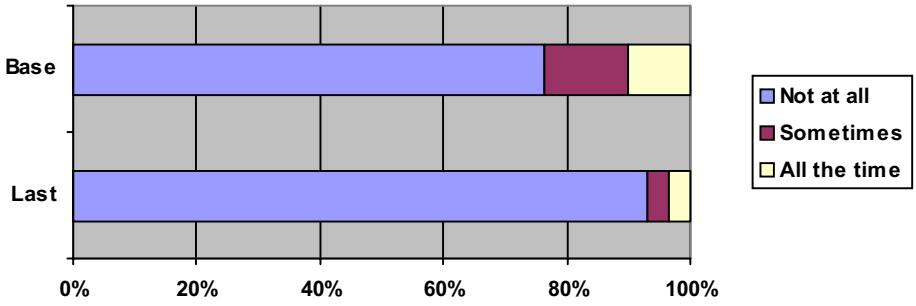
Figure 59 Do you get tired?



5.6.8 Change in reported impact of financial situation from middle to last

There was an increase in respondents who felt that their illness did not affect their financial situation at all from baseline (76.3%) to last (93.2%) and a decrease in respondents who felt that their illness affected their financial situation 'all the time' from baseline (10.2%) to last (3.4%), see Figure 60 (where n=59). These changes were statistically significant (p=0.015).

Figure 60 Does your illness affect your financial situation?



5.7 Sustainability

This Section sets out the extent to which the DPs were able to build capacity over the life of the SHCI, and thus increase the potential for the ongoing sustainability of some or all aspects of their respective self-management programs.

5.7.1 Organisational processes

The complementary nature of process mapping (process evaluation) and the key informant interviews has been illustrated in the figure presented in Section 3.2.1.3 (impact evaluation). While process mapping and key informant interviews each refer to the organisational processes the DPs had in place, process mapping had an operational focus, while the key informant interviews had a strategic focus.

The themes that each evaluation method covered included: network partnerships, knowledge transfer, problem solving and infrastructure. Process mapping concentrated on how these capacities occurred in day to day operations at a client, carer, HSP, community and health service system level while key informant interviews concentrated on how these capacities were developed from a strategic viewpoint to influence capacity building and the health service system. In order to discuss the capacity DPs demonstrated for sustainability, it is necessary to refer to both the process maps and key informant interviews.

5.7.1.1 Process mapping

5.7.1.1.1 Baseline

Infrastructure development

Both the Indigenous DPs were co-located within their local Aboriginal health service. As a result the DPs were able to utilise infrastructure such as IT/IM systems, office furniture and part funding of some of the DP personnel positions, however spacing issues were of concern. Primary infrastructure developments for the DPs at baseline were primarily around the development of DP personnel.

One of the Indigenous DPs needed to establish infrastructure for office sites in three communities. Not only were there remoteness and access issues regarding the three communities, there was very little infrastructure to support these communities in the very early stages of the DP self-management program and the DP was therefore required to work with what existed. The other DP, however, had better access to existing infrastructure.

Governance and management

Governance and management structures were generated across the Indigenous DPs. Both DPs developed a steering committee and Project Management Group, which were comprised of a range of participants including representatives of partner organisations and other key personnel who had an involvement with the DPs. However, whilst one of the DPs was managed by the Aboriginal Health Board, the other DP came under the management of rural and remote health centre, but also required the support of its respective Aboriginal Health Board.

Integration/network partnerships

Both Indigenous DPs were in the early stages of developing their strategies for integration, but a key focus was on integration into the health service/health board and building partnerships with steering committee member organisations.

One of the DPs had a limited range of DP partners, as its partnerships extended to the sponsor organisation only which potentially may have affected its success regarding integration.

As both Indigenous DPs were taking a whole of community approach to CCSM, the initial consultation and input from the communities in the development of the DP self-management programs was viewed as being critical to integration.

Capacity building and sustainability

The training of AHWs and CSWs was viewed as being an integral part of building the capacity of the local communities and the local health workforce.

However, the existing low level of capacity present in the communities presented a challenge for the DPs but also meant that capacity building was a key outcome for the Indigenous DPs.

5.7.1.1.2 Middle measurement point

Infrastructure development

At the middle measurement point, both DPs had experienced some turnover of DP personnel, this proved to be problematic in finding skilled appropriate replacement personnel and meant positions remained vacant for long periods of time. Which in turn caused frustration for the DPs as the orientation and training process was resource intensive. In addition, one of the DPs was continuing to support (through the provision of funds) a personnel position that was not originally intended to be funded by the DP. As a result, more funding was being spent on staffing than originally anticipated.

A second initiative that was operating out of the same location as one of the DPs was providing funding support to the care planning and health promotion processes for the SHCI DP at the middle measurement point.

Infrastructure was continuing to be developed in the community sites for one of the DPs. Office space had been located in each community and were continuing to be developed.

Governance and management

The steering committees for both DPs were meeting less often. For one of the DPs, the meetings were held monthly at baseline but by the middle measurement point they were meeting on a bimonthly basis. This was due to the DP requiring less consultation with the steering committee at this stage of the self-management program, unlike at baseline when the committee was involved with the set up of the DP.

However, the strengthening of communication networks, improved attendance at committee meetings and the offering of resources were identified as facilitators at the middle measurement point by this DP.

The other DP steering committee met rarely. It was felt that this was due to membership duplication with the project management group and this was leading to poor attendance at one of the committee meetings.

Integration/network partnerships

Communication networks and the provision of resources from DP partners were seen to be strengthening by one of the DPs at the middle measurement point.

The DPs felt integration was assisted by the co-location within the local Aboriginal health service, along with the support and participation of the community in the self-management programs and the increasing profile of the DPs within the communities.

Capacity building and sustainability

Organisational development

The intended approach to sustainability developed by the DPs was to take a 'bottom-up' approach. This was somewhat achieved by working in the communities and at the organisational level with the HSPs, in which capacity building activities such as education and training could be put into place. This meant that the sustainability of DP activities, such as care planning, was less reliant on the high level networks such as the Aboriginal health service and more on the HSPs.

Workforce development

Capacity building at this stage of the DP self-management program was focussed on the training of both the HSPs and the AHWs/CSWs recruited to the DPs.

The constant turnover of HSP and DP personnel in Indigenous communities was identified as a hindrance to capacity building. The high turnover of personnel meant that the engagement and training efforts made by the DPs at the beginning of the self-management programs was lost, and would have to start anew with the replacement personnel, which was frustrating for the DPs as the workforce development processes was much slower than anticipated.

Resource allocation

The employment of local community members and providing them with training and skills was proving to be a successful strategy for capacity building at the middle measurement point.

Another strategy for capacity building was the focus on empowering the community to take ownership of their health, via health promotion activities and informal education and training sessions.

A feature of the Indigenous capacity building was the ability of the DPs to get funding for DP personnel positions through systems such as Medicare or the Aboriginal health service.

5.7.1.1.3 Last measurement point

Infrastructure development

Infrastructure development in the communities was continual over the life of the DP self-management programs, and by the last measurement point, the DP offices in the communities (where relevant) were fully equipped with a range of office and basic medical equipment (for example, blood pressure monitor and blood sugar level kits).

One of the DPs re-located their main office and now had their own office space.

Both Indigenous DPs experienced problems with IT systems over the course of the self-management programs (for example, network issues, client data not on the IT system and the changing of electronic care planning tools) and these were still unresolved at the last measurement point. However, one of the DPs was hopeful that outsource funding would help to resolve those IT issues.

The turnover of DP personnel was still problematic for one of the DPs at the last measurement point, as was trying finding skilled personnel to fill the positions.

Governance and management

For one of the DPs, the Project Management Group ended up playing a larger role in the development and evolution of the self-management program than the steering committee, this was thought to be due to a lack of attendance by committee members and the committee lacking a purpose.

The other DP experienced little turnover of committee members and the steering committee maintained its original role and continued to meet on a regular basis throughout the DP self-management program.

Integration/network partnerships

By the last measurement point there was an increased focus on integration by both Indigenous DPs. The Indigenous DPs had intended to integrate self-management into their Aboriginal health services in order for self-management to become a part of core business, this had not been achieved at the last measurement point for either of the DPs. However, strategies were being put into place that included forming support mechanisms for the HSPs through the provision of care planning support, continuing to develop new and existing networks, and raising the profile of the DP self-management program in both the HSP and client communities.

However, the success of integrating the DP self-management programs into the health systems was felt to be largely dependent on the priority the Aboriginal health services placed on CCSM along with the DPs perception that CCSM needs a designated driver within the Health Service/Board in order for it to continue as without it activities may slow down or stop altogether.

At the last measurement point, clients, the community and a range of HSPs had a greater awareness of the DP self-management programs and what they were trying to achieve, along with raising the awareness of CCSM which is an integral part of achieving integration.

Capacity building and sustainability

Organisational development

As identified under integration, in order for the DPs and DP activities to be sustained post DP, CCSM needs a driver to ensure its continuation and evolution, as without it the progress the DPs have made will stagnate.

A new activity at the last measurement point was all the DPs had the opportunity to develop a proposal to DoHA to apply for transitional funding to allow successful DP activities to be ongoing, and provide more time for those activities to be integrated further into the health system.

Workforce development

Capacity building was focussed on workforce development, and this was being achieved through the education and training and developing of skills for the HSPs and members of the community.

As part of a sustainability strategy for one of the DPs, an AHW trained as a Master Trainer in the Stanford CDSM course, and is currently the only Indigenous Master Trainer in the world. This meant that the capability to train leaders of the Stanford course could be sustained both within the DP and potentially within other Aboriginal health services.

The other DP was concerned about the newly created CSW role, and how it would be sustained post DP if these positions were not to be adopted by its Aboriginal health service.

Resource allocation

The resources that were purchased over the course of the DP self-management programs, such as media equipment (for example, digital camera, video editing equipment and poster printer) and medical equipment (for example, blood pressure monitors and blood sugar level kits), along with education and training resources, the modified Stanford course and policies and procedures developed throughout the self-management programs were to remain at the Aboriginal health services for future use.

For one of the DPs the sustainability of the self-management program and many of its activities was largely dependent on whether or not it was to receive transitional funding. Whilst the other DP had integrated some activities into its Aboriginal health service.

Activities such as care planning (for which funds are received via the medical benefits schedule) and health promotion (ongoing activity) would continue to operate in both Aboriginal health services after the DPs had come to a close.

5.7.2 Community capacity and DP self-management program sustainability

5.7.2.1 Key informant interviews results

The results from key informant interviews for the Indigenous DPs at baseline, middle and last measurement points are shown in the following Section. The tables show the median ratings for the key informants aggregated for each capacity indicator of the key informant interview framework. Results from each measurement point are discussed individually, followed by a summary table of changes over time. Results from the non-Indigenous key informant interviews are reported in Section 4.6.2.1.

5.7.2.2 Explanation of key used in results tables

As outlined in Methods Section 3.3.3.2, the ratings indicate relative achievement against each indicator, ranging from weaker (rating=1) to stronger (rating=4). There is an expectation of logical progression of development *within* capacity components and *across* capacity components of the key informant interviews. Therefore, within each capacity component, the indicator ratings should go from high to low. Taking network partnerships as an example, it would be expected that the 'Identify'indicator would be rated higher than or equal to the 'Deliver' indicator which, in turn, should be rated higher than or equal to the 'Maintain' indicator. Similarly across capacity components the average total rating should go from high to low, so that the rating for the 'Network Partnerships' should be greater than or equal to 'Knowledge Transfer', which should in turn be greater than or equal to 'Problem Solving' and so on.

5.7.2.2.1 Baseline measurement point

Median ratings across capacity components for the key informants from the Indigenous DPs at baseline are listed in the grey column in Table 117. While the majority of scores are at the lower end of the scale, ratings for knowledge transfer and network partnerships were higher in accordance with the expected progression of capacity per the CCI (demonstrated by the solid arrow to the right of the table). Within the four capacity components, ratings were in the expected direction (as demonstrated by the dashed arrows) for all except infrastructure.

Table 117 Median ratings for key informants from Indigenous DPs at baseline

Capacity Component	Indicator	Indigenous Median Baseline
Network Partnerships	Identify Deliver Maintain	2 2 1
Knowledge Transfer	Develop Transfer Integrate	3 3 1
Problem Solving	Work together Identify Sustain	1 1,2 1
Infrastructure	Policy capital Financial capital Human/Intellectual capital Social capital	1 1 1 2

Across Capacities

Higher

Lower

Network Partnerships

The ratings for network partnerships suggest that the DPs, on average, had some capacity to identify organisations with resources to implement and sustain the self-management program. Similarly, the rating suggests that they had some capacity to deliver their self-management programs, although at this early stage, it was felt that the networks only had limited ability to maintain and resource their programs.

Knowledge Transfer

In terms of knowledge transfer, DPs were rated as having substantial capacity to develop self-management programs that met local needs as well as in their capacity to transfer knowledge to achieve the desired outcomes. Despite these high scores for developing DPs and transferring knowledge, DPs were rated as having limited capacity to integrate the self-management programs into the practices of the network partners. This is not surprising, given the early stage of the DPs and the fact that the focus would have been on establishing the DPs rather than integrating and maintaining them.

Problem Solving

Problem solving scores were slightly lower than those for network partnerships and knowledge transfer at this stage. There was limited evidence of capacity within the networks to work together to solve problems, however, there was 'limited' to 'some' capacity to identify and overcome problems encountered. Scores at this stage also suggested that the DPs had limited capacity to sustain flexible problem solving, although again, the lower score for this item regarding sustainability is expected within this capacity component.

Infrastructure

The infrastructure ratings are in the opposite direction from that anticipated, reflecting an emphasis on their capacity to develop social capital. At this early stage, the DPs were rated as only having limited capacity to develop policy, financial and human/intellectual capital. In order for the DPs to be sustainable, they need to demonstrate increased investment in all aspects of infrastructure in future measurement points.

5.7.2.2.2 Middle measurement point

Median ratings across capacity components for the key informants from the Indigenous DPs at the middle measurement point are listed in the grey column in Table 118 below. The scores at this period are quite consistent across capacities and do not reflect the expected direction of scores as outlined by the solid arrow to the right of the table. Scores are generally at the higher end of the scale,

suggesting that DPs had capacity that was ‘substantial’ to ‘almost entirely/entirely’ to meet the requirements of each component, a considerable improvement since the baseline measurement point.

Table 118 Median ratings for key informants from Indigenous DPs at middle

Capacity Component	Indicator	Indigenous Median Middle	Across Capacities
			Higher
Network Partnerships	Identify	3,4	
	Deliver	3	
	Maintain	3,4	
Knowledge Transfer	Develop	4	
	Transfer	3,4	
	Integrate	3,4	
Problem Solving	Work together	3,4	
	Identify	3,4	
	Sustain	3,4	
Infrastructure	Policy capital	2	
	Financial capital	2,3	
	Human/Intellectual capital	3,4	
	Social capital	3,4	Lower

Network Partnerships

The ratings for network partnerships suggest that the DPs, on average, demonstrated a ‘substantial’ to almost entire ability to identify organisations with the resources to implement a DP. The scores also suggest that networks had developed clear roles and responsibilities in order to deliver their self-management programs and one DP reported that they had built a relationship with their local council who could provide facilities necessary for the DP.

At this measurement point, DPs reported substantial capacity to maintain and resource their self-management programs. For example, one DP stated that they were integrating aspects of self-management into the core business of the network organisations.

Knowledge Transfer

Scores within this capacity were in the expected direction from high to low (as represented by the dashed arrow), although the scores for the capacity to transfer knowledge and the ability to integrate knowledge were only slightly lower than that that for developing a self-management program.

Scores for knowledge transfer suggest that DPs demonstrated complete capacity to develop self-management programs that met local needs. DPs were rated as having 'substantial' to almost full capacity to transfer knowledge to achieve the desired outcomes of the self-management program, as well as to integrate a self-management program into the core practices of the network partners.

Problem Solving

These high scores continued with problem solving, where DPs were rated as having 'substantial' to almost entire capacity to work together to solve problems, identify and overcome problems and to sustain flexible problem solving. This considerable increase in scores from the baseline measurement point may be attributed to the difficulties initially faced by DPs in operationalising DPs in rural and remote settings at baseline.

Infrastructure

As with the previous measurement point, infrastructure ratings went from lower to higher, contrary to the expected direction. DPs demonstrated only some capacity to develop self-management program related policy capital and although this was the lowest scoring item at this measurement point, it is important to note that the rating improved by one (from 'not at all/very limited' to 'somewhat' capacity) when compared with the baseline score.

Capacity to develop financial capital was rated from 'somewhat' to 'substantial', also an improvement from baseline. This rating implies that the DPs had investigated where further funding could be obtained from, and that some additional funding had been obtained. For example, one DP stated that they were trying to develop financial capital by utilising Medicare funding via the care planning item number.

Capacity to develop human/intellectual capital was rated as 'substantial' to 'almost entirely/entirely', suggesting that DPs had clear plans regarding how this capacity would be built and there was evidence that this would be of benefit to the wider community. One DP stated that they were training health care workers in self-management and that these workers would continue to pass on their knowledge to others through future training and information sessions.

Similarly for capacity to build social capital, DPs were rated as 'substantial' to 'almost entirely/entirely'. One DP gave the example of including Elders in the network in order to build social capital that would be of benefit to the wider community.

5.7.2.2.3 Last measurement point

Median ratings across capacity components for the key informants from the Indigenous DPs at the last measuremet point are listed in the shaded column in Table 119. With the exception of infrastructure, the patterns of scores within capacities for this period are not in the expected direction outlined by the dashed arrows. Similarly, the scores across capacities do not reflect the solid arrow to the right of the table, as generally, the higher scores are not clustered around network partnerships and knowledge transfer. It is also worth noting that the majority of scores decreased from the middle to the last measurement points.

Table 119 Median ratings for key informants from Indigenous DPs at last

Capacity Component	Indicator	Indigenous Median Last
Network Partnerships	Identify	2
	Deliver	2
	Maintain	3
Knowledge Transfer	Develop	2
	Transfer	4
	Integrate	3
Problem Solving	Work together	3
	Identify	2
	Sustain	3
Infrastructure	Policy capital	3
	Financial capital	3
	Human/Intellectual capital	3
	Social capital	2

Across Capacities

Higher

Lower

Network Partnerships

The ratings for network partnerships suggest that the DPs, on average, only demonstrated some capacity to identify organisations with the resources to implement the DP self-management program. This suggests that there was somewhat limited understanding demonstrated of how the network could benefit the DP self-management program and what each of the partners would contribute. Similarly, the DPs were only rated as having some capacity to deliver a self-management program, implying a lack of formalisation of DP roles and responsibilities.

This decrease in scores from middle to last measurement point may be explained by some of the reports provided by key informants regarding barriers to the maintenance of their networks. For example, it was felt that as other

opportunities were constantly arising, resources of the network partners had to be reorganised.

The highest score for network partnerships was for capacity to maintain and resource a self-management program, for which DPs were rated as having 'substantial' capacity. Key informants suggested that this capacity was evident in their DPs as they were integrating the principles of the DP self-management program into the mainstream practices of the partners. It was believed that the partners could maintain the self-management program in the health system.

Knowledge Transfer

Contrary to the middle measurement point where DPs were rated as having complete capacity to develop a self-management program that met local needs, DPs at the last time period were believed to only have some such capacity. Key informants at this measurement point reiterated the difficulties experienced by one DP due to the variety of languages spoken in the DP region.

DPs maintained their capacity to transfer knowledge to achieve desired outcomes and it was felt they had complete capacity to do so (rated 4). It was suggested that the network partners had 'substantial' capacity to integrate the DP self-management programs into their practices and it was clear how they intended to do so, however, it had not been carried out as yet. For example, a key informant from one DP stated that their organisation had a Master Trainer who would continue to train course leaders to maintain the DP self-management program. A key informant from another DP reported that the HSPs within their organisation would continue CCSM education and campaigns.

Problem Solving

Problem solving scores suggested that DPs had substantial capacity to work together to solve problems. It was reported by the key informants that the DPs had substantial capacity to sustain these problem solving mechanisms they had in place and key informants reported that these mechanisms had been integrated into the core practices of the network partners. Despite this, some DPs reported that they were lacking in their ability to identify potential problems and felt they had no structures in place to do so.

Infrastructure

The scores for infrastructure were in the expected direction from higher to lower. The score for policy capital increased from that at the middle measurement point as at the last measurement point, with DPs having 'substantial' capacity to develop self-management program related policy capital and a structured approach had been taken to ensure this. Informants from one DP stated that they had capacity to increase policy capital as they were already part of the Health

Service System of the area and had developed a chronic condition model of care that was being implemented at the health service system level. Similarly, it was reported that DPs had substantial capacity to develop financial capital and the example was given that additional funding had been obtained.

At this last measurement point, clear plans were articulated regarding how human and intellectual capital would be built as a part of the DPs, suggesting they had 'substantial' capacity in this regard. For example, one DP stated that they were continuing training for staff in self-management to create a pool of potential leaders. It was mentioned that this measure was also being taken in an attempt to prevent knowledge loss that was occurring due to high staff turnover.

Ratings for capacity to develop social capital suggest that DPs only had some capacity to develop this aspect of the DP. The overall score for capacity to develop social capital decreased at this measurement point from 'substantial'/'almost entirely/entirely' to 'somewhat'.

5.7.2.3 Summary of the key informant ratings across the three measurement points

Table 120 provides a summary of the key informant ratings for the Indigenous DPs across the three measurement points. Overall, the ratings for the Indigenous DPs increased from baseline to middle and then decreased from middle to last which can be explained in part by one of the Indigenous DPs losing some of its momentum as a result of some internal management difficulties after the middle measurement point.

Nevertheless, it can be noted that the ratings at the last measurement point were still generally higher than those at baseline, suggesting that the Indigenous DPs were able to progressively build capacity over the life of the SHCI. However, all capacity components still had room to improve.

Table 120 Median ratings for key informants from Indigenous DPs over time

Capacity Component	Indicator	Indigenous Median Baseline	Indigenous Median Middle	Indigenous Median End
Network Partnerships	Identify	2	3,4	2
	Deliver	2	3	2
	Maintain	1	3,4	3
Knowledge Transfer	Develop	3	4	2
	Transfer	3	3,4	4
	Integrate	1	3,4	3
Problem Solving	Work together	1	3,4	3
	Identify	1,2	3,4	2
	Sustain	1	3,4	3
Infrastructure	Policy capital	1	2	3
	Financial capital	1	2,3	3
	Human/Intellectual capital	1	3,4	3
	Social capital	2	3,4	2

Across Capacities

Higher

Lower

5.7.3 Main facilitators and barriers to sustainability

As illustrated above, the ability of DPs to sustain their self-management programs depends on a number of factors. Table 121 summarises the main facilitators and barriers to sustainability which were observed during the process mapping visits and described during the key informant interviews across the three measurement points. As described in Section 3.2.1.3, the capacity components for the key informant interviews have been used to categorise the identified themes.

Table 121 Facilitators and barriers to sustainability for the Indigenous DPs

	Facilitators	Barriers
Network Partnerships	• Integrating the DP into mainstream practices of the network partners and building partnerships with Steering Committee member organisations. • Involving key community members and utilising community facilities. • Holding regular Steering Committee and network partner meetings. • Creating links with the local council who were able to provide resources and facilities if required.	• Network partners reported that they needed to consider other project opportunities that arose during the life of the DP which often led to a shift in resources. • Limited range of potential network partners in rural and remote areas.
Knowledge Transfer	• Continuing training/education (for example, staff training to ensure pool of leaders and training of Aboriginal Health Workers and Community Support Workers). • Whole of community approach to CCSM (i.e. a 'bottom-up approach') achieved through education and training and employing community members. • Empowering local community members through employment (as they remain in the community long-term).	• Lack of client engagement.
Problem Solving	• Overcoming problems led to the creation of problem identification and solving mechanisms being put into place which could be referred to post-DP.	*No barriers to problem solving were reported*
Infrastructure:	• Utilising infrastructure within local Aboriginal Health Services (for example, IT systems and furniture).	• Low community infrastructure and remote locations.
a. Policy Capital	• Having the DP located within the Health Service System and having created a model of care that was being utilised in the System.	*No barriers to developing policy capital were reported.*
b. Financial Capital	• Generating funding through EPC MBS items.	• Lack of funding (other than that provided by the Department).
c. Human/Intellectual Capital	• Ability to utilise personnel from the Aboriginal Health Service to assist with the DP. • Training health care workers in self management so they could transfer this knowledge through training and information sessions (for example, one DP staff member was trained as a Master Trainer and could, therefore, continue to train leaders to run courses).	• High turnover of HSPs and DP staff and difficulty replacing staff.
d. Social Capital	• Including Elders in the network to increase social capital that would benefit the community.	*No barriers to developing social capital were reported*