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

Assess Self-Management

Medical Management

Community / Family Support

Psychosocial Support

Problems and Goals

Action Plan
Agreed Issues
Agreed Interventions
Shared Responsibilities
Review Process
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**
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:

<table>
<thead>
<tr>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very little</td>
<td>Something</td>
<td>A lot</td>
<td></td>
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</table>

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

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<tr>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
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<td></td>
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</tbody>
</table>

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

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<tr>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never</td>
<td>Sometimes</td>
<td>Always</td>
<td></td>
<td></td>
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</table>
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.

## Client Goal Statement
I will go to the community club one afternoon a week for 2 hours.

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


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

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
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

<table>
<thead>
<tr>
<th></th>
<th>Baseline</th>
<th>9 months</th>
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<tbody>
<tr>
<td><strong>Alcohol-related DSM-IV diagnoses</strong></td>
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<tr>
<td>Intervention n=46 (%)</td>
<td></td>
<td></td>
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<tr>
<td>Control n=31 (%)</td>
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<tr>
<td><strong>Alcohol Dependence</strong></td>
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</tr>
<tr>
<td>28 (61%)</td>
<td>13 (42%)</td>
<td>16 (41%)</td>
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<tr>
<td>13 (48%)</td>
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</table>
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)
Important notice:
The 2015 revised and updated CVC online training modules are now available at
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
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

My Health Story
...developing my care plan
Closing the Gap
Ethel's Story
Total number trained 760

Numbers trained per state

- WA, 132, 17%
- ACT, 7, 1%
- NSW, 52, 7%
- NT, 75, 10%
- VIC, 217, 29%
- TAS, 10, 1%
- QLD, 182, 24%
- SA, 85, 11%
## Barriers to implementation

<table>
<thead>
<tr>
<th>Barriers</th>
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<tbody>
<tr>
<td>IT system and communication</td>
</tr>
<tr>
<td>Delivery system design and integration of the Flinders Closing the Gap Program™ into the client journey</td>
</tr>
<tr>
<td>Lack of mentoring support for care coordinators</td>
</tr>
<tr>
<td>Ability to capture data on existing data sets</td>
</tr>
<tr>
<td>Current changes to health system reforms and services</td>
</tr>
<tr>
<td>Staff mobility</td>
</tr>
<tr>
<td>Availability of staff resources (EFT) to dedicate to Project</td>
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</table>
Addressing the barriers

<table>
<thead>
<tr>
<th>Overcoming the barriers</th>
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<tbody>
<tr>
<td>My Health Story ... Yarn with me</td>
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<tr>
<td>Implementation Kit</td>
</tr>
<tr>
<td>Client Journal “My Health story”</td>
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<tr>
<td>Web Page</td>
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<tr>
<td>Client Journal “My Health story”</td>
</tr>
<tr>
<td>Training DVD’s</td>
</tr>
<tr>
<td>Procedure Manual</td>
</tr>
<tr>
<td>Targeted mentoring support</td>
</tr>
<tr>
<td>Integration of Flinders Closing the Gap Program tools into Major data systems</td>
</tr>
</tbody>
</table>
ACIC- Chronic Illness Care changing health service delivery
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
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.flinicare.com

malcolm.battersby@flinders.edu.au