



The Flinders Program™ for Chronic Condition Management Information Paper

What is the Flinders Program™?

The Flinders Program™ was formerly known as the Flinders Model. There are a number of reasons for the name change. The Flinders Program™ is no longer a model. Ten years of research and clinical use in a variety of settings and countries has led to more robust reinforcement of the components of the Program, the education and training options and adaptations for special populations.

A. Based on its inception in the SA HealthPlus coordinated care trial (1997-99), and subsequent research and development, the Flinders care planning process has five functions:

1. *Generic and holistic chronic condition management:* it provides a generic clinical process for assessment and planning for disease specific management. It uses a semi-structured framework which could be applied to any chronic disease or condition and co-morbid conditions in the same person, that is patient centred and holistic i.e., incorporates the bio (disease) psychosocial aspects of a person into a plan, and is motivational.
2. *Case management:* The Partners in Health scale can be used as a screening tool to determine who requires full care planning and case management. The care plan itself then becomes the case management model by defining the roles of the health professionals and the client, the need for case management or coordination could be determined. (Not all people with chronic conditions need support or education or case management).
3. *Self-management support:* The care planning process enables assessment of the person's self-management knowledge, behaviours and barriers so as to be able to target self-management education and support to the person.
4. *Systemic and organisational change:* the program provides a longitudinal structure, which if followed naturally leads to the development of an integrated care plan for each patient which addresses: self-management issues; evidence based medical care; motivation and maintenance of effort; a care plan for each medical condition which is measurable and monitored and meshes with public or private practice business processes.
5. *Clinician change:* Use of the Flinders Program™ can change a clinician's understanding of their practice in delivering patient centred care. The FP provides a semi-structured method of ensuring that patients are fully engaged in the delivery of their own care. The quality of the therapeutic alliance is optimised.

B. Components of the Flinders Program™

The Flinders Program™ chronic care philosophy and tools present an assessment, planning and motivational process which has been applied to chronic medical or mental conditions and co-morbidities.

1. Specialty areas include:

1.1 Mental health.

1.2 Children, adolescents and their families: chronic conditions such as cystic fibrosis, and asthma.

1.3 Indigenous health: chronic care planning in combination with Point of Care testing, has been trialled and incorporated into Aboriginal medical services.

1.4 Disabilities: autism, spina bifida.

2. Education and training:

2.1 Vocational or professional education

- 2.1.1 *Flinders Chronic Condition Care Planning Process*: includes a two day workshop followed by support to achieve a Certificate of Competence in the use of the Flinders Care Planning Tools.
- 2.1.2 The Flinders Program™ on-line: the two day program is being developed into an on-line program that will be available in the second half of 2010.
- 2.1.3 Flinders Chronic Condition Care Planning Process Trainer Accreditation (2 day workshop) leading to Accredited Trainer status: health professionals who have a Certificate of Competence can complete a trainers program and with support achieve Accredited Trainer status.
- 2.1.4 Flinders Chronic Condition Prevention Program: The Flinders Program™ has been adapted for risk factor modification under the South Australian Department of Health 'Do it For life' program, targeted at disadvantaged people. Fifty lifestyle advisors have been trained in the Flinders approach and are applying these processes to assist people with one or more of the 5 SNAPS (smoking, nutrition, alcohol, physical activity, stress) risk factors for chronic conditions. This program is undergoing evaluation which will inform the use of the adapted Flinders tools for general use.
- 2.1.5 Communication and motivation workshop (1 day): We have developed a one day communication and motivation workshop based on feedback from clinicians attending the two day care planning workshops, and our own observations. We believe these communication skills are essential for health professionals working with people with chronic conditions and will become a pre-requisite for people learning the Flinders care planning process. This workshop is now on the FHBHRU workshop timetable.
- 2.1.6 Implementation program: Based on feedback ('I have learnt the process but how do I implement this in my practice?'), we plan to develop a one day 'embedding' workshop and related activities. This will be targeted at managers as well as practitioners. It will include the preparation of a service before Flinders care planning training is provided to understand the incentives, barriers and solutions to embedding the Flinders care planning process into routine clinical practice.

2.2 Post Graduate education: Flinders University

Graduate Certificate in Health (Self-Management)
Graduate Diploma in Chronic Condition Management
Master of Public Health (Chronic Condition Management)

2.3 Undergraduate/graduate entry: Flinders University

Flinders School of Medicine chronic condition and self-management curriculum.
Bachelor of Health Sciences course, Flinders University

History and Development

FHBHRU, originally the Coordinated Care Training Unit (CCTU), was established within the School of Medicine at Flinders University, to provide support and training for service coordinators and general practitioners during the SA HealthPlus trial. The SA HealthPlus Trial was one of the larger of the first round Coordinated Care Trials, enrolling 3,100 clients into its intervention arm. The Problem and Goals assessment was used routinely with all SA HealthPlus intervention clients (Battersby *et al.*, 2002).

The Partners in Health (PIH) scale and the Cue and Response interview were developed in response to the learning from this trial (Battersby, 2005). It became evident that 'self-management' was a key factor in determining a client's need for a 'coordinator' to work with them and their general practitioner. The CCTU undertook an extensive literature review to look at 'self-management'. What do we mean by 'good' self-management? What research has been undertaken? Are there assessment tools available to look at client's self-management ability or status? What would be the use of such tools?

It was found that there was substantial evidence around characteristics of good self-management and the characteristics of programs that improve people's ability to self-manage, as well as evidence that structured self-management and behavioural change programs improve health outcomes for people with a range of chronic diseases. While there were some disease specific assessment tools described, there were no generic assessment tools, or processes, to measure self-management.

In 2009 the research and clinical team at FHBHRU changed the name of the Flinders approach to chronic condition prevention and management (the 'Flinders Model' of self-management) to the Flinders Program™. The reasons for this change were two fold i.e., that the Flinders care planning process was originally designed as a set of processes and tools that could be used for many aspects of chronic care management with self-management support being but one important element of this process, secondly, that since its development 10 years ago, the process and philosophy has been adapted for many clinical areas and evolved into a series of training and education modalities.

What is effective management of chronic disease?

The literature suggests that we need to consider these 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?

The definition of self-management as developed by the Centre for Advancement of Health (Centre for the Advancement of Health, 1996, p1):

Self-management:

“involves (the person with the chronic disease) engaging in activities that protect and promote health, monitoring and managing the symptoms and signs of illness, managing the impact of illness on functioning, emotions and interpersonal relationships and adhering to treatment regimes.”

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 practise 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. They are individuals who:

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.

Aim of the Flinders Program™

The program aims to provide a consistent, reproducible approach to assessing the key components of self-management that:

- improves the partnership between the client and health professional(s)
- collaboratively identifies problems and therefore better (i.e. more successfully) targets interventions
- is a motivational process for the client and leads to sustained behaviour change
- allows measurement over time and tracks change
- has a predictive ability, i.e. improvements in self-management behaviour as measured by the PIH scale, relate to improved health outcomes.

Assessment Tools

- Partners in Health Scale
- Cue and Response interview
- Problems and Goals Assessment

Leading to

- Identification of Issues
- Formation of an individualised Care Plan
- Monitoring and reviewing

Partners in Health Scale (PIH)

The PIH is a questionnaire that is based on the principles of self-management. The client completes the questionnaire by scoring their response to each question on a nine point scale, zero being the worst response and eight being the best.

The questions cover the following areas:

- Knowledge of condition
- Knowledge of treatment
- Ability to take medication
- Ability to share in decisions
- Ability to arrange appointments
- Ability to attend appointments
- Understanding of monitoring and recording
- Ability to monitor and record
- Understanding of symptom management
- Ability to manage symptoms

- Ability to manage the physical impact
- Ability to manage the social impact
- Ability to manage the emotional impact
- Progress towards a healthy lifestyle
- Ability to know and navigate the health system

Cue and Response Interview (C&R)

The 'Cue and Response' (C&R) interview is an adjunct to the PIH scale. The C&R process uses a series of open-ended questions or cues to explore the patient's responses to the PIH Scale in more depth. It enables the barriers to self-management to be explored, and it checks the assumptions that either the clinician or the client may have. The clinician can score the responses and compare their score with the client's scores. Whilst originally developed to enable the patient's perception of their self-management, as recorded on the PIH scale, to be 'validated' by the health professional, it has proved to be a useful clinical tool in its own right.

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

Table 1: Examples of Cue Questions

<p>Knowledge of Treatment</p> <p>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?</p> <p>Sharing in Decisions</p> <p>Does your doctor/health worker listen to you? How involved to you feel in making decisions about your health?</p> <p>Healthy Lifestyle</p> <p>What are you doing to stay healthy as possible? What things to you do that could make your health worse? What are the things you would like to change?</p>
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The PIH scale and C&R interview tools can be used together or individually.

The C&R interview is a motivational process for the client and a prompt for behaviour change. It allows the individual the opportunity to look at the impact of their condition on their life, some time to reflect on cause and effect.

Scores rated on the lower end of the scale, by either client or health professional or both, flag issues for further discussion. This allows for clarification of issues and a common set of problems to be identified by client and health professionals. It also allows the clinician to acknowledge areas where the client is managing well. Collaborative problem identification has been found to be 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.

This information is easily incorporated into a care plan, whether it is a care plan supported by the Enhanced Primary Care (EPC) MBS or simply one that involves the health professional and the client.

The process is generic not 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 eg managing the impact of the disease on their life, monitoring and managing the symptoms, adopting healthy lifestyles etc (Lorig *et al.*, 1999).

Preliminary Data

There have been two psychometric investigations of the Partners in Health Scale. The first study of forty-six (46) subjects used the original eleven (11) item version which showed high internal reliability, inter-rater reliability and construct validity using factor analysis. A second study of the twelve (12) item version with one hundred and seventy-five (175) subjects again showed high internal reliability and construct validity was confirmed with four factors emerging: Knowledge, symptom management, coping and adherence. Further studies of the new version are underway.

Problem and Goals (P&G) Assessment

The Problems and Goals assessment is another tool that can be used as an adjunct to the PIH and C&R process or as a stand-alone assessment. The PIH and C&R enable the clinician and the client to identify a range of issues or problems that are affecting the client. The health worker 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 clinician 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 everyday 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.

Self-management Care Plan

The information is gained from the PIH, C&R, and P&G assessments and can be summarised on the self-management care plan which documents the medical investigations, self-management tasks by the patient, self-management education and allied health and community services the person will access over the following twelve months.

The information on a self-management 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.

Clinical Applications

The Flinders ProgramTM is being trialled in a variety of clinical settings and across a range of conditions. The Commonwealth Government, through the "Sharing Health Care" initiative funded the development of an education module in chronic disease self-management that includes the use of the Flinders tools. There were eight "Sharing Health Care" projects, one in each State and Territory, and, in addition, three indigenous projects had the opportunity of using the education module and the tools as one of the strategies within their project (Francis, *et al.*, 2007). A randomised control trial completed with Vietnam Veterans with alcohol problems showed positive outcomes. Two randomised control trials have commenced to assess the value of this program in people aged sixty (60) years and over and to test patient competencies in self-management.

Other studies have targeted population groups which include the culturally and linguistically diverse, Aboriginal and low socio-economic. These are not randomised controlled trials but demonstration projects, however they will allow for further studies into the validation and use of the tools and the clinical impact of the Flinders ProgramTM when combined with other interventions such as the Stanford course.

In addition four projects funded by Department of Health in South Australia have been completed. These projects have shown encouraging outcomes both statistically and clinically. These projects have been in the areas of mental health, diabetes in rural aboriginal populations, chronic lung disease and heart

disease. Details of these projects can be obtained from our website at <http://som.flinders.edu.au/FUSA/CCTU/projects.htm> and the publication lists (below).

Do clinicians find this a useful process? Worth the time?

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 disease and that it encourages the client to have ownership of the management process and their care plan.

These are comments from a range of health workers using the Flinders Program™ clinically:

- “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” (general practitioner)
- “allows patients to bring up [other] issues” (health worker)
- “relatively quick and simple system for care planning” (general practitioner)
- “the process has changed my focus to what I don’t know about the patient rather than what I think I know” (general practitioner)
- “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)

References

- Battersby, M., Higgins, P., Collins, J., Reece, M., Holmwood, C. and Daniel, B. (2002) Partners in Health: the development of self-management for SA HealthPlus participants in *The Australian Coordinated Care Trials: Recollections of an Evaluation*, Publications Production Unit (Public Affairs, Parliamentary and Access Branch) Commonwealth Department of Health and Ageing, Canberra, Canberra, Australia, pp. 201-211.
- Battersby, M. W. (2005) Health reform through coordinated care: SA HealthPlus, *British Medical Journal*, **330**, 662-665.
- Center for the Advancement of Health and Center for Health Studies Group Health Cooperative of Puget Sound (1996) An indexed bibliography on self-management for people with chronic disease, Center for the Advancement of Health.
- Lorig, K. (1993) Self-management of Chronic Illness: a model for the future (self care and older adults), *Generations*, **17**, 11-14.
- Lorig, K., Sobel, D., Stewart, A., Brown, B., Bandura, A., Ritter, P., Gonzalez, V., Laurent, D. and Holman, H. (1999) Evidence Suggesting that a Chronic Disease Self-Management Program Can Improve Health Status While Reducing Hospitalization: A Randomized Trial, *Medical Care*, **37**, 5-14.
- Francis, F., Feyer A., Smith, B.J. (2007). "Implementing chronic disease self-management in community settings: lessons from Australian demonstration projects." *Australian Health Review* **31**(4): 499-509.
- Wagner, E., Austin, B. and Von Korff, M. (1996) Organizing Care for Patients with Chronic Illness, *The Milbank Quarterly*, **74**, 511 - 542.

FHBHRU publications relating to the use of the Flinders Program™

Crotty, M., Prendergast, J., Battersby, M., Rowett, D., Graves, S., Leach, G. & Giles, G. (2009) Self-management and peer support among people with arthritis on a hospital joint replacement waiting list: A randomized controlled list. *Osteoarthritis & Cartilage* **17**, 1428-1433.

150 on joint replacement waiting list. Randomised: 75 intervention patients – most had Flinders care planning and half of these had Stanford course with about 2/3 having telephone coaching follow up. At 6 months the intervention group had significant changes in 2 domains of HEI-Q and stiffness, not quality of life (AQUOL).

Lawn, S., Pols, R. G., Battersby, M. (2009). "Working effectively with patients with comorbid mental illness and substance abuse: a case study using a structured motivational behavioural approach." *BMJ Case Reports* doi: 10.1136/bcr.08.2008.0674.

Battersby, M., S. Lawn and R. G. Pols (2009). "Conceptualisation of self-management". *Translating chronic illness research into practice*. D. Kralik and B. Paterson, Wiley-Blackwell.

Fotu, M. and T. Tafu (2009). "The Popao model: A Pacific Recovery and Strength Concept in Mental Health." *Pacific Health Dialog* 15(1)

Pols R.G., Battersby M.W (2008) "Coordinated care in the management of patients with unexplained physical symptoms: depression is a key issue." *Medical Journal of Australia Supplement*. 188(12):133-7.

Battersby, M. W., J. Ah Kit, C. Prideaux, P. W. Harvey, J. P. Collins and P. D. Mills (2008). "Implementing the Flinders Model of self-management support with Aboriginal people who have diabetes: findings from a pilot study." *Australian Journal of Primary Health* 14(1): 66-74.

60 Aboriginal people with diabetes provided care planning with Aboriginal Health Workers. Training split over two sections. There were significant improvements in HbA1c over 12 months. PLAHS embeds Flinders care planning for its diabetes and other chronic condition patients.

Harvey, P. W., J. Petkov, G. Misan, K. Warren, J. Fuller, M. Battersby, N. Cayetano and P. Holmes (2008). "Self-management support and training for patients with chronic and complex conditions improves health related behaviour and health outcomes." *Australian Health Review* 32(2): 330- 338.

Describes Sharing Health Care project in Whyalla – 175 people with a range of chronic conditions had flinders care planning, Stanford and disease specific education. Benefits in PIH, C&R Stanford scores, reduced GP, specialist and hospital visits maintained over 18 months.

Battersby, M., P. Harvey, P. D. Mills, E. Kalucy, R. G. Pols, P. A. Frith, P. McDonald, A. Esterman, G. Tsourtos, R. Donato, R. Pearce and C. McGowan (2007). "SA HealthPlus: a controlled trial of a statewide application of a generic model of chronic illness care." *Milbank Quarterly* 85(1): 37-67.

It provides the detail of the coordinated care trial and the role of the service coordinator and the rationale for the development of the Flinders self-management assessment ie targeting those who actually needed coordinated care. Showed who should be targeted to reduce hospitalisations within a 2 year time frame.

Lawn, S., M. Battersby, R. G. Pols, J. Lawrence, T. Parry and M. Urukalo (2007). "The mental health expert patient: Findings from a pilot study of a generic chronic condition self-management programme for people with mental illness." *International Journal of Social Psychiatry* 53(1): 63-74.

Pilot program of 38 people with long term mental illness – all on disability benefits who had flinders care planning and half had the Stanford program. Showed that both approaches are feasible and acceptable for people with co-morbid mental and physical illness and significant improvements in SF-12 mental summary score from baseline to 12 months.

Regan-Smith, M., K. Hirschmann, W. Iobst (2006). "Teaching residents chronic disease management using the Flinders model." *Journal of Cancer Education* 21(2): 60-62.

Battersby M. W., SA Health Plus team (2005). "Health reform through coordinated care: SA HealthPlus". *British Medical Journal*. 330 (7492): 662-665.

Demonstrated improvements in SF-36 (the principle national outcome measure) and benefits of problem and goal approach.

Battersby M, Ask A, Reece M, Markwick M, and Collins J (2003). "The partners in health scale: The development and psychometric properties of a generic assessment scale for chronic condition self-management". *Australian Journal of Primary Health* 9(2&3): 41-52.

Describes the development of the PIH and C&R interview and the factor structure of the PIH. Shows that the PIH and the assessment is based on a definition of self-management.

Battersby M., Ask A., Reece M., Markwick M., Collins J (2001). A Case Study Using the "Problems and Goals Approach" in a Coordinated Care Trial: SA HealthPlus. *Australian Journal of Primary Health* **7**(3): 45-8.

Shows a detailed example of a man who had the P&G approach and how this led to changes in his health and life.