

# **Developing clinician competencies in self-management support for people with chronic conditions: The Flinders model**

## **Introduction**

Self-management support is one of the 6 elements of the Chronic Care Model (Wagner E, Austin B and Von Korff M, 1996) adopted by the World Health Organisation (2002) as the basis of a framework for chronic care which is planned and preventative rather than reactive. This paper describes the development of the 'Flinders model' for self-management support developed by the Flinders Human Behaviour and Health Research Unit at Flinders University, South Australia. This clinician provided program compliments the Stanford chronic disease self-management course in which peers with chronic conditions are trained to lead groups of 8-16 people with any chronic condition to teach self-management skills (Lorig et al 1999). The Flinders model is an individual clinician led assessment and planning process which aims to provide clinicians with a systematic method to assist their patients' self-management of chronic conditions. It provides a patient centred process which elicits patients' knowledge, attitudes, behaviours, strengths and barriers to self-management. This enables a plan to be negotiated between the patient and clinician which describes patient determined problems and goals, medical management and self-management education interventions over a 12 month period. One possible outcome of the planning process is that the patient attends a Stanford course to learn a range of self-management skills.

## **Background**

A mid trial review of a 2 year controlled trial of a model of coordinated care (SA Health Plus) for 3,115 intervention and 1,488 control patients with chronic conditions (Battersby, 2005) identified the need for clinicians to have an objective method to assess patients' ability to self-manage their chronic conditions. This need was based on service coordinators' observation that they provided coordinated care based on how well patients self-managed their condition(s) rather than their conditions' severity (Battersby et al, 2003).

The assessment and planning approach was designed to be generic, not disease specific so that multiple conditions in the one patient could be addressed. This pilot program was encouraged by the evidence of improved outcomes of the Stanford chronic disease self-management course which over 25 years had developed from a disease specific (arthritis) to a generic (multiple chronic conditions) program.

Additionally, few people had access to or preferred group education and clinicians were not linked to these self-management courses. From a literature review and focus group analysis, a definition of self-management was agreed (Battersby et al 2003) and from this, 6 principles of self-management were defined: 1) Have knowledge of your condition, 2) Follow a treatment plan, (care plan) agreed with your health professionals, 3) Actively share in decision making with your health professionals, 4) Monitor and manage signs and symptoms of your condition, 5) Manage the impact of the condition on your physical, emotional and social life and 6) Adopt lifestyles that promote health.

### **The Flinders self-management model**

From these 6 principles, the Partners in Health scale<sup>9</sup> (Battersby et al 2003) was developed as a patient self-rated assessment of self-management. The original 11 item scale has been revised to a 13 item scale. The patient scores him/herself on a 0-8 likert scale on each of 13 items derived from the 6 principles of self-management. This is followed by a clinician -patient Cue and Response (C&R) interview using open-ended questions that focus on the same 13 items. The clinician scores the patient using the same 0-8 scale for each of the 13 items. Self-management items receiving a score of more than 4 by the patient are kept for inclusion as issues to be addressed on the care plan (8 indicates highest self-management difficulties). Next the clinician asks questions that assess the patient's identified main (life) problem. The patient determined main problem is often non medical and enables psycho social issues to be identified which may be more important to the patient than their medical problems. Adapted from therapeutic assessment and intervention techniques used in the behavioural psychotherapy field, the patient is then assisted to set their own medium term goal (6-12 months) and assisted toward goal attainment (Battersby et al, 2001). Then the patient rates the problem severity on a 0-8 scale and also rates his/her "progress achieved towards the goal – complete success (0) to no success (8)."

Finally the clinician and patient negotiate a care plan starting from the identified self-management issues, followed by management aims, interventions, who is responsible and the date to be reviewed to record progress. Both the patient and the clinician sign the plan and the patient receives a copy to take to others involved in his/her care. This enables a number of short term goals to be agreed which ultimately will achieve the main medium term goal identified by the patient. The Flinders Model provides the clinician with a new role in the management of chronic disease. It creates a

partnership between health professional and patient in which the patient is the decision maker and the clinician is facilitator, coach and advisor.

Multi disciplinary training for doctors, nurses and allied health professionals in the Flinders model is provided in a 2 day program which was developed as part of clinician education for the National Sharing Health Care demonstration projects. The 2 day training includes patients with chronic conditions who assist skill acquisition and attitude change in the clinicians. A certificate of competency is obtained when 3 care plans have been completed. Those health professionals who have achieved competency are then able to attend a trainer accreditation course and provide training to their own organisations. Since 2001 training in the Flinders model has been provided to over 2000 clinicians across Australia, New Zealand, the United States and the United Kingdom.

### **Does the Flinders model make a difference?**

The National Sharing Health Care initiative aimed to test a range of models of self-management support. A variety of interventions including telephone coaching were used in the projects. Most involved some level of clinician training in the Flinders model and use of the Stanford model of self-management patient education. The national evaluation of the 8 Sharing Health Care projects in a non-controlled pre-post design showed improved health outcomes, improved quality of life and reduced use of health services for people with a wide range of chronic conditions. The evaluation recommended that:

‘Program characteristics with the greatest potential for increasing effectiveness of self-management include:

- ∞ flexible approaches with tailoring of interventions to meet client need in terms of content and mode of delivery;
- ∞ ability to identify and respond to client need through the use of appropriate planning tools at the start of the program, reinforced by ongoing coaching and follow-up; and
- ∞ ability to provide appropriate and structured support to clients, finding the balance between over-dependence on the support on offer and being isolated from the program.’ (Australian Government Department of Health and Ageing, 2004).

In a pilot program with patients with long term severe mental health conditions, the Flinders approach when combined with the Stanford course demonstrated improved mental summary scores on the SF-12 and reduced hospitalization (Lawn et al, 2007). Aboriginal patients with diabetes in Eyre Peninsula, South Australia, received Flinders care planning and targeted self-management applied by Aboriginal Health Workers and achieved a mean reduction of HbA1c from 8.74 – 8.09 (Collins, 2003). In a randomized controlled design in patients with chronic obstructive pulmonary disease, patients receiving the Flinders approach with pulmonary rehabilitation had increased 6 minute walk at 12 months than those receiving rehabilitation alone (Rowett et al, 2005). A larger randomized trial trialing the use of the Flinders model in Vietnam Veterans with alcohol problems is currently underway.

## **Conclusion**

In summary, the Flinders model provides a comprehensive, patient centered method for clinicians to engage with their patients to develop a shared plan to assist patients

to self-manage their chronic conditions. The Flinders model provides a semi-structured systematic way to prioritize patients' needs in a planned preventative way. This model challenges current medical practice which is based on an acute and reactive fee-for-service model in many countries. In addition to highlighting the need to address the design of systems of care, the Flinders approach makes it explicit that patients with chronic and complex conditions require a multi-disciplinary approach i.e., a physician needs the support of nurses and allied health professionals to maximize the outcomes of their patients with chronic and complex conditions. The Flinders model shows promise as a generic process which enables clinicians and patients to work together to improve outcomes in chronic illness care.

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