

INTRODUCTION

The Flinders Chronic Condition Management Program (henceforth referred to as The Flinders Program) is a generic set of tools and processes enabling health professionals to support their clients to more effectively self-manage their chronic condition(s). The Flinders Program is a self-management partnership based on cognitive behaviour therapy, problem solving and motivational interviewing techniques. Clients actively participate in making decisions about their physical, emotional and social well-being. Health practitioners work individually with clients using the Program tools to assess self-management behaviours, barriers, psychosocial issues and preferences, and produce an individualised Care Plan that includes problem and goal statements, interventions, steps and responsibilities that align with the client's values, priorities and beliefs.

The Program is based on extensive research identifying the importance of self-management and self-management support in chronic condition management (see Effective Management of Chronic Conditions). The need for health professionals and their clients to work together in the management of chronic conditions is supported by professional organisations in Australia (e.g., RACGP) and internationally (e.g., Royal College of Physicians).

Aims of the Flinders Program

The Flinders Program tools and processes provide a framework for practitioners and clients to:

- a) Undertake a structured assessment of self-management
- b) Collaborate in identifying problems and goals, leading to
- c) Development of an individualised care plan

The process is generic rather than disease-specific. It looks at the components of self-management; that is, how the tasks associated with self-management are being completed. These are common tasks across diseases, e.g., managing the impact of the disease on their life, monitoring and managing the symptoms, adopting healthy lifestyles, etc.

History and Development of the Flinders Program

The Flinders Human Behaviour & Health Research Unit (FHBRU) at Flinders University was originally established to provide support and training for service coordinators and general practitioners during the SA HealthPlus Trial, 1997-1998. This trial was one of the larger of the first round of Coordinated Care Trials, enrolling 3,100 clients into its interventions arm.

The Flinders Program tools and processes were developed in response to the outcomes from this trial, and further trialled and refined during the Sharing Healthcare Initiative 2000-2004, funded by the Australian Government. The Program continued to develop over the following decade of research and clinical use. The processes and tools have been tested and evaluated with a number of different patient populations both within Australia and internationally¹⁻¹⁶. See 'Evidence Summary' for more information about the evidence base for the Flinders Program.

Flinders Program Care Planning Tools

The Flinders Program consists of a set of tools that are completed by both the client and the health care professional/worker, working together as a team. The Flinders Program Care Planning Tools provide a formal, systematic approach to assessing self-management capacity and care planning.

The Flinders Program Care Planning Tools are as follows:

- Partners in Health Scale (to assess the client's self-management knowledge and capacity)
- Cue and Response interview (a series of open-ended questions or cues to explore the patient's responses to the Partners in Health Scale in more depth)
- Problem and Goals Statement (used to define the problem(s) affecting the client, and identify a goal/goals that the client can work towards)
- Chronic Condition Management Care Plan (based on the information gained from the Partners in Health, Cue and Response interview, and Problem and Goals assessment).

Use of these tools enables the health professional and the client to identify issues and form an individualised Care Plan, and provides a system for monitoring and reviewing progress. The reliability and validity of the tools has been established^{15,16}.

For more information see 'The Flinders Program Tools'.

Application of the Flinders Program

The Flinders Program has been applied to the management of chronic medical or mental conditions and co-morbidities in a variety of clinical settings and countries.

Clinical settings include, for example: General Practice networks, rural and remote health, respiratory care, cardiac care, aged care, mental health, disability, renal dialysis.

Population groups include, for example: Aboriginals and Torres Strait Islanders, children, adolescents, veterans, carers.

Patient groups include, for example: multiple sclerosis, autism, cystic fibrosis.

Education and Training

Flinders Human Behaviour and Health Research & Unit (FHBHRU) offer a number of options for education and training. Vocational or professional education can be modified depending on the needs of the group.

See 'Study with Us' <http://www.flinders.edu.au/medicine/sites/fhbhru/education/study.cfm> for more information.

Implementing the Flinders Program

The Flinders Program is used in primary health services to support the delivery of integrated, patient-centred care for people with chronic conditions. Successful implementation of program requires an understanding of the characteristics of health care at organisational, system and individual levels.

Our online Implementation online courses provide more information about the skills needed across different levels to implement the Flinders Program as a consumer-directed, collaborative approach to care and provides a structured process to develop an action plan for implementing the Flinders Program within your service.

What health professionals say about the Flinders Program

The most common responses by health professionals are that the Flinders Program adds structure to how they are already working with their clients with chronic conditions and that it encourages the client to have involvement and ownership of their care plan.

The following comments are from health workers using the Flinders Program in clinical practice:

“Challenged my assumptions about chronicity” (mental health worker)

“Made me focus on the client and goal setting that led to achievable outcomes” (nurse)

“It does require a commitment to do it as you need to set aside time” but “I feel we are working more as a team” (GP)

“Allows patients to bring up [other] issues” (health worker) “Relatively quick and simple system for care planning” (GP)

“The process has changed my focus to what I don’t know about the patient rather than what I think I know” (GP)

“It’s helped me to understand the effect my illness has had on me” (client)

“It’s pretty in-your-face in that it challenges your own current practice. Such challenges are essential in health care” (health worker)

Effective Management of Chronic Conditions

The literature suggests that we need to consider the following components in effective management of chronic disease (Wagner et al., 1996):

- Collaboration
- Personalised care plans
- Self-management education
- Adherence to treatment
- Follow up and monitoring.

The research also suggests that programs that are successful in improving self-management have the following characteristics:

- Targeting
- Goal Setting
- Planning.

So what is self-management?

Self-management may seem to be a relatively simple concept with very simple elements; it is often equated to an individual taking sole responsibility for their health and chronic condition (i.e., 'Self-care'). However, the elements of self-management are not as self-evident, and it certainly is not self-care.

Based on a comprehensive literature review of over 400 articles, Gruman and Von Korff (1996) have proposed the following definition:

Self-management “Involves [the person with the chronic condition] engaging in activities that protect and promote health, monitoring and managing of symptoms and signs of illness, managing the impacts of illness on functioning, emotions and interpersonal relationships and adhering to treatment regimens” (p1).

Kate Lorig (1993) one of the leading researchers in this area adds that self-management is also about enabling:

... participants to make informed choices, to adapt new perspectives and generic skills that can be applied to new problems as they arise, to practice new health behaviours, and to maintain or regain emotional stability.

The Principles of Self-Management

The following characteristics could therefore be seen to summarise a 'good' self-manager and are an important part of the Flinders Program, known as the seven Principles of Self-Management (**KICMRILS**: **K**nowledge, **I**nvolvement, **C**are plan, **M**onitor & **R**espond, **I**mpact, **L**ifestyle, **S**upport services).

These Principles of Self-Management refer to the capacity of individuals to:

1. Have knowledge of their condition
2. Follow a treatment plan (care plan) agreed with their health professionals
3. Actively share in decision making with health professionals
4. Monitor and manage signs and symptoms of their condition
5. Manage the impact of the condition on their physical, emotional and social life
6. Adopt lifestyles that promote health
7. Have confidence, access and the ability to use support services.

Self-Management Support

Self-management is not an alternative to medical care; rather, it is “aimed at helping the participant to become an active, non-adversarial, partner with health care providers. Chronic disease is best treated by a balance of traditional medical care and the day-to-day practice of self-management skills” (Lorig 1993, p.11).

Self-management support is therefore a key role for health providers in the management of chronic conditions. Self-management support is the systematic provision of education and supportive interventions by health care staff to increase clients' skills and confidence in managing their health problems, including regular assessment of progress and problems, goal setting and problem-solving support.

The Flinders Program Tools

The Flinders Program care planning tools include both tools used to assess self-management capacity and a care planning tool.

Tools used to assess self-management capacity are:

- Partners in Health Scale
- Cue and Response interview
- Problem and Goals Statement

The care planning tool is the:

- Chronic Condition Management Care Plan.

Use of these tools enables the health professional and the client to identify issues, form an individualised Care Plan and provide a system for monitoring and reviewing progress.

Partners in Health Scale

The Partners in Health Scale is a validated questionnaire based on the principles of self-management. The client completes the questionnaire by scoring their response to each of the twelve questions on a nine-point scale (zero being the lowest response, reflecting low self-management capacity, and eight being the highest, reflecting good self-management capacity). The questions cover the following areas:

1. Knowledge of the condition
2. Knowledge of treatment
3. Ability to take medication
4. Ability to share in decisions
5. Ability to deal with health professionals
6. Ability to attend appointments
7. Ability to monitor and record
8. Ability to manage symptoms
9. Ability to manage the physical impact
10. Ability to manage the emotional impact
11. Ability to manage the social impact
12. Progress towards a healthy lifestyle

The questionnaire takes 5-10 minutes to complete and can be used to record change over time.

Cue and Response Interview

The Cue and Response interview is an adjunct to the Partners in Health scale. The Cue and Response process uses a series of open-ended questions (cues) to explore the client's responses to the Partners in Health Scale in more depth. It enables the barriers to self-management to be explored, and it checks the assumptions that either the health professional or the client may have.

The health professional can score the responses and compare their score with the client's scores. While originally developed to enable the client's perception of their self-management (as recorded on the Partners in Health scale) to be 'validated' by the health professional, it has proved to be a useful clinical tool in its own right to explore self-management.

Some examples of cue questions are listed in Table 1. The cue questions are not prescriptive and serve as examples of the types of questions that may be asked.

Table 1: Example of Cue Questions

Principle of self-management	Sample questions in the Cue and Response interview
Knowledge of treatment	<ul style="list-style-type: none"> • What can you tell me about your treatment? • What other treatment options including alternative therapies do you know about? • What does your family/carer understand about your treatment?
Sharing in decisions	<ul style="list-style-type: none"> • Does your doctor/health worker listen to you? • How involved do you feel in making decisions about your health with your doctor / health worker?
Healthy lifestyle	<ul style="list-style-type: none"> • What are you doing to stay healthy as possible? • What things do you do that could make your health worse? • What aspects of your lifestyle would you like to change?

The Partners in Health scale and Cue and Response interview tools can be used together or individually.

The Cue and Response interview is a motivational process for the client and a prompt for behaviour change. It allows the individual the opportunity to look at the effect of their condition on their life.

Scores rated on the lower end of the scale by the client, the health professional or both, flag issues for further discussion. Scores rated on the higher end of the scale allow the health professional to acknowledge areas where the client is managing well. Discussion of lower scores, or scores where there is a discrepancy in rating between client and health professional, allows for clarification of issues and identification of a common set of problems. Collaborative problem identification is a key indicator in successful self-management programs (Wagner et al., 1996). Identification of issues allows relevant strategies and interventions to be discussed and agreed on.

Problem and Goals Assessment

The Problems and Goals assessment is another tool that can be used as an adjunct to the Partners in Health and Cue and Response or as a stand-alone assessment. The Partners in Health and Cue and Response enable the health professional and the client to identify a range of issues or problems that are affecting the client. The health professional may well see

one of these issues as the main or biggest problem for the client. The client may see the same thing as their biggest problem, but they may see something else as having a far greater impact.

For example, the health professional might think that the way the client uses their medication is the biggest problem; however the client may think their biggest problem is the demands the family places on them - perhaps they are caring for grandchildren every day and have little time for themselves.

As well as defining the problem from the client's perspective, this assessment also clearly identifies a goal or goals that the client can work towards.

Problem Statement

The client's problem statement is based on three open-ended questions:

1. What do you see as your main problem?
2. What happens because of the problem?
3. How does this problem make you feel?

The problem statement should include the Problem, Impact and Feelings and can be clearly and simply evaluated using a scale from 0 (not at all) to 8 (a lot) measuring 'How much of a problem is this for me?'

Example: *'Lack of support from my family means I am overwhelmed by the household jobs and I don't go out and feel depressed'*.

Goal Statement

The Goal Statement is the client's goal and should be written positively and be a personal reward. Goals should be long/medium term and involve a degree of challenge (Locke & Latham 2006), and can be clearly and simply evaluated using a 0 (no success) to 8 (complete success) measuring 'My progress towards achieving this goal'.

The goal should be a **SMART** goal:

- S** – Specific (clearly defined)
- M** – Measurable (observable)
- A** – Action based (behavioural)
- R** – Realistic (not too reliant on others)
- T** – Timely (how long/how often?)

Example: 'I will go out to the community club one afternoon a week for 2 hours'.

Chronic Condition Management Care Plan

The information gained from the Partners in Health, Cue and Response (interview and discussion) and Problem and Goals assessments can be summarised on the care plan. The care plan documents the medical investigations, self-management tasks, self-management education and allied health and community services the person will access over the following twelve months.

The information on a Care Plan should include:

- The identified issues / including the main problem
- Agreed goals – What I want to achieve

- Agreed interventions – Steps to get there
- A sign off by both the patient and health professional
- Review dates.

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