

APPENDIX 1**TrueBlue Focus Group (Northern Rivers)**

1. Which parts of the project helped you (practice nurses) with your enhanced roles with the new role of being a case manager for these patients?
2. Any other people that were involved as practice nurses in the project have any other thoughts?
3. Did anyone find the manual, the handbook that went with the training program useful or not useful?
4. To what extent was the template for the GP management plan involved, useful or not useful in the way you delivered the care?
5. To what extent was the support that you had from GPs or the communication with GPs helpful for you taking on your enhanced roles of being a case manager?
6. To what extent has the nurse-led chronic disease management affected your practices as GPs?
7. Was the recall scheduling, the actual bringing people back at 3 month intervals a helpful structure or not?
8. The checklist that the patients can fill out in the waiting room before coming in to see the nurses, are you used to that or not?
9. And the PHQ-9 score and what changes. Was the actual number useful or not?
10. Did you use what had gone on in the practice nurse to generate care plans, and team care?? And mental health plans or just a proportion of those things?
11. So you added the mental health plans to what was already going on here. Is that the same with other practices?
12. I'm interested in just getting some. Seeking some opinions about communication next because chronic disease management, if it's done by a team, one of the benefits and one of the problems is communicating. Between nurses and GPs?
13. Was the GP management plan the main tool of communication or was discussion in the corridor or whatever the main tool for communication?
14. What about between nurses and allied health providers including mental health workers. Most of the communication, and this is more the case management role, was it the nurse to allied health provider or GP to allied health provider?

15. I was also wondering within the setting whether, what used to be a GP role which is doing all the referrals to any other external person have been taken over by practice nurses
16. To what extent is TrueBlue giving the patients a comprehensive management plan as opposed to a ...local aid one? Has it helped with or hindered communication with patients and their carers?
17. Would you to continue with a formalised project like TrueBlue? Would you continue including the depression screening and monitoring as part of project of disease management in a collaborative care way like this?
18. Could admin staff take more of a role or less of a role in chronic disease management? Could nurses take on even more tasks than we've asked them to in this project? Could doctors take on more tasks? What are people's thoughts getting around to that sort of balance of task sharing?
19. Are there more tasks that could make the job of chronic disease management easier for GPs by shifting more of the responsibilities to the nurses than we have in this project?
20. Do you feel like there's been a shift in the doctors' opinions of what nurses can do, or not?
21. Has there been a shift in what patients think of who their care team is?