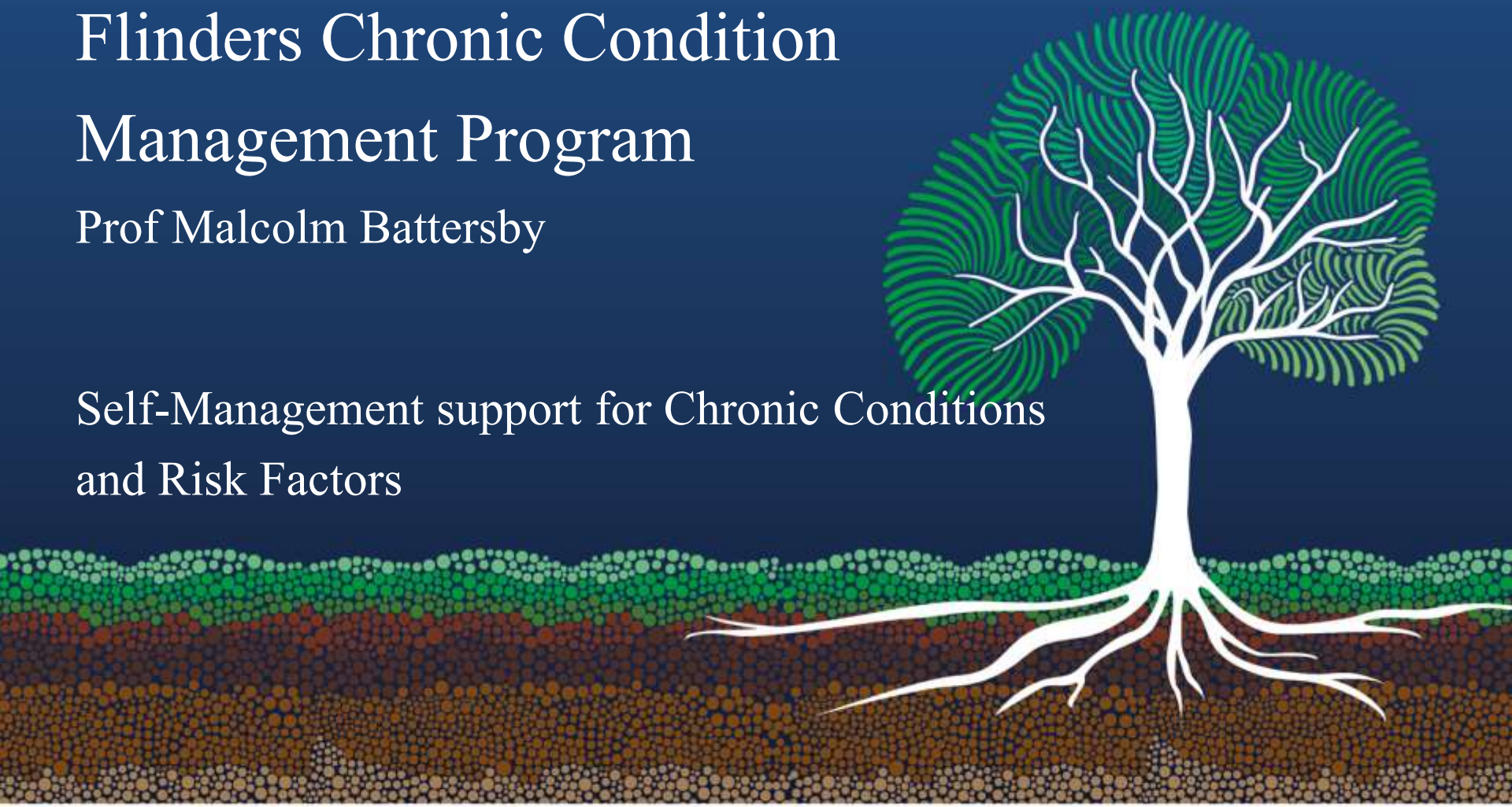
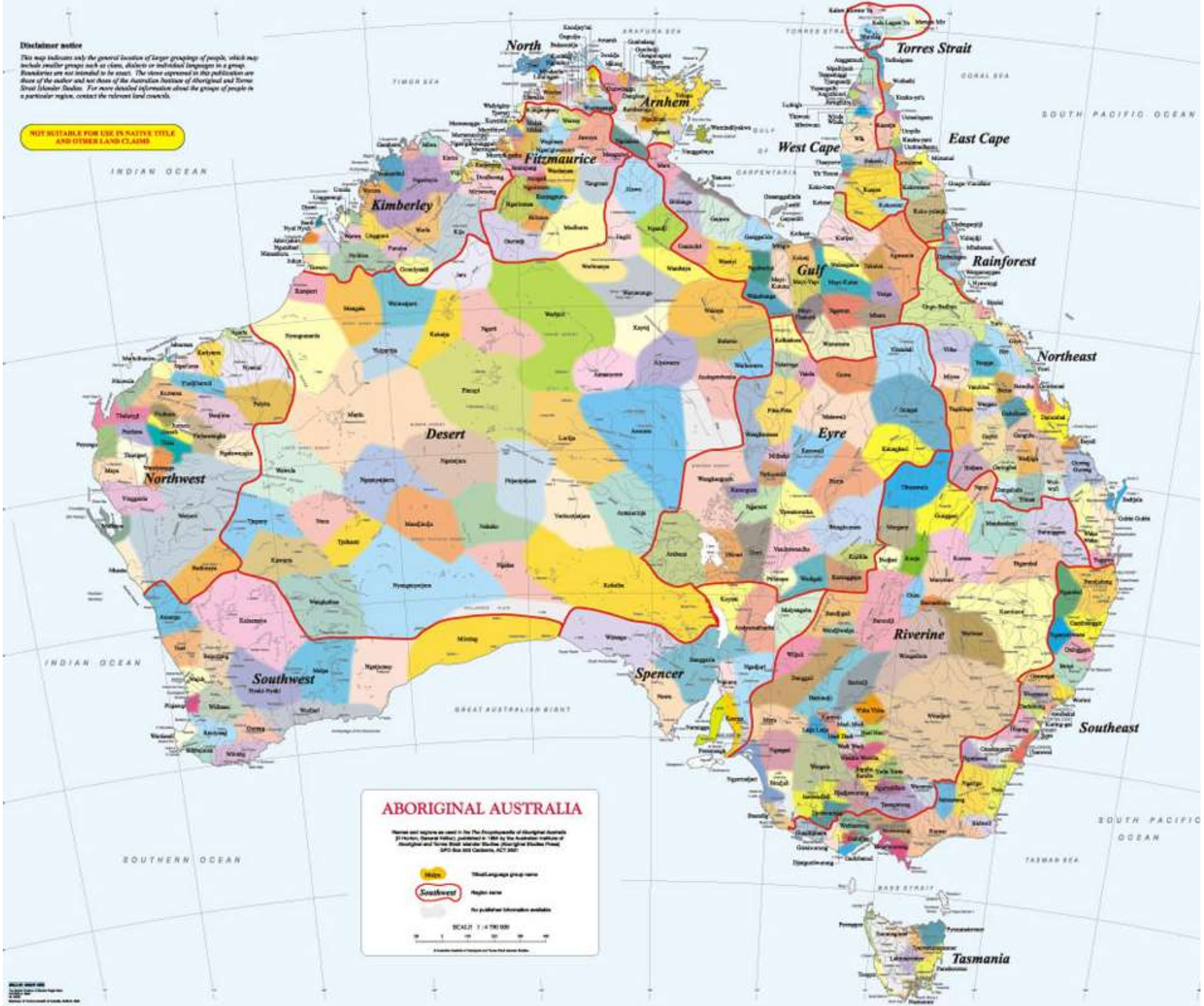
Flinders Chronic Condition Management Program

Prof Malcolm Battersby

Self-Management support for Chronic Conditions and Risk Factors



Flinders UNIVERSITY


Disclaimer notice
This map indicates only the general location of larger groupings of people, which may include smaller groups such as clans, dialects or individual languages in a group. Boundaries are not intended to be exact. The views expressed in this publication are those of the author and not those of the Australian Institute of Aboriginal and Torres Strait Islander Studies. For more detailed information about the groups of people in a particular region, contact the relevant land councils.
NOT SUITABLE FOR USE IN NATIVE TITLE AND OTHER LAND CLAIMS
North
Arnhem
Torres Strait
East Cape
West Cape
Fitzmaurice
Kimberley
Gulf
Rainforest
Northeast
Desert
Eyre
Northwest
Riverine
Spencer
Southwest
Southeast
Tasmania
INDIAN OCEAN
TIMOR SEA
ARAFURA SEA
TORRES STRAIT
CORAL SEA
SOUTH PACIFIC OCEAN
GULF OF CARPENTARIA
GREAT AUSTRALIAN BIGHT
SOUTHERN OCEAN
BASS STRAIT
TASMAN SEA
ABORIGINAL AUSTRALIA
Major tribal/language group name
Region name
No published information available
SCALE 1 : 4 750 000

Team members and partners

- FHBHRU team –
  - Assoc Professor Sharon Lawn
  - Professor Peter Harvey
  - Dr Rene Pols
  - Dr Marie Heartfield
  - Research officers: Melanie Harris, Andrea Morello, Inge Kowanko,
  - Trainers: Coral Trowbridge, Barbara Oerman, Vee Pols, Arlene Ackland, Sue Bertossa
  - Implementation managers: Raylene Liddicoat, Elizabeth Ellis and team
- Partners
- Aboriginal Health Council of SA, Australian Medicare Local Alliance,
- Baker IDI, Australian Practice Nurse Association, United Care Wesley, Pt Adelaide
- Funding: Commonwealth Dept of Health and Ageing, Department of Veterans Affairs

Presentation outline

- Research questions
- Research programs
- Implementation
- Hong Kong/Chinese collaborations

Background - SA HealthPlus

- SA HealthPlus Coordinated Care Trial 1997 – 1999

- Patients with chronic and complex illnesses
  - Cardiac
  - Respiratory
  - Mental health
  - Aged care
  - Diabetes
- 8 projects in 4 regions of South Australia

- 4,600 patients randomised into Intervention (3100) and Control (1500) groups in the 8 projects

Battersby et al, BMJ, March 2005
Battersby et al, Millbank Quarterly, 2007

Year 1 review

- Some people with severe complex conditions, who were good self-managers, did not need coordinated care
- **Coordination was based on whether a person was a good self-manager or not**
- Self-management needed to be assessed
- Self-management support and coordination should be tailored according to needs and motivation

Care Plan: should

- Facilitate the persons engagement in their own healthcare
- Enhance the person / provider relationship
- Enhance the person's self-efficacy for self-management and achieving health outcomes
- Enhance the person's ability to maintain changes
- Lead to skill acquisition by the client

Research questions

- What is self-management?
- Can it be assessed and measured?
- Can self-management assessment be used to tailor interventions and services to the individual?
- Can self-management support motivate people to improve health outcomes?
- Can self-management care planning be used generically for multiple chronic conditions?
- Can self-management support be implemented into routine clinical practice?

Self-management support

- Is what health professionals, the health system, carers and family do to assist the person to self-manage their chronic conditions.

Health worker roles in self-management support

- Assess self-management
- Assist patient to overcome barriers to self-management
- Disease specific education (skills)
- Generic self-management education (skills)
- Coaching
- Coordination

National consensus operational definition of self-management

- Having **knowledge** of the condition and/or its management
- Adopting a **self-management care plan** agreed and negotiated in partnership with health professionals, significant others and/or carers and other supporters
- Actively **sharing in decision-making** with health professionals, significant others and/or carers and other supporters
- **Monitoring and managing** signs and symptoms of the condition

Def’n of self-management

- Managing the **impact** of the condition on physical, emotional, occupational and social functioning
- Adopting **lifestyles** that address risk factors and promote health by focusing on prevention and early intervention
- Having **access** to, and confidence in the ability to use support services

Patient-centred care

- ‘explores the patients' main reason for the visit, concerns, and need for information;
- seeks an integrated understanding of the patients' world—that is, their whole person, emotional needs, and life issues;
- finds common ground on what the problem is and mutually agrees on management;
- enhances prevention and health promotion; and
- enhances the continuing relationship

  between the patient and the doctor.’ (Little et al)

Flinders Program:
7 Principles of Self-Management

K **Knowledge**

I **Involvement**

C **Care plan**

MR **Monitor and Respond**

I **Impact**

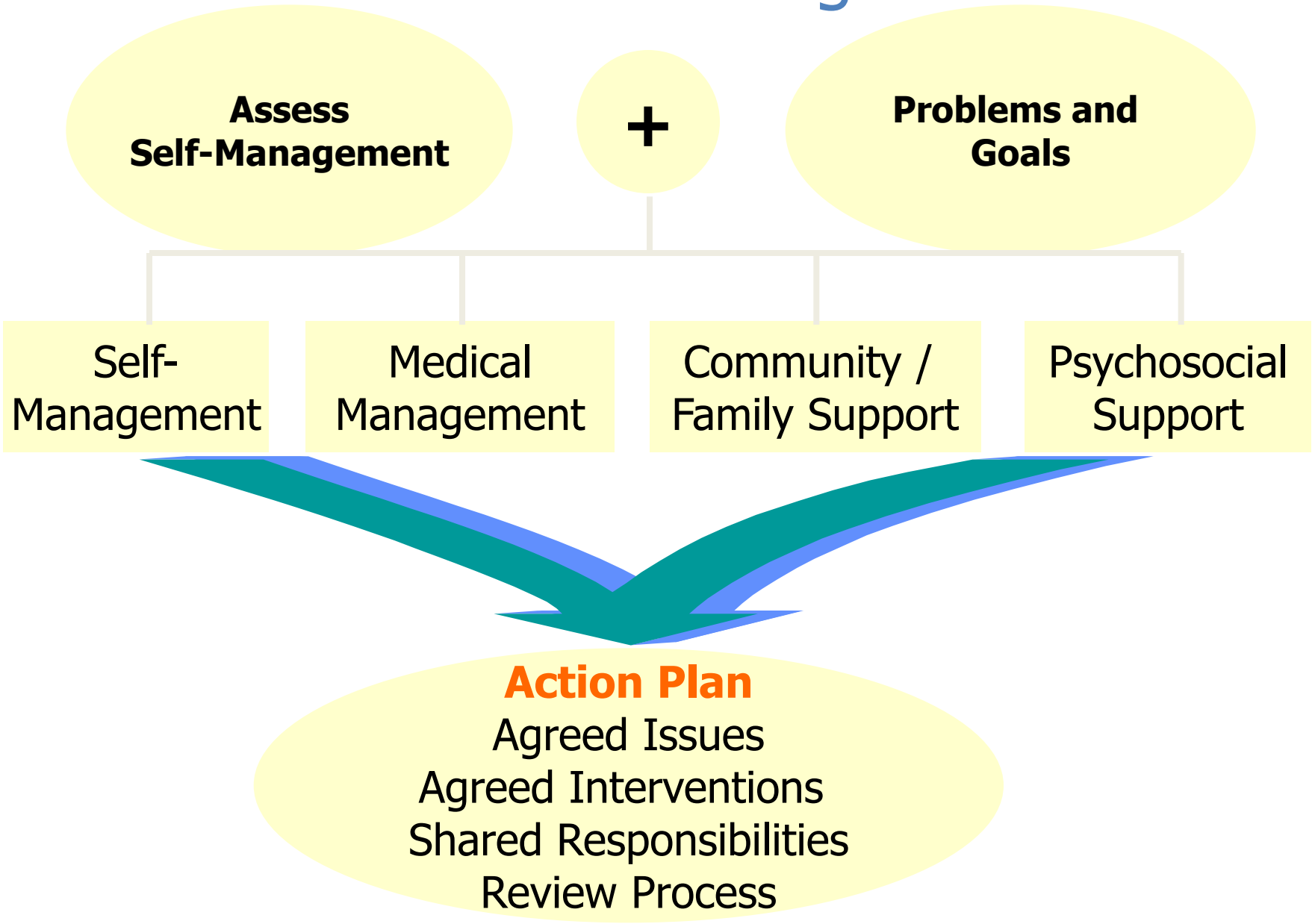
L **Lifestyle**

S **Services**

Improved outcomes for patients with chronic conditions

- Medical management
- Self-management
- Coordination
- Coaching

The Flinders Program



Assessment of self-management

Partners in Health Scale (PIH)

- 12 questions
- self assessed and scored on 9 point scale

Cue and Response Interview (C&R)

- 12 questions with cues
- explores the strengths and barriers
- HP assessed and scored on 9 point scale

Leads to collaboratively identified issues

PARTNERS IN HEALTH SCALE V10 JUNE 2010

Name: _____ **ID:** L JL JL JL JL JL J

Assessment Date: / / **Review Date: / /**

Person with Chronic Health Condition to Complete

Please circle the number that most closely fits for you

1 Overall, what I know about my health condition(s) is:

0 1 2 3 4 5 6 7 8

Very little **Something** **A lot**

2 Overall, what I know about the treatment, including medications of my health condition(s) is:

0 1 2 3 4 5 6 7 8

Very little **Something** **A lot**

3 I take medications or carry out the treatments asked by my doctor/health worker:

0 1 2 3 4 5 6 7 8

Never **Sometimes** **Always**

Problems & Goals assessment

- Identifies what the person sees as the biggest problem

and

- Identifies the goal(s) the person wants to achieve

Client Problem Statement: **Lack of support from my family means I am overwhelmed by the household jobs and I don't go out and I feel depressed.**	How much of a problem is this for me 0 1 2 3 4 5 6 7 **8** Not at all — very little — somewhat — a fair bit — a lot
Client Goal Statement: **I will go to the community club one afternoon a week for 2 hours.**	My progress towards achieving this goal **0** 1 2 3 4 5 6 7 8 No success — 25% — 50% — 75% — complete success

Managing impact on emotions and social aspects of life (10,11)	I want to feel more energetic and positive about my life.	• Learn some relaxation techniques from Diabetes Educator	Roger / Diabetes Educator	2 weeks later	
		• Make contact with VVCS to consider contact for counselling	Roger	2 weeks	
		• Ask GP to assess for depression	Roger / GP	2 weeks later	
		• Attend anxiety management course at community centre	Roger	4 weeks	
		• Ring community club and ask for a program of activities	Roger / local council/DVA	2 weeks	
Managing impact on physical activity (9)	To have a clean and tidy house.	• Contact local council about help with the housework	Roger	8 weeks	
	I want less pain in my feet.	• Ask GP for a referral to a Podiatrist	Roger / GP	2 weeks later	
		• Attend Podiatry every month	Roger /Podiatrist	2 weeks	
Knowledge of diabetes treatment and medication (1,2,3)	To know about my treatments and tablets and what they do for me.	• Attend Diabetes update sessions at community centre with husband	Roger / Wife / Diabetes Educator	2 weeks	
		• Read information handouts	Roger		
		• Ask GP for referral for home medications review	Roger / GP	4 weeks	
Symptom management (7,8)	To feel better and have more energy	• Measure my blood sugar levels with the Glucometer every day and away from family and record in a diary	Roger / Diabetes Educator	2 weeks	
		• Discuss diary record with Diabetes Educator	Roger / Diabetes Educator	2 weeks	
		• Set up a Symptom Action Plan with Diabetes Educator	Roger / Diabetes Educator	2 weeks	

Coaching and coordination

- Monitoring
  - provider-initiated follow up
  - self-monitoring
- Motivational enhancement
- Review progress on care plan goals
- Problem solving
- Coordination: assist with access, communication and advocacy

Flinders Program Research

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

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.

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.

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): 45-48.

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.

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.

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.

Crotty M, Prendergast J, Battersby M, Rowett D, Graves S, Leach G, et al. "Self-management and peer support among people with arthritis on a hospital joint replacement waiting list: A randomized controlled trial" *Osteoarthritis & Cartilage*.

Petkov, J, Harvey M, Battersby M,(2010)'Tthe internal consistency and construct validity of the Partners in Health scale:valikdation of a patient rated chronic condition self-management measure" Quality of life research 19(7) 1079-1085

Battersby M, Beattie, J et al (2013). "A randomised controlled trial of the Flinders Program of chronic condition management in Vietnam Veterans with co-morbid alcohol misuse, and psychiatric and medical condtions' ANZJP, 47(5) 451-462

Vietnam Veterans – Real Partners in Health: Does self-management support improve your health?

A Trial of Evidence-Based Care and Self-Management for Vietnam Veterans with Alcohol-Related Disorders

Funded by the Department of Veteran's Affairs

Investigators:
Prof Malcolm Battersby, Director, FHBHRU
Prof John Condon, Professor of Psychiatry, Flinders University; Senior Staff Specialist, RGH
Dr Rene Pols, Deputy Director FHBHRU
Dr Jill Beattie, Senior Research Fellow, FHBHRU

Project team:
Dr Sarah Blunden, Project Manager to May 07
Barbara Oerman, Research Associate
Jill Western, Research Associate
Amanda Carne, Project Officer
Prof Simon Eckermann, Health Economist
David Smith, Project Office, Stats.
Dr Richard Woodman, Senior Lecturer, Biostatistics.

Study design

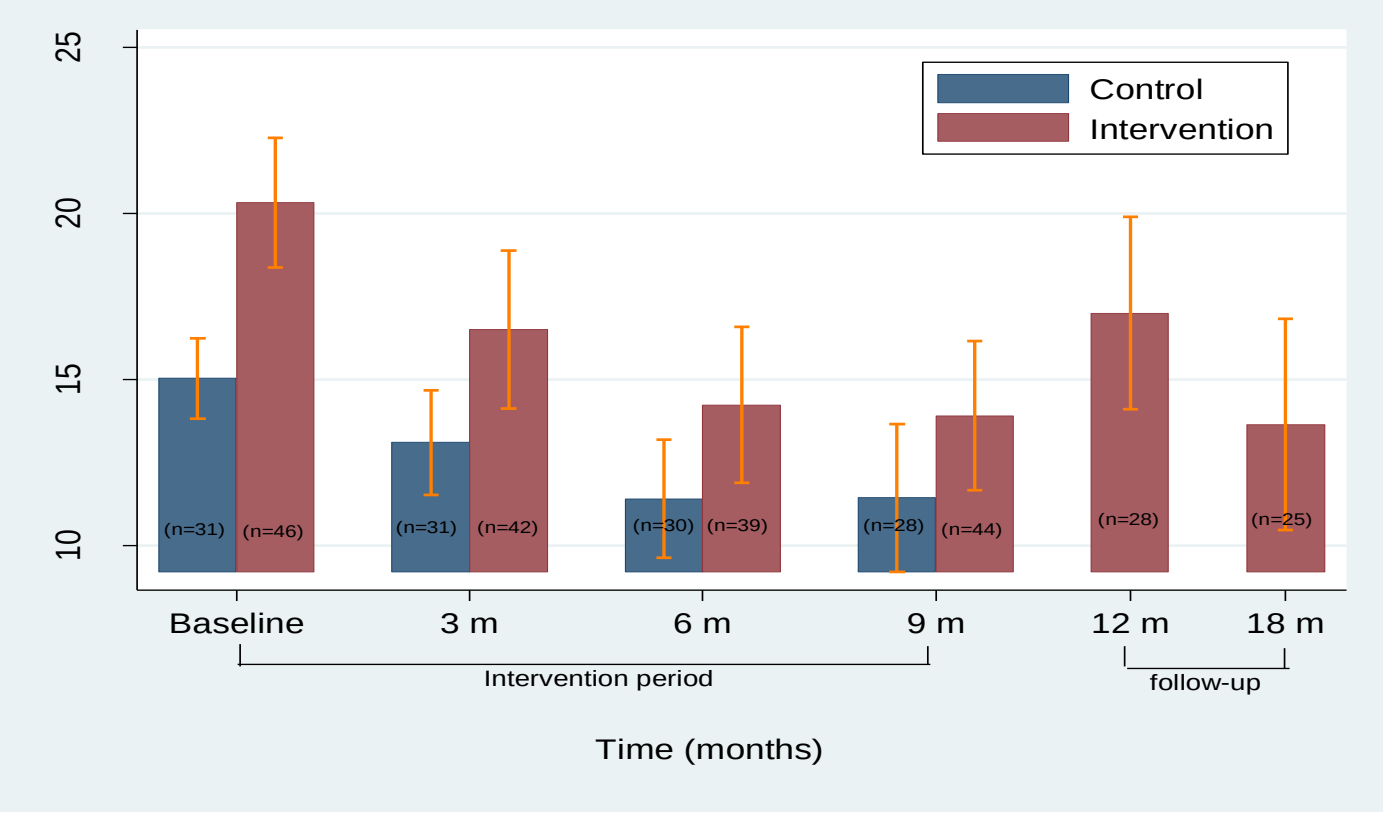
Flinders Program, alcohol self-management, Stanford course vs Usual care

- 9 month wait list randomised controlled trial
- 9 month follow up for the intervention group
- Eligibility: Vietnam Veteran, alcohol AUDIT score >8, co-morbidities

Results

- 46 intervention:31 controls
- Mean age 60
- 75% married
- 55% retired
- 98% PTSD
- 76% major depression
- Average of 3 co-morbid medical conditions

AUDIT scores



Mean AUDIT scores with 95% confidence intervals of intervention participants with control participants for comparative purposes
Lower scores indicate improvement (i.e. a reduction) in alcohol hazardous drinking or dependence

Alcohol dependence

	Baseline		9 months	
Alcohol-related DSM-IV diagnoses	**Intervention** n=46 (%)	**Control** n=31 (%)	**Intervention** n=39 (%)	**Control** n=27 (%)
Alcohol Dependence	28 (**61%**)	13 (42%)	16 (**41%**)	13 (48%)

Translation 1: Coordinated Veterans Care

Aim: target 19,000 veterans with complex conditions.

Fund GPs and practice nurses $1800 per veteran per year to coordinate care

Use self-management approaches to reduce hospitalisation

Model of care

1. Needs assessment
   - Self-management (PIH)
   - Mental health (K-10)
2. Care planning – medical and self-management
3. Coordination
4. Coaching (self-management support)

Coordinated Veterans' Care Program

Australian Government
Department of Veterans' Affairs

Important notice:

The 2015 revised and updated CVC online training modules are now available at https://onlinetraining.cvcprogram.net.au/auth/flinders/login.php

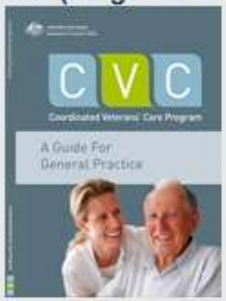
For assistance, please call 1800 652 357 (toll free)

The Coordinated Veterans' Care (CVC) Program

Strengthening Primary and Community Care for Australia's Veterans Most at Risk

The CVC Program is a planned and coordinated health care model for eligible Gold Card holders with one or more chronic conditions, complex care needs and who are at risk of

CVC - A Guide for General Practice (Large file 4.4mB)



Information for GPs and practice nurses

CVC Program modules

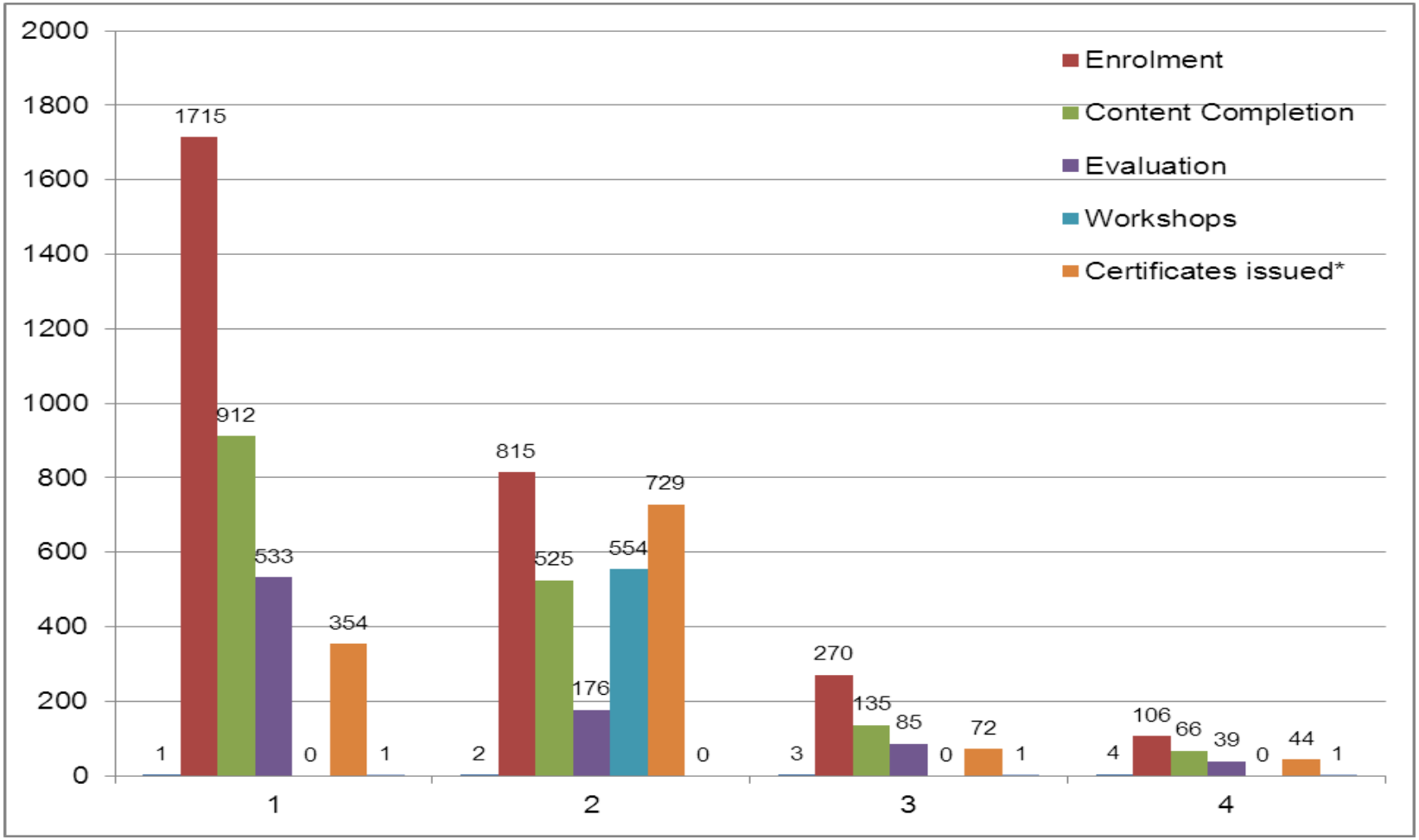
Module One Is your Service Ready?
CVC Program, Chronic Care Model & implementing self-management support at the service systems level.

Module 2: Care Planning & Coordination with the Flinders Program™
Chronic condition management support for veterans care planning & coordination

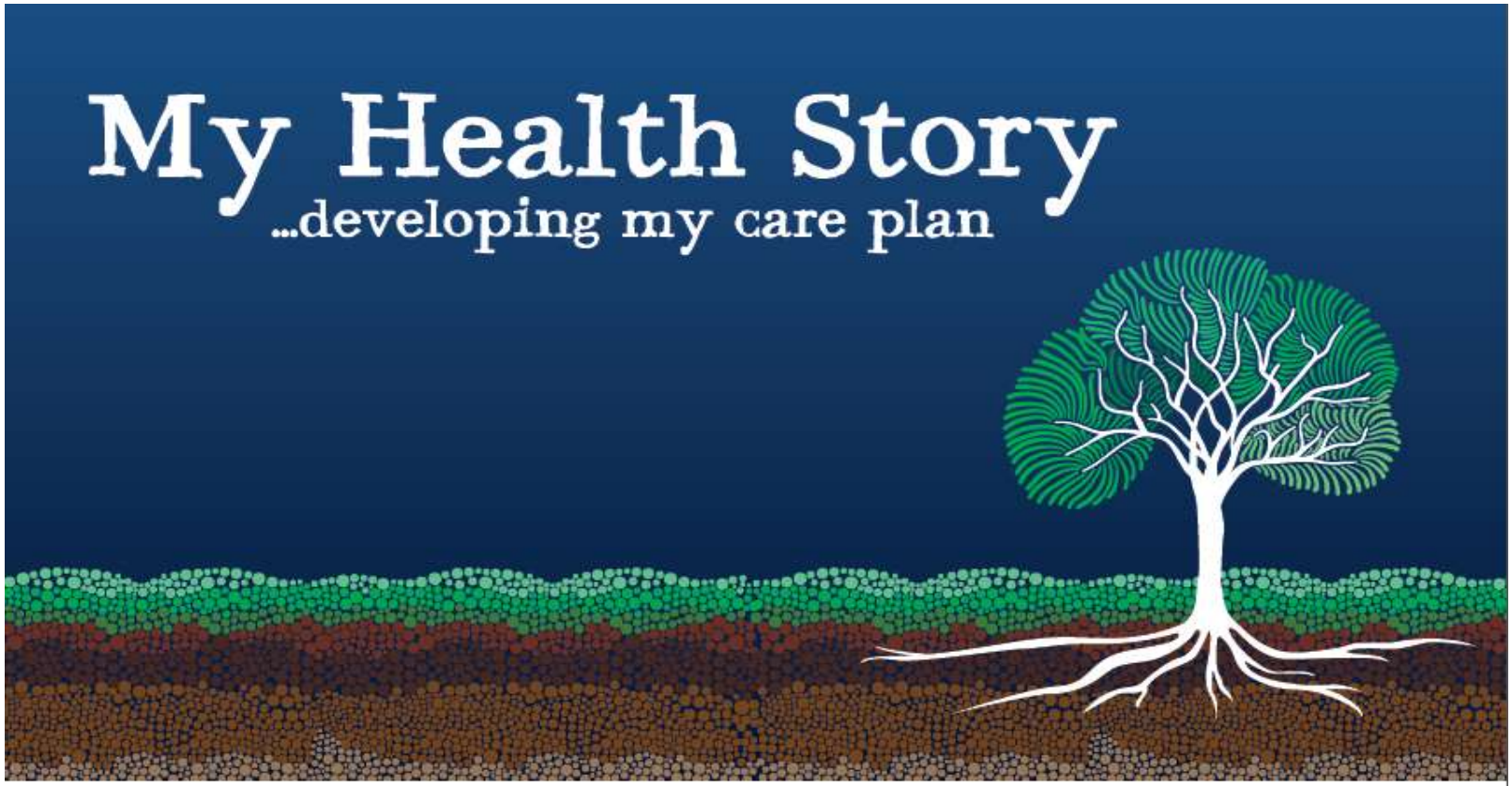
Module 3: Managing Care Plans with Disease-Specific Elements
Congestive heart failure, coronary heart disease, pneumonia, chronic obstructive pulmonary disease & diabetes as they relate to the veteran community

Module 4: Veterans' Social Isolation, Mental Health & Wellbeing
Impacts of social isolation & psychosocial & mental health needs for veterans & carers.

CVC on line and face to face training



Translation 2: Flinders Closing the Gap Program

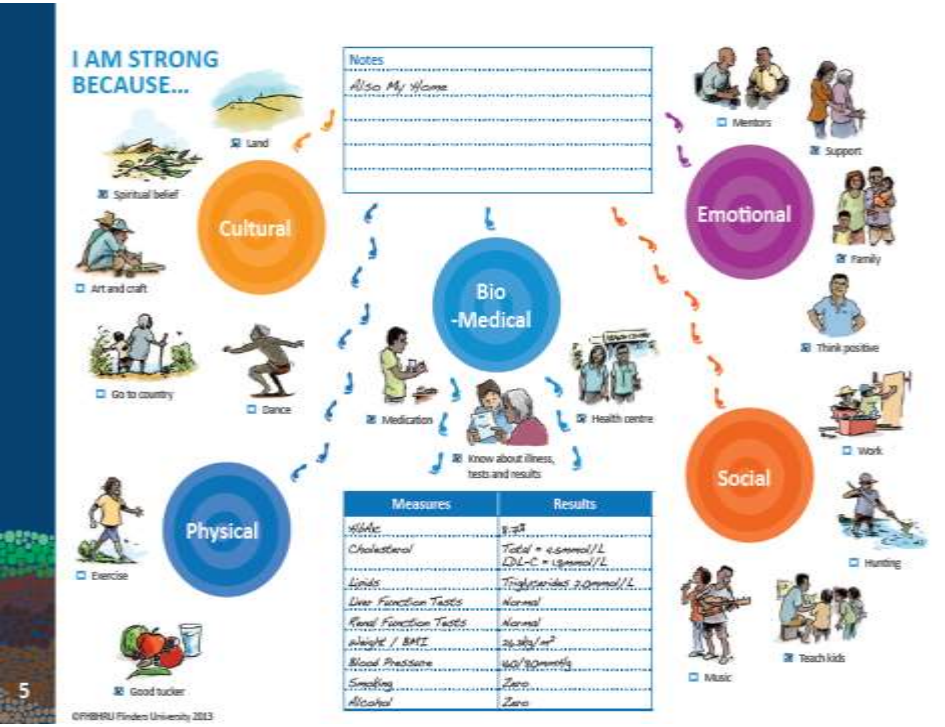


CLOSING THE GAP
tackling Indigenous chronic disease

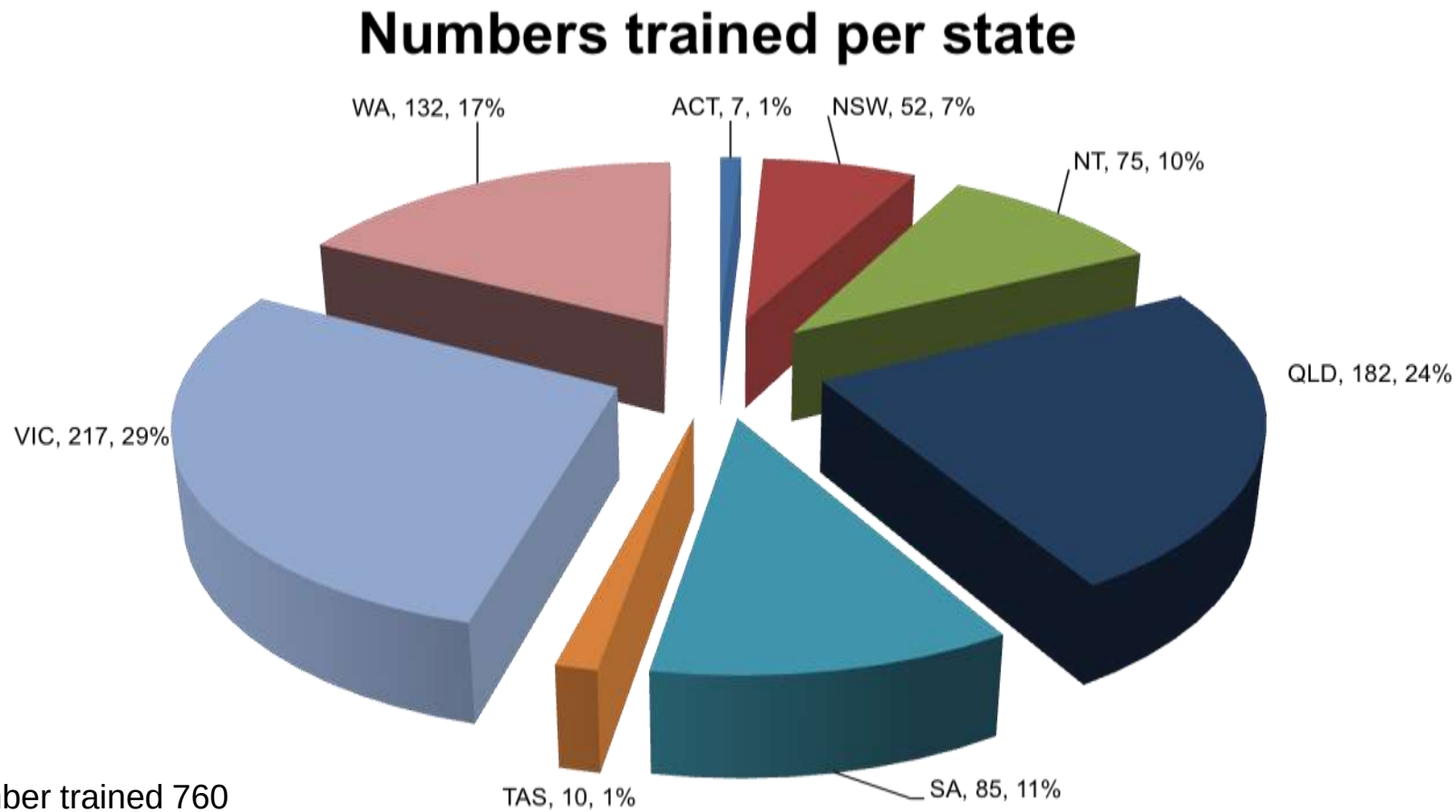
Flinders UNIVERSITY

Closing the Gap

Ethel's Story



Training



Total number trained 760

Barriers to implementation

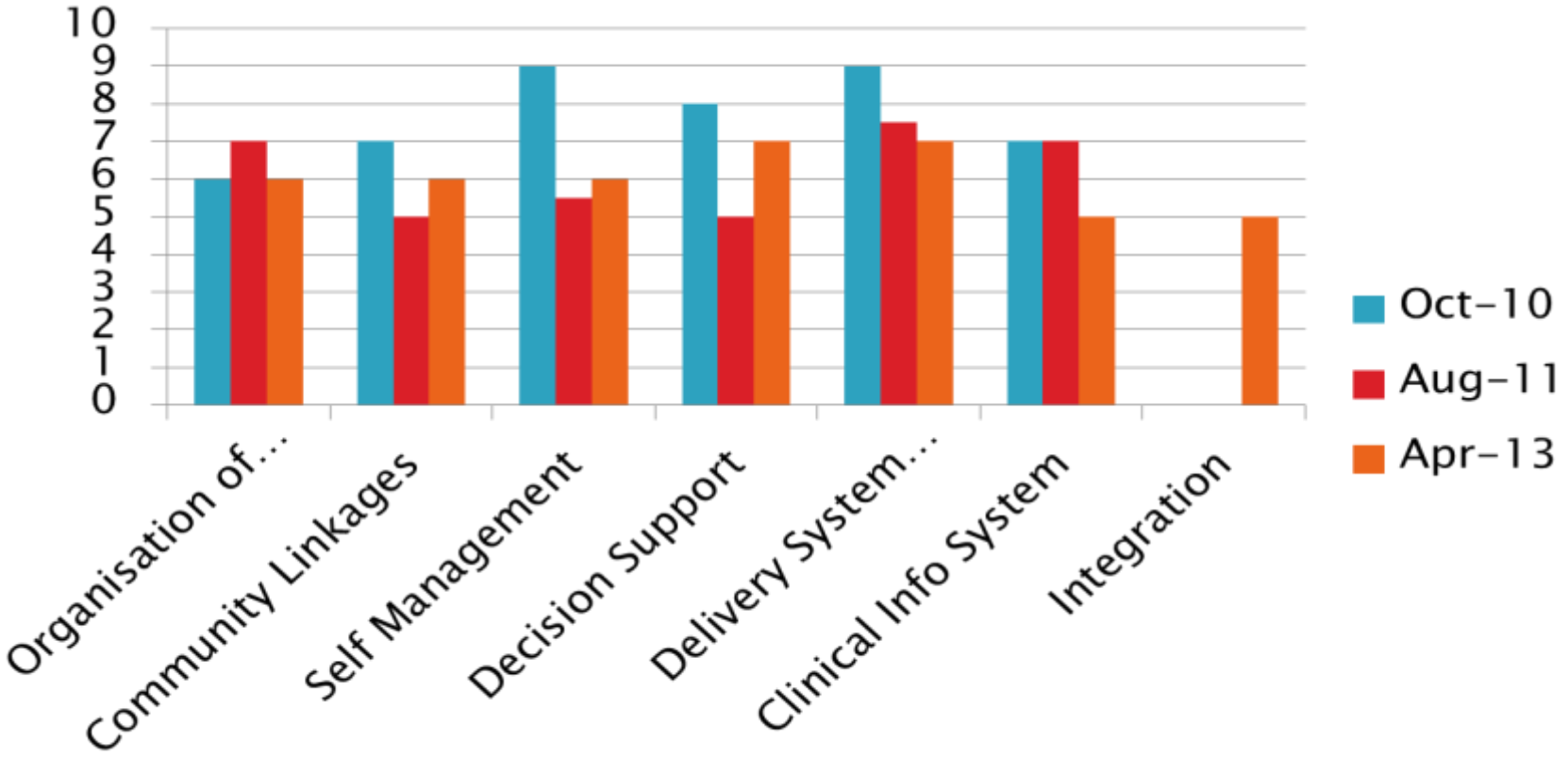
IT system and communication
Delivery system design and integration of the Flinders Closing the Gap Program™ into the client journey
Lack of mentoring support for care coordinators
Ability to capture data on existing data sets
Current changes to health system reforms and services
Staff mobility
Availability of staff resources (EFT) to dedicate to Project

Addressing the barriers

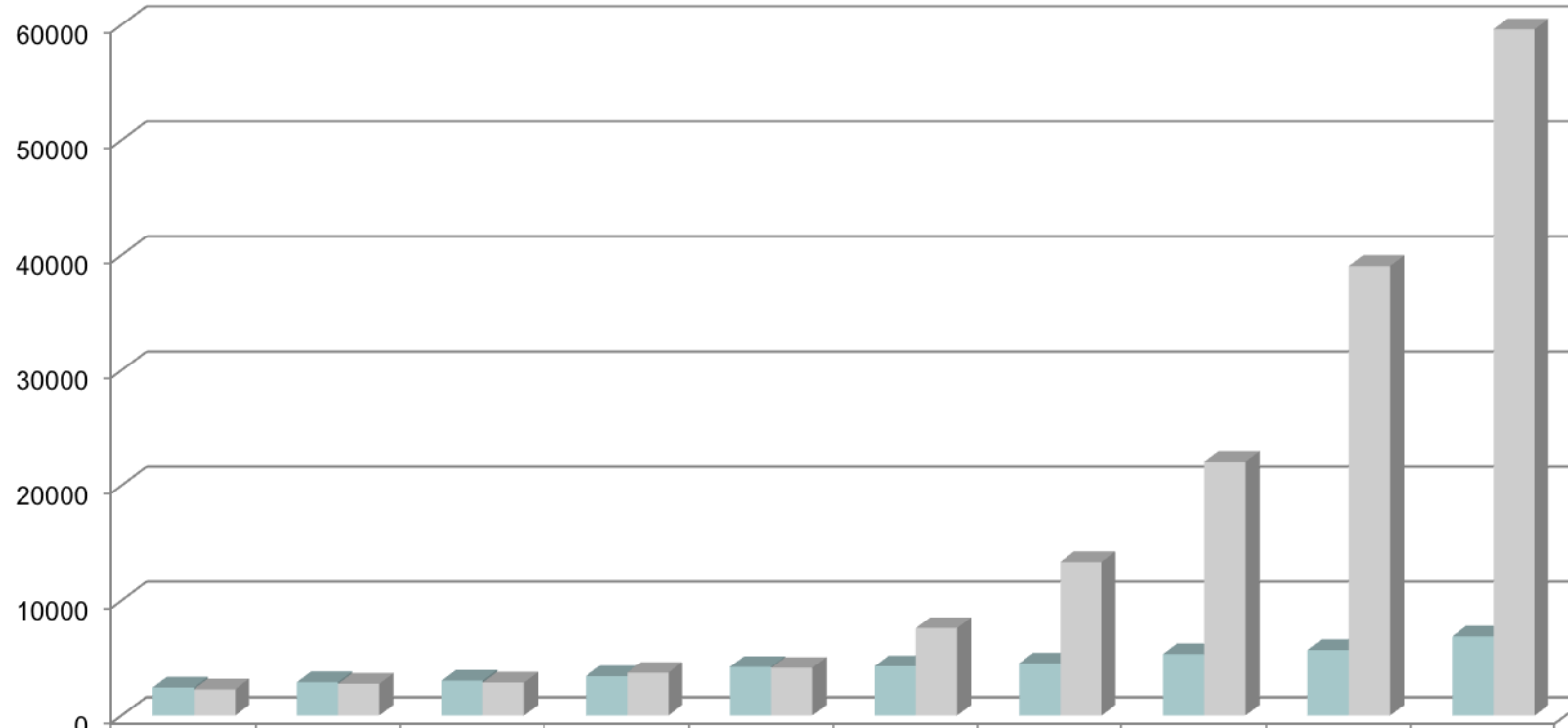
Overcoming the barriers
My Health Story … Yarn with me
Implementation Kit
Client Journal “My Health story”
Web Page
Client Journal “My Health story”
Training DVD’s
Procedure Manual
Targeted mentoring support
Integration of Flinders Closing the Gap Program tools into Major data systems


1. Consider developing a chronic care model for your organisation
2. Intent to implement the Flinders Closing the Gap Program™
3. Obtain management support
4. Conduct audit/s: Agency Health Systems Assessment, Skills Audit, Process Mapping, Clinical Audit
5. Develop an organisational action plan
6. Test action plan
7. Training from Flinders University
8. Train key staff
9. Staff obtain certificate of completion/ competence
10. Select staff become accredited trainers (Succession planning)
11. Use Flinders Tools with clients
12. Ongoing evaluation and review
START HERE

ACIC- Chronic Illness Care changing health service delivery



Occasions of service



	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct
Care Plans	2434	2906	3044	3413	4245	4298	4529	5357	5717	6868
Occasions of Service	2288	2759	2872	3732	4167	7604	13349	22016	39064	59611

Care Plans Occasions of Service

Total Care Plans = 6868

Total Occasions of Service = 59611

Chinese research

- Hong Kong Rehabilitation Society – Peter Poon
- Hong Kong Polytechnic University -Teresa Chiu
- Chinese translation of PIH
- Trial of Chinese adapted Flinders Program
- Central South China University

Research answers

- What is self-management? – national definition
- Can it be assessed and measured? YES - PIH
- Can self-management assessment be used to tailor interventions and services to the individual?- YES
- Can self-management support motivate people to improve health outcomes? - YES
- Can self-management care planning be used generically for multiple chronic conditions? YES
- Can self-management support be implemented into routine clinical practice? YES

Future directions – www.FlinCare.com

Patients

The Flinders Program™ has been shown to change the lives of patients with chronic conditions by promoting self- management and helping them to take control of their health.

Read More

Health Care Organisations

The Flinders Program™ can help your organisation to reduce its healthcare expenditure. Effective self- management of chronic conditions reduces patient hospitalisation rates and improves a patient's health.

Read More

Health Professionals

The FlinCare™ software delivers the Flinders Program™ on a web- based system for use by both health professionals and patients.

Read More

What is FlinCare™?

FlinCare™ is a patient- centred care planning tool designed to promote effective self-management of chronic conditions.

FlinCare™ is a web-based system, which contains the components of the Flinders Program™ and provides access for both the patient and health professional.

THANK YOU

Flinders Human Behaviour Health Research Unit

http://cvcprogram.flinders.edu.au/

http://som.flinders.edu.au/fhbhru (Courses)

http://www.flindersclosingthegapprogram.com

www.flincare.com

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