

Figure A5.19 Chronic obstructive pulmonary disease smoking cessation provided in the community, emergency department and at discharge

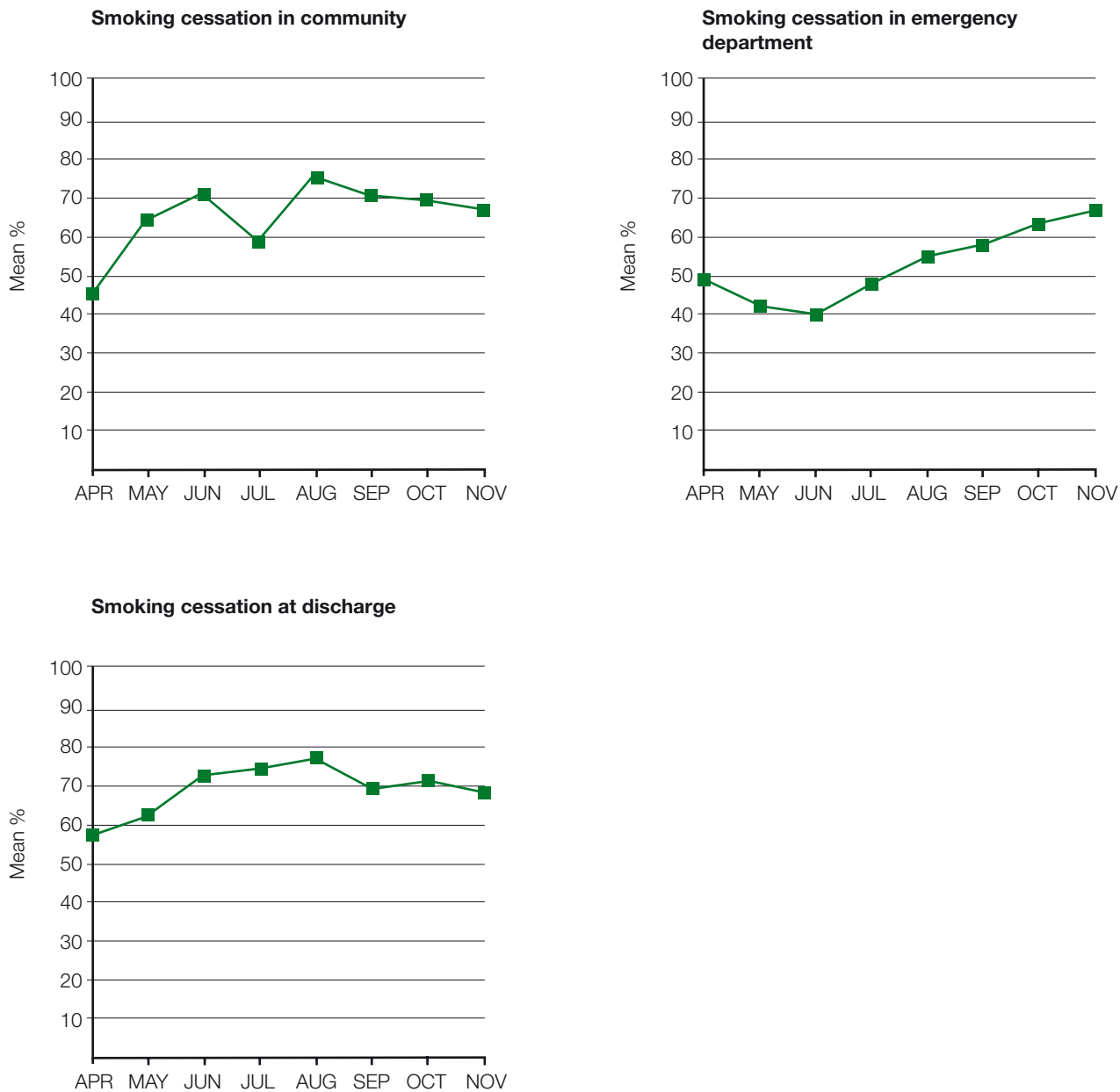


Figure A5.20 Chronic obstructive pulmonary disease self-management support provided in the community, emergency department and at discharge

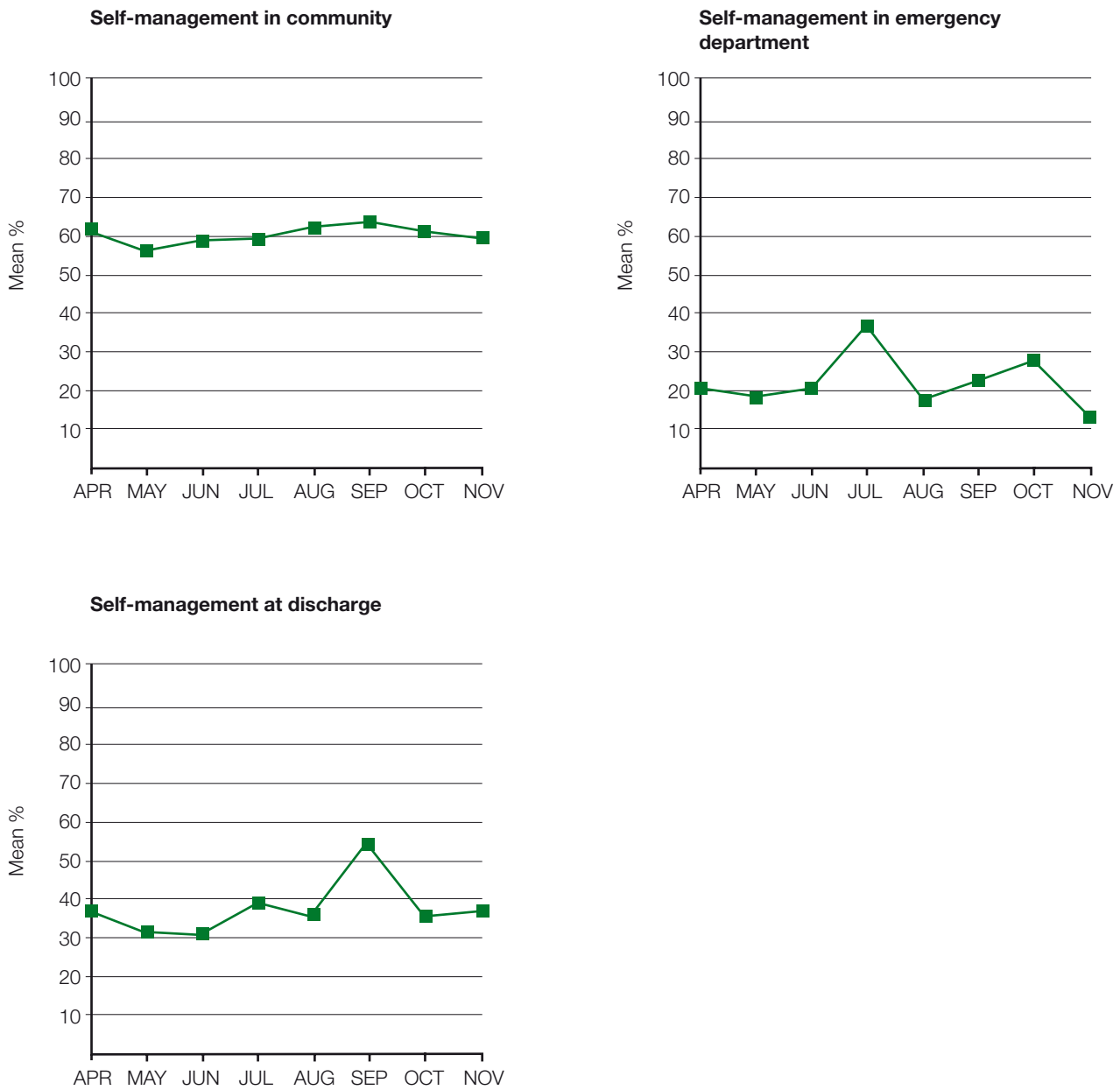
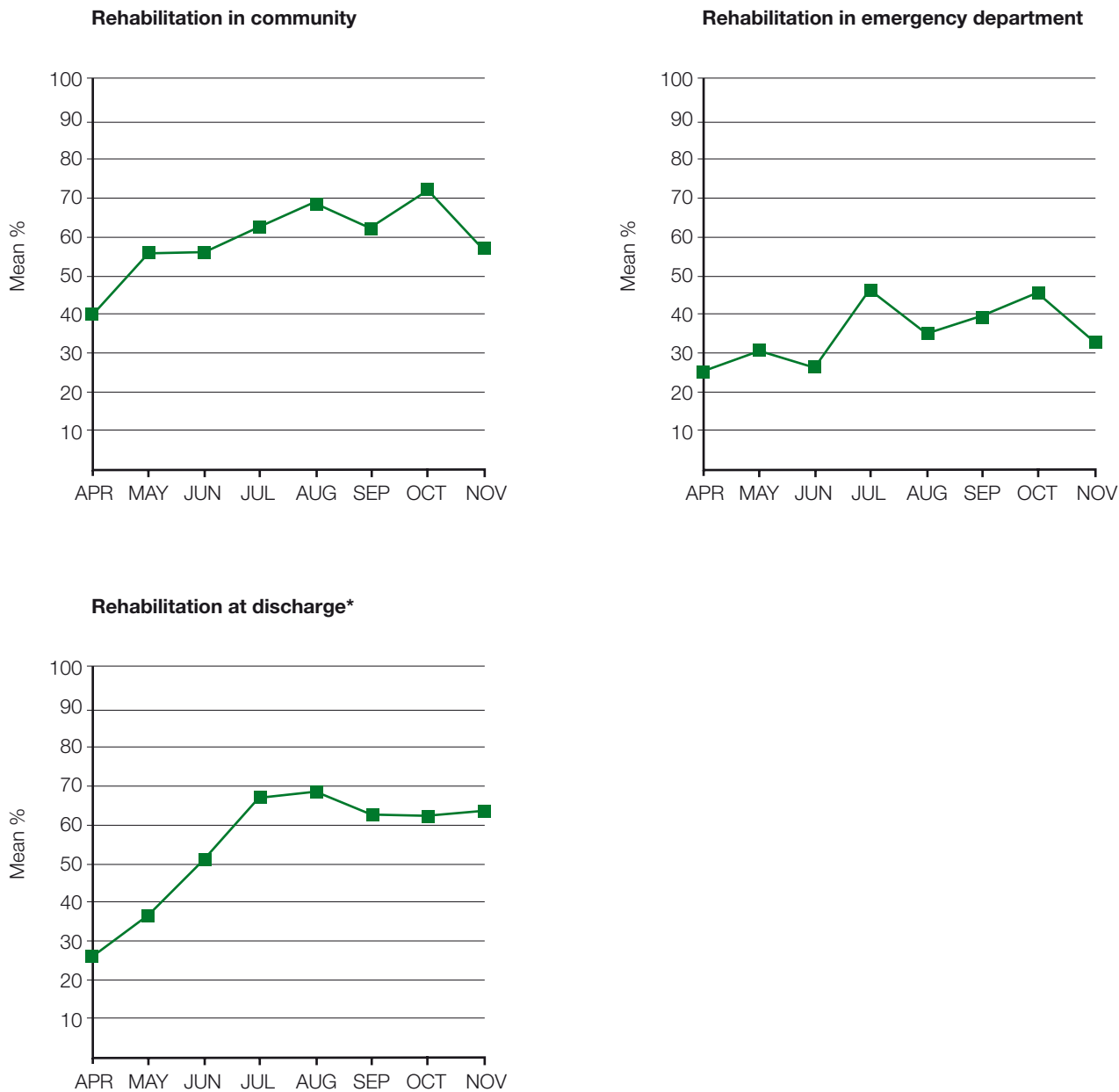
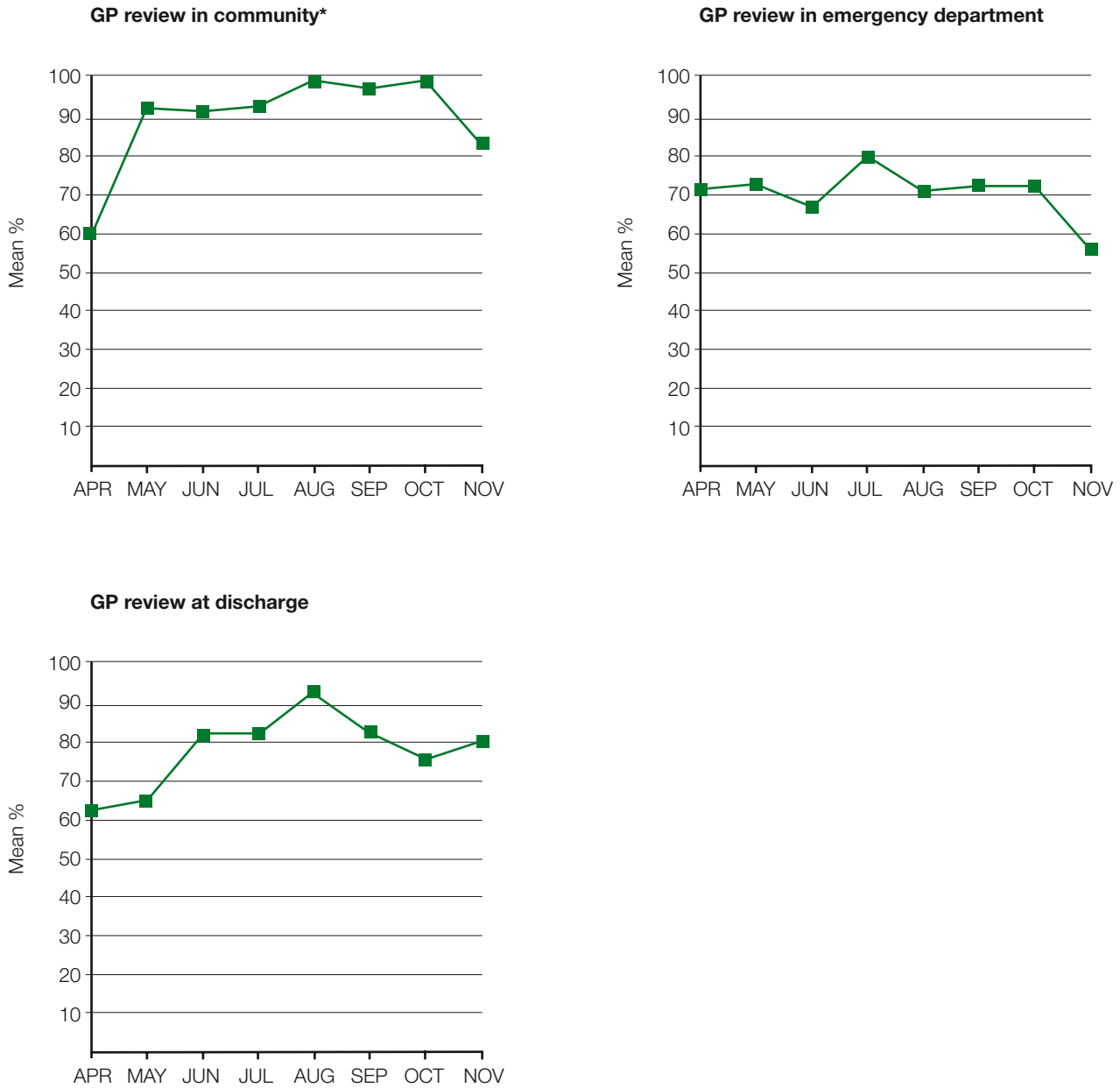


Figure A5.21 Chronic obstructive pulmonary disease rehabilitation program referred or completed in the community, emergency department or at discharge



* Significance P<0.05 change per month.

Figure A5.22 Chronic obstructive pulmonary disease schedule of general practitioner review recommended in the community, emergency department and at discharge



* Significance P<0.05 change per month.

Figure A5.23 Chronic obstructive pulmonary disease influenza immunisation completed in the community, emergency department and at discharge

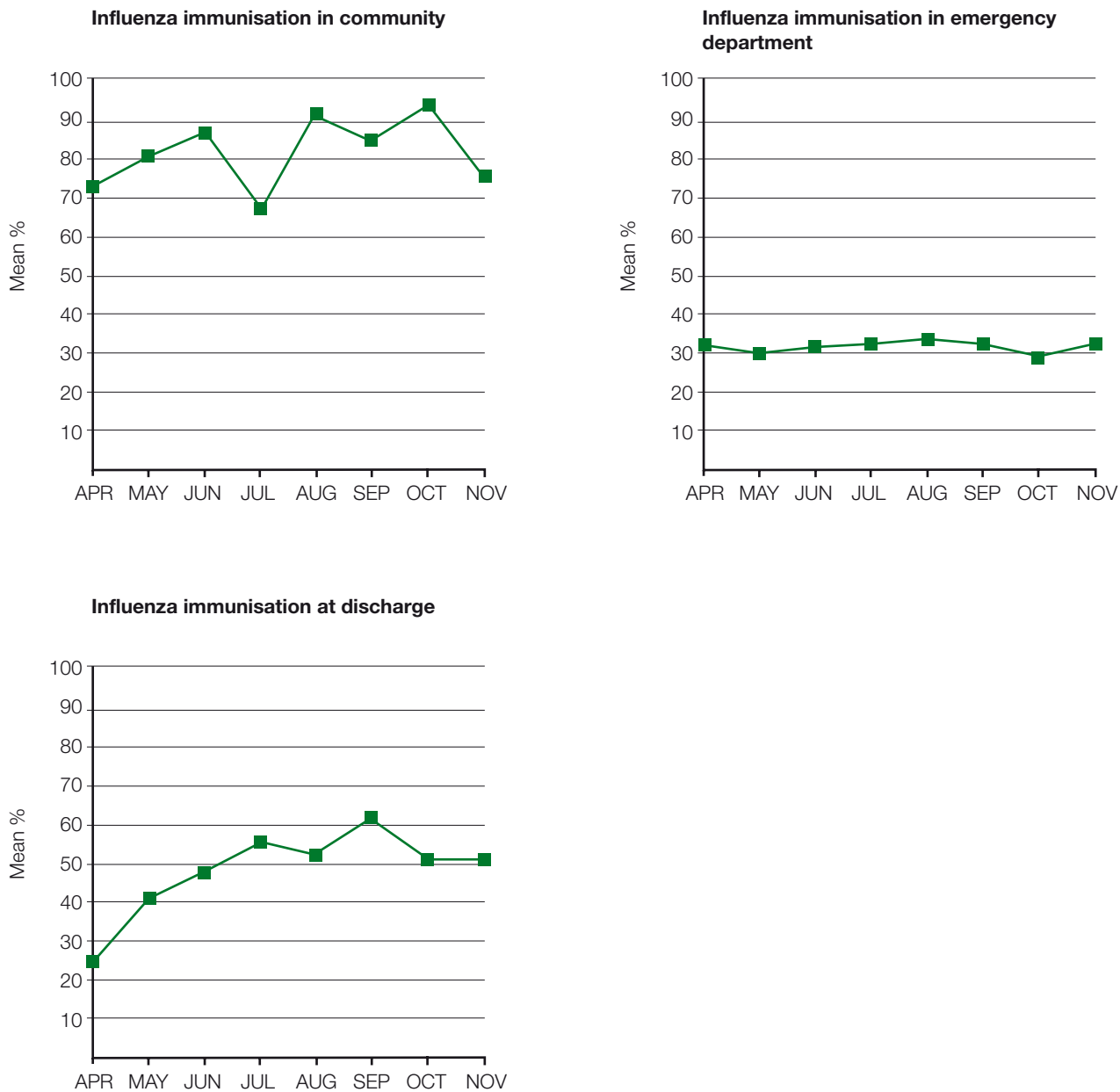


Figure A5.24 Chronic obstructive pulmonary disease pneumococcal immunisation completed in the community, emergency department and at discharge

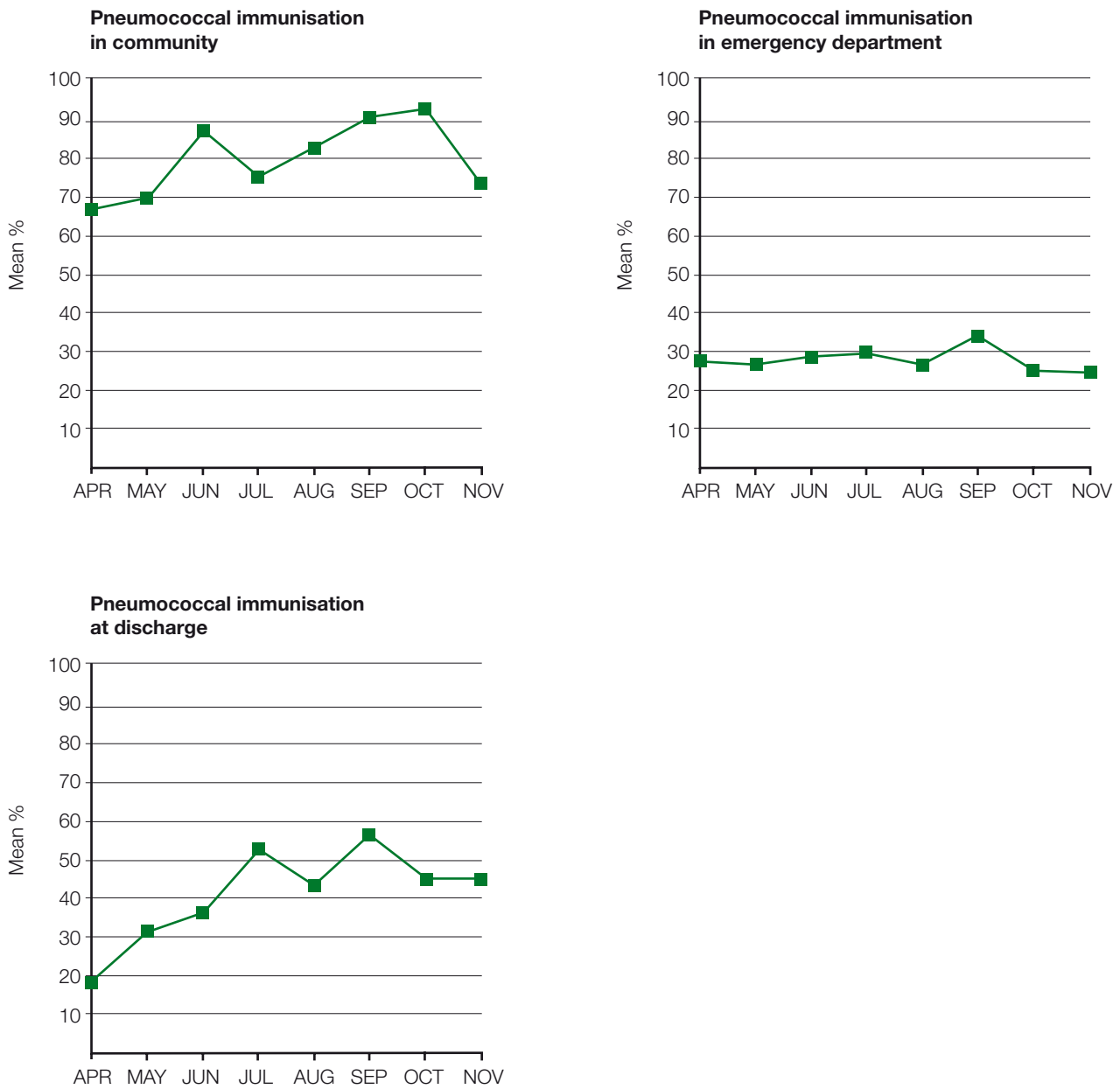
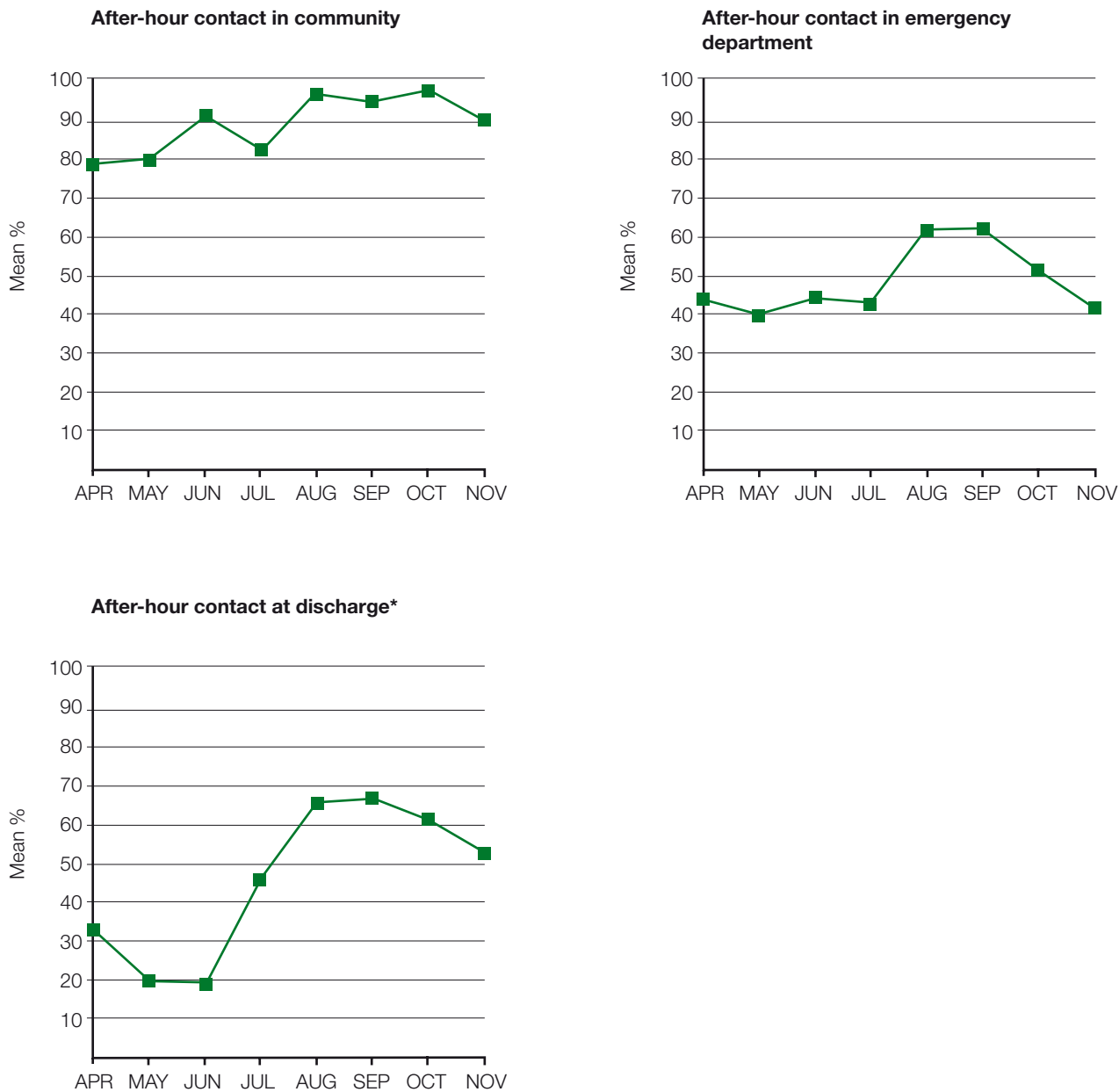
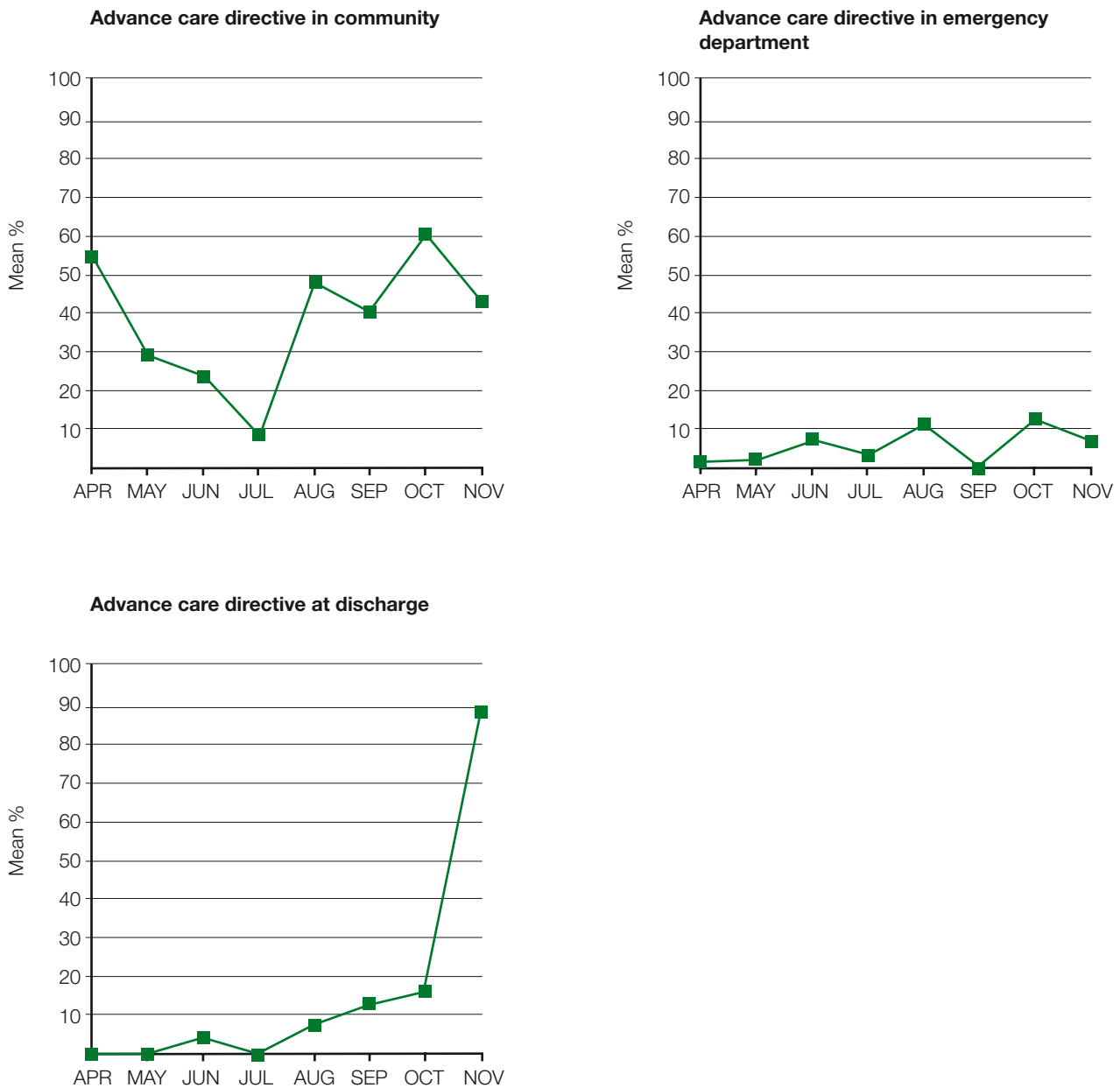


Figure A5.25 Chronic obstructive pulmonary disease after-hour points of contact provided in the community, emergency department and at discharge



* Significance P<0.05 change per month.

Figure A5.26 Chronic obstructive pulmonary disease advance care directives in the community, emergency department and at discharge



Appendix 6

Additional learning session results

Table A6.1 Rating of aspects of learning session 1 by attendees

	N	Level of usefulness			
		None	Some	Good	High
		%	%	%	%
Opening	108	0.0	17.8	55.1	27.1
Progress to date	111	1.8	22.7	54.5	20.9
Achieving health care improvement in heart failure	108	0.0	20.4	50.9	28.7
Achieving health care improvement in chronic obstructive pulmonary disease	105	1.0	16.2	46.6	36.2

Table A6.2 Rating of aspects of learning session 2 by attendees

	N	Level of usefulness			
		None	Some	Good	High
		%	%	%	%
Welcome	84	7.1	34.5	48.8	9.5
Team reports and workshop	94	0.0	6.4	42.6	51.1
Next steps and close	81	6.2	35.8	49.4	8.6
Team planning for action period 2	91	1.1	14.3	49.5	35.2
Managing chronic obstructive pulmonary disease in general practice	92	2.2	17.4	48.9	31.5
Effective strategies for managing people with chronic illness in the community	91	2.2	24.2	56.0	17.6
Improving uptake of echocardiography	92	3.3	25.0	54.3	17.4
Improving care for Aboriginal people with chronic conditions	94	1.1	33.0	50.0	16.0
Flinders University approach to patient self-management	92	2.2	37.0	51.1	9.8
Direction setting	94	1.1	37.2	54.3	7.4

Table A6.3 Rating of aspects of learning session 3 by attendees

	N	Level of usefulness			
		None %	Some %	Good %	High %
Welcome	73	45.2	37.0	17.8	0.0
Team reports and workshop	77	0.0	14.3	46.8	39.0
Self-management in South Western Sydney, a community based approach	76	1.3	17.1	64.5	17.1
Team planning for action period 3	21	0.0	19.0	66.7	14.3
Spreading and sustaining improvements	82	12.2	8.5	31.7	47.6
Accessing diagnostic services – a statewide perspective	77	7.8	20.8	54.5	16.9
Meeting community respiratory needs in a metro setting	77	2.6	31.2	46.8	19.5
Filling the gaps – achieving the Collaborative aims	79	5.1	34.2	48.1	12.7
Next steps and close	62	6.5	33.9	50.0	9.7
Rural rehabilitation program – meeting the needs of patients	79	7.6	34.2	36.7	21.5

Table A6.4 Results for a question asked at the beginning of the learning session about the level of benefit obtained during the preceding action period¹.

During preceding action period¹ what level of benefit did you obtain from using:

	N	Did not use	Minimal	Satisfactory	High
		%	%	%	%
1. Monthly audit results					
Learning session 2	107	13.2	26.2	37.4	22.4
Learning session 3	65	1.5	18.5	44.6	35.4
2. The change package					
Learning session 2	104	17.3	10.6	59.6	12.5
Learning session 3	66	6.1	13.6	53.0	27.3
3. The website					
Learning session 2	106	28.3	35.8	23.6	12.3
Learning session 3	66	7.6	19.7	65.2	7.6
4. The listserve					
Learning session 2	108	24.1	26.9	35.2	13.9
Learning session 3	67	7.5	17.9	50.7	23.9
5. The teleconference					
Learning session 2	107	27.1	28.0	35.5	9.3
Learning session 3	66	10.6	36.4	40.9	12.1

1. Each learning session marked the end of an action period. Thus learning session 2 came at the end of action period 1; learning session 3 at the end of action period 2, and learning session 4 at the end of action period 3. There is no data in this table for action period 3 because these questions were not asked at learning session 4.

Appendix 7

Facilitator reactivity at focus groups and interviews

When the data from the focus group meetings and from the interviews were analysed it was expected that what was said would to some extent be induced by the technique, style, perceived interests or perceived needs of the facilitator/interviewer. The two examples which follow illustrate this effect. Here the facilitator thinks that he knows something which has been implied sometime during the session, but which has not been said, and he sets up a situation where it is said. Apart from examples such as these, we found no evidence of reactivity leading to bias, in the sense of discussants being intentionally or unintentionally influenced to present a view other than their own.

The following extract is from the transcript of a focus group meeting held at a rural hospital. It illustrates how the facilitator leading the meeting can communicate to group members the direction he/she wants group members to follow. In this example the facilitator believes that he has not introduced a direction of his own, but has brought together points he thinks were stated, implied, and/or indicated by gesture by the group during the preceding few minutes. It is easy to see how bias in the material covered in a focus group meeting could be generated by members trying to suss out what was required by the facilitator, or how a facilitator could intentionally or unintentionally bias the data collected by exploiting the willingness of participants to help. A reflexive examination made after analysis has been concluded seeks to estimate the influence of exchanges such as this on the validity of the results. Clearly in the present instance a series of positive examples follow the remark by the team coordinator 'OK, we know where you are going then (laughter)'.

There has just been discussion and agreement amongst several speakers that the basic methodology of the Collaborative was 'nothing particularly new'.

Physician and senior clinical team leader: *'It's just putting it in a much more formal structure, adding a lot of jargon which I think is actually a barrier to a lot of people becoming involved. They hear a lot of jargon and they, puts them off'.*

A discussion follows with general agreement in the group. It is said that all the Collaborative has done is add: *'volume and the short timeframe'.*

Facilitator: *'What I was trying to get to, without expressing an opinion myself, was whether although this was building or using what some people may have been even pessimistic about at the start, because they might have thought this is all old stuff, but formalising it in this way, and bringing you together as a team and talking about it and getting this extra load of work, did that add anything?'*

This question is, of course packed tight with implied opinion and leads, even though these are based on what the facilitator believes he has heard discussants say previously. Rapid responses from discussants follows with several people talking at the same time.

Emergency Department nursing unit manager: *'Did it add anything, was there benefit? Of course'.*

Other voices over talking: *'Of course, of course'.*
(pause) Facilitator: *'I wish someone would say something'.* Emergency department nursing unit manager: *'Oh, OK, we ... (interrupted, various voices)'*
Clinical nurse consultant & project leader: *'OK, we know where you are going then'.* (laughter).

Physician and senior clinical team leader: *'Having a formal structure for this sort of thing is a major benefit because I think a lot of this stuff is done on an ad hoc and very informal basis ... (he has accepted the lead and goes on to list positive outcomes)'.*

Appendix 7

Clinical nurse consultant and project leader: '*... times when you do feel like a poor county cousin but the listserv and the networking opportunities was just wonderful, that should just not stop, that was the best...*' (she has accepted the lead and moved to something positive and others do the same).

Emergency Department nursing unit manager: '*...it's that whole exposure to emergency departments of the importance of documentation, history, assessment at the front end and how that links with the next phase*'.

Nursing unit manager generalist community health: '*Well, it's worked well, you know, we've got a good partnership now and also we are starting to pick up referrals ...*'.

Exchange at the end of a 90 minute focus group meeting. At the start of the meeting there was mention of an impressive dinner given to team members at the orientation session in Sydney, and during the meeting there was much evidence of commitment and work by team members but the focus had turned to difficulties and overwork.

Facilitator: '*So I would like to come to a devil's kind of question then. Obviously, I mean why are you doing it for such a small reward, one dinner?*'

Project coordinator: '*Its' not, it's not the one dinner*' (voices and laughter).

Team member (emergency department): '*No, I didn't even go to the dinner*'. Voice: '*She wasn't even there!*'

Facilitator: '*You didn't go! So why are you doing it?*'

Team member (emergency department): '*You know it makes a difference, you believe in it, and at the end of the day it's about the clients, it's about the patients, and making a difference in their quality of life*'.

Appendix 8

Team assessment test used by the Clinical Excellence Commission

See following page

NSW Chronic Care Collaborative Team Progress Assessment Scale

TEAM NAME:

DATE:

Assessment of your team's progress in relation to Collaborative Aims

Assessment/Description	Definition
1.0 Forming team	<input type="checkbox"/> Team formed; <input type="checkbox"/> Target population identified; <input type="checkbox"/> Focus of work determined; <input type="checkbox"/> Baseline measurement started.
1.5 Planning for the project has begun	<input type="checkbox"/> Team is meeting & discussion is occurring; <input type="checkbox"/> Aims agreed (core and/or optional); <input type="checkbox"/> Planning for project started; <input type="checkbox"/> Baseline measurement completed.
2.0 Activity, but no changes tested	<input type="checkbox"/> Team actively engaged in development, research & discussion but no changes tested.
2.5 Changes tested, but no improvement	<input type="checkbox"/> (Components of Chronic Care Collaborative) Changes (package) being tested; <input type="checkbox"/> No improvement in measures; <input type="checkbox"/> Data on key measures reported.
3.0 Modest improvement	<input type="checkbox"/> Initial test cycles completed and implementation begun for several components; <input type="checkbox"/> Improvement in process measures achieved.
3.5 Improvement	<input type="checkbox"/> Moderate improvement in process measures; <input type="checkbox"/> Some improvement in outcome measures; <input type="checkbox"/> Process measures continuing to improve; <input type="checkbox"/> Changes tested on multiple components of diagnostic and management bundles.
4.0 Significant improvement	<input type="checkbox"/> Evidence of sustained improvement in outcome measures; <input type="checkbox"/> Halfway toward accomplishing all of the goals; <input type="checkbox"/> Plans for spread the improvement are in place.
4.5 Sustainable improvement	<input type="checkbox"/> Improvement sustained for at least 3 months in most outcomes measures <input type="checkbox"/> 75% of goals achieved <input type="checkbox"/> Spread to a larger population has begun.
5.0 Outstanding sustainable results	<input type="checkbox"/> Major change in multiple components of diagnostic and management bundles implemented; <input type="checkbox"/> All goals of the aim accomplished, <input type="checkbox"/> Outcome measures at statewide benchmark levels, <input type="checkbox"/> Spread to other facilities within the Area Health Service underway.

Please return on the last Monday of every month to ICE by Email to Melanie McKinnon at mckinnonm@ice.nsw.gov.au

Appendix 9

Diagnostic and management bundles – indicators

NSW Chronic Care Collaborative Indicators

For chronic obstructive pulmonary disease:

- Clinical assessment including focused clinical history¹ and physical examination²
- Spirometry³
- Baseline investigations to guide clinical management⁶
- Smoking cessation intervention
- Bronchodilators (beta agonists and/or anti-cholinergics)
- Self-management support⁷ (including action plan⁸) that has been delivered in the context of appropriate education)
- Referral to OR completion of/ongoing attendance at an individually tailored multidisciplinary pulmonary rehabilitation program⁹ (individual or group)
- Recommended schedule of review by GP (and other health care providers if required)
- Influenza vaccination
- Pneumococcal vaccination
- After-hours points of contact

For Heart Failure:

- Clinical assessment including focused clinical history⁴ and physical examination⁵
- Echocardiograph
- Baseline investigations to guide clinical management¹⁰
- ACE inhibitor for patients with systolic heart failure if no contra-indications
- Dose titration schedules for ACE inhibitors and beta-blockers where prescribed
- Smoking cessation intervention if relevant
- Self-management support (including action plan) that has been delivered in the context of appropriate education)
- Referral to OR completion of/ongoing attendance at an individually tailored multidisciplinary pulmonary rehabilitation program¹¹ (individual or group)
- Recommended schedule of review by GP (and other health care providers if required)
- Influenza vaccination
- Pneumococcal vaccination
- After-hours points of contact

Source: NSW Chronic Care Collaborative, the Clinical Excellence Commission and New South Health Department

- 1 Focused clinical history would include assessment of dyspnoea, exercise capacity, chronic cough and sputum production, exacerbations of chronic bronchitis, quantitated total cigarette intake, assessment -of nicotine dependence, and exclusion of asthma
- 2 Physical examination would include full respiratory examination, and assessment of presence of chronic obstructive pulmonary disease, and simple assessment of exercise tolerance where possible
- 3 Spirometry - to confirm diagnosis and assess severity of airway obstruction - should be performed before and after 200-400 mcg salbutamol or equivalent bronchodilator
- 4 Focused clinical history would include assessment of:
(a) symptoms of heart failure (i.e. dyspnoea, orthopnea, paroxysmal nocturnal dyspnoea, fatigue, oedema, palpitations/syncope) and severity of symptoms using New York Heart Association class
(b) history of past CVD and risk factors, alcohol use and medications
- 5 Physical examination would include pulse rate and rhythm, blood pressure, jugular venous pressure, peripheral oedema and ascites, cardiomegaly, murmurs, lung crepitations, hepatomegaly
- 6 Baseline investigations to guide clinical management may include chestX-ray to exclude focal lung lesions, resting oximetry to assess need for arterial blood gases, echocardiogram, full blood count, 6 minute walk test, and sleep study
- 7 Self-management support (Robert Wood Johnson Foundation and Institute for Health Care Improvement, www.improvingchroniccare.org/change/model/smsupport-test.htm), - focuses on empowering and preparing patients to manage their health and health care through:
 - Emphasizing the patient's central role in managing their health.
 - Use of effective self-management support strategies that include assessment, goal setting, action planning, problem solving and follow-up.
 - Organising internal and community resources to provide ongoing self-management support to patients.

Appendix 9

- 8 Action plan (NSW Department of Health: Heart Failure Clinical Service Framework, 2003) - [a written plan] which covers self-management of important aspects of the disease, recognition of symptoms and signs that signal the need for professional attention and information on how to obtain this attention
- 9 Pulmonary rehabilitation (NSW Department of Health: Respiratory Clinical Service Framework, 2003) - Program designed to improve quality of life, reduce dyspnoea, anxiety and depression, and improve exercise capacity (as measured by six minutes walk distance)
- 10 Baseline investigations to guide clinical management may include biochemistry profile including electrolytes, full blood count, chest X-ray, ECG and thyroid function - refer Algorithm, Appendix B, Heart Failure Clinical Service Framework, volume 2 (NSW Department of Health, 2003)
- 11 Cardiac rehabilitation (NSW Department of Health: Heart Failure Clinical Service Framework, 2003) - Interventions used to help cardiac patients maximise physical, psychological and social functioning to live productively and with confidence, and to assist and encourage behaviours likely to minimise the risk of further cardiac events and conditions. Service should include physical.

