The ‘Flinders Model’

of

Chronic Condition Self-Management

Information Paper

What is the Flinders Model?

Flinders Human Behaviour & Health Research Unit (FHBHRU) has developed a generic set of tools and processes that enables clinicians and clients to undertake a structured process that allows for assessment of self-management behaviours, collaborative identification of problems and goal setting leading to the development of individualised care plans. These care plans are important cornerstones in enhancing self-management in people with chronic conditions. The tools include the Partners in Health Scale © (Battersby et al., 2003), Cue and Response Interview © and Problem and Goals assessment.

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 learnings 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.
What is effective management of chronic disease?

The literature suggests that we need to consider these components in effective management of chronic disease:

- 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 (Center for the Advancement of Health, 1996) was adopted by SA HealthPlus.

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.” (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 practise new health behaviours, and to maintain or regain emotional stability.” (p11)

The Six 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.

These six characteristics could be considered to be the Six Principles of Self-management.

Aim of the Flinders Model

The aim of the model is 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 (ie 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 twelve part questionnaire that is based on the six principles of self management. The client completes the questionnaire by scoring their response to each question on a nine point scale, zero being the best response and eight being the worst.

The questions cover the following 12 areas:

- Knowledge of condition
- Knowledge of treatment
- Ability to take medication
- Ability to share in decisions
- Ability to arrange and 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 and emotional impact
- Progress towards a healthy lifestyle.

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

<table>
<thead>
<tr>
<th>Knowledge of Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tell me about the treatment are you having</td>
</tr>
<tr>
<td>What can you tell me about your medication?</td>
</tr>
<tr>
<td>What do you know about alternative treatment?</td>
</tr>
<tr>
<td>Tell me about any other treatment that has helped you</td>
</tr>
<tr>
<td>What are the things that stop you having, (or following) your treatment?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Sharing in Decisions</th>
</tr>
</thead>
<tbody>
<tr>
<td>How comfortable are you talking to your doctor or other health professionals?</td>
</tr>
<tr>
<td>What are the problems?</td>
</tr>
<tr>
<td>How are you included in decisions about your health?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Healthy Lifestyle</th>
</tr>
</thead>
<tbody>
<tr>
<td>What are you doing to keep yourself healthy?</td>
</tr>
<tr>
<td>What are the things that you are doing that don’t help?</td>
</tr>
<tr>
<td>What are the things you would like to change?</td>
</tr>
</tbody>
</table>

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 higher 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 has been preliminary statistical investigation of the Partners in Health Self-management Scale that showed the following. The Partners in Health Scale has face validity amongst patients, gps and other health professionals, and it is based on a sound definition of self-management giving it concept validity. Moreover, the reliability of the Partners in Health Scale was well demonstrated in two areas, viz, internal consistency and inter-rater reliability.

An exploratory factor analysis, whilst based on small numbers, showed that the Partners in Health Scale has a stable and meaningful underlying factor structure. There were three demonstrated factors underlying the scale, including core self-management, condition knowledge and symptom monitoring (Battersby et al., 2003).
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&Gs assessments and can be summarised on the self-management care plan.

The information on a self-management care plan should include:

- The identified issues / including the main problem
- Agreed goals
- Agreed interventions
- A sign off
- And review dates.

It may also include the “medical care plan” for example planned visits and tests.

Clinical Applications

The Flinders Model is being trialed in a variety of clinical settings and across a range of conditions. The Commonwealth Government, through the “Sharing Health Care” initiative has 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, 3 indigenous projects that have the opportunity of using the education module and the tools as one of the strategies within their project.

Targeted population groups 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.

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

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

The most common responses by health professionals are that the Flinders Model 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 Model 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


