The Flinders Program™ of Chronic Condition Self-Management in New Zealand: survey findings

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ABSTRACT

INTRODUCTION: The Flinders Program™ of Chronic Condition Self-Management in New Zealand (NZ) has been given focus as a useful and appropriate approach for self-management support and improvement of long-term condition management.

AIM: To determine the use of the Flinders Program™ in NZ and identify barriers and enablers to its use.

METHOD: A web-based survey was undertaken in June 2009 with 355 eligible participants of the 500 who had completed 'Flinders' training in NZ since 2005.

RESULTS: 152 (43%) respondents completed the survey over a one-month time frame. Of those who responded, the majority were primary care nurses (80%; 118). Fifty-five percent (82) of survey respondents reported using some or all of the Flinders tools. Of these, 11% (16) reported using all of the tools or processes with 77% (104) of respondents having completed six or fewer client assessments utilising the Flinders tools. This indicates that respondents were relatively inexperienced with use of the Flinders Program™. Barriers to implementation were identified as the time needed for structured appointments (up to one hour), funding, resistance from colleagues, lack of space and insufficient ongoing support.

DISCUSSION: Despite the extent of training in the use of the Flinders Program™, there is limited use in clinical practice of the tools and processes associated with the model. Without structured support for quality improvement initiatives and self-management programmes, the ability to implement learned skills and complex interventions is limited.

KEYWORDS: Self-management; long-term conditions; chronic conditions; chronic illness; primary care; nurses

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Introduction

Long-term or chronic conditions account for approximately 70% of all general practice encounters and 78% of all health care spending in New Zealand (NZ).[1] The 2006/7 NZ Health Survey[2] found that two out of three New Zealanders have a long-term health condition. In Australia, general practice is estimated to engage with 87% of a population each year[3] and provide most of the long-term conditions care. The challenges for primary care to respond to chronic illness are considerable and increasing. The NZ report *Meeting the Needs of People with Chronic Conditions*[1] identifies client self-management as a key component of long-term condition care and recommends incorporating self-management support into chronic care frameworks in NZ.

Self-management support is defined by Adams and colleagues as 'the systematic provision of education and supportive interventions by health care staff to increase patients' skills and confidence in managing health problems, including regular assessment of progress and problems, goal setting, and problem solving support'.[4]

A recent Cochrane review concluded a lack of clarity around the active ingredient of successful self-management, and that the evidence for the effectiveness of self-management programmes on long-term health outcomes is inconclusive.[5] Uptake of self-management programmes within primary care is also inconsistent. Organisational barriers to implementing self-management programmes have been identified as limited team work in general practice, resistance to change and an approach where 'doctors know best'.[6]

One study has identified the enablers for self-management programmes in Australian general practice as including education of staff, skills training, inclusion of negotiated self-management support in client care plans, assessment of clients' self-management capacity and developing the role of practice nurses to provide self-management support.[3] Increasingly the role of practice nurses in self-management programmes is recognised.[3] A United Kingdom (UK) study suggests that clients find nurses easier to approach for information than doctors.[7] The capacity of nurses, the largest group of health professionals, to engage in this role however may require attention, with little being done to equip them with knowledge and skills for self-management education.[8] Many practice nurses lack the time and competencies to undertake self-management programmes.[3] A UK study of practice nurse involvement in self-management programmes found that little attention had been given to the ways practice nurses work and support self-management for chronically ill clients.[9] Nurses were more confident with clients in the early stages of their illness. When clients did not make suggested lifestyle changes, nurses resorted to didactic information-giving. This study highlighted the complexities of delivering self-management programmes where health professionals must create partnerships with clients.

The Flinders Program™ of Chronic Condition Self-Management is a self-management programme developed from the 1990 Australian Coordinated Care Trials,[10] based on cognitive behaviour therapy, problem solving and motivational interviewing techniques. This model utilises a set of tools (Partners in Health Scale, Cue and Response Interview, Problems and Goals Assessment and a Client Care Plan) and processes. Clinicians work one-on-one with clients to assess collaboratively self-management behaviours, barriers, psychosocial issues and client preferences, followed by client-identified problems and goal setting, leading to individualised care plans.[11] A key point of difference from traditional care planning includes the shift in power towards a client-centred partnership with clients actively sharing decision-making on their physical, emotional and social well-being. The care plan is based on shared, agreed issues, goals and interventions that align with the client's values, priorities and beliefs. Approximately 45 to 60 minutes is required for a Flinders assessment once a clinician has become confident and reached competency.

The Flinders Program™ has been given focus in NZ as a useful and appropriate approach for increasing knowledge and understanding around self-management support and improving long-term condition management. Since 2005 approximately 500 NZ health professionals have participated in Flinders training, attending a two-day workshop. For health professionals to use the Flinders Program™ they first attend a training workshop conducted by a trainer accredited by the Flinders Human Behaviour and Health Research Unit (FHBHRU). Following this, completion of three client assessments and care plans to an acceptable standard, as assessed by the accredited trainer, enables the health professional to receive a Certificate of Competence in Chronic Condition Self-Management from Flinders University. Flinders University charge a licence fee for each workshop attendee. This fee entitles the workshop participant to access ongoing programme updates. The Partners in Health

WHAT GAP THIS FILLS

What we already know: The Flinders Program™ of self-management has been adopted in NZ as a useful and appropriate approach for improving long-term condition management. Over 500 health professionals have been trained in the use of the programme. The evidence for the effectiveness of self-management is, however, inconclusive, and support for the introduction of new and complex interventions in primary care inconsistent.

What this study adds: This paper demonstrates that, despite the considerable resource being directed to training primary care nurses in particular in the Flinders Program™, there is limited use of the Flinders tools and processes in clinical practice. Training for new and complex interventions in primary care may not be aligned with structured support and general practice priorities.

(PIH) tool is available for general use, but the other Flinders tools are available only to people who have completed a Flinders 'workshop'.

The requirements for the Certificate of Competence are also embedded in a NZ postgraduate primary care nurse course offered since 2007 by three university academic nursing departments. The intent of this has been to enable nurses enrolled in a 'long-term conditions' postgraduate course to also achieve the Flinders University Certificate of Competence, increasingly valued by employers. Principles of client self-management and other models of self-management are included in the academic course.

Anecdotal evidence suggests that in NZ, as in Australia,[12,13] there has been limited uptake of self-management programmes and it is not clear whether findings from international studies of self-management programmes translate into NZ primary care settings.

In 2008/9 a pilot study to assess the feasibility of undertaking a substantive long-term trial to gauge the effectiveness of the Flinders Program™ when used by practice nurses in NZ was undertaken. The report of this study is published separately.

This paper reports the findings from a survey of NZ primary health care professionals who had completed training in the Flinders Program™ of Chronic Condition Self-Management. The survey was undertaken in conjunction with the feasibility study. The purpose of the survey was to determine use of the Flinders Program™ and to identify barriers and enablers to its use.

Method

A web-based survey was undertaken in June 2009 using the LimeSurvey tool (open source software http://www.limesurvey.org/) with participants who had completed Flinders training in NZ since 2005.

The survey contained multiple choice and free text responses to ascertain patterns of use, barriers and enablers, preferences and experiences. The tool was piloted to reduce question ambiguity prior to wider distribution.

The FHBHRU hold a database of people who have attended training in the Flinders Program™. While the database does not hold complete records, of the New Zealanders in this database, 400 had given permission at the time of training to be contacted at future dates. There were 45 out-of-date or duplicate addresses giving a potential of 355 participants.

The survey was sent from The University of Auckland. Respondents had one month to respond with a reminder at two weeks.

Ethical approval was granted by the NZ Northern Y Regional Ethics Committee as an extension to the feasibility study.

Results

One hundred and fifty-two (43%) survey responses were received, with 148 responses included in the analysis. Four respondents had not completed Flinders training and their responses were excluded.

Respondents

The majority of respondents were primary care or practice nurses (118 or 80%). Of these, 73 (49%) stated that they were practice nurses. 'Other' primary care nurses included chronic care, diabetic or respiratory nurses. Other health workers included general practitioners, dietitians, psychologists, social worker and community health workers.

One hundred and twenty-three (83%) respondents were aged over 40 years. Females numbered 140 (95%), the majority being NZ European (107; 72%). Four Maori health professionals participated together with six Pacific and six who recorded their ethnicity as Asian. Respondents were from a wide geographic area, with the majority (112; 76%) in the central and upper North Island, reflecting NZ's population spread.

Use of Flinders Program™ in clinical practice

Within the survey, 81 (55%) respondents were currently using some or all of the Flinders tools, with 16 (11%) using all of the tools and processes (Table 1).

Respondents were asked how many assessments they had completed, how long an assessment takes and to rate their confidence in the use of the Flinders tools using a 5-point Likert scale (1=Not at all confident, to 5=Totally confident). Responses to this include those from respondents who may be using only the assessment component of the Flinders Program™. Results are shown in Table 2. The majority (114; 77%) had completed six or fewer assessments, including the three assessments required to achieve the Certificate of Competence, and took one hour or less to complete an assessment, all with reasonably high self-reported confidence with use of the tools.

Participants who indicated that they used all or some of the Flinders tools in their practice were asked which they were using. The 82 respondents who replied to this section used SMART goal setting most frequently (Table 3). Multiple options were possible.

Of the 16 respondents using all the Flinders tools, one respondent indicated that she would complete one Flinders assessment each week; three respondents once a fortnight and eight would use the tools once a month on average.

Table 1. Use of Flinders model/programme

Use of Model	Number	Percentage
Currently use model	16	11
Use some of the Flinders tools	65	44
Used to use	23	16
Not at all	44	29
TOTAL	148	100

Table 2. Number of Flinders assessments completed

Assessments completed	Number	Percentage	Mean Confidence Score (1–5)
None	9	6	
1–3	36	24	3.2
4–6	69	47	3.7
7–10	22	15	3.7
11–25	8	5	4.1
More than 25	4	3	4.0
TOTAL	148	100	

Table 3. Flinders tools used in practice

Flinders tool	Number using	Percentage
SMART goal setting	67	82
Self-management care plans	53	65
PIH	48	59
Cue and Response	39	48

Training

The majority of respondents had completed the Flinders training since 2007 (133; 90%), with 21 (14%) completing in 2009. Only seven people had completed training in either 2005 or 2006. Of those who had completed training, 100 (68%) had completed the three assessments and care plans required to receive the Flinders Certificate of Competence.

Barriers

Lack of time was considered the major barrier to using the Flinders Program™. This related to the length of time needed for a structured appointment to complete an initial assessment within a busy working environment. A significant number of respondents (126; 85%) stated that they had experienced barriers. Multiple options were selected. (Table 4).

Free text comments endorsed the identified barriers, but also indicated that time as a barrier may be reduced as experience was gained:

> At the moment time is the main barrier but as I get more experienced in assessing I anticipate that this barrier will lessen.

Enablers

The 82 respondents who indicated that they used some of the tools, also listed enablers to the use of the Flinders Program™. Multiple options were selected with 55 indicating that there were no specific enablers (Table 5).

When asked what might be useful to assist with implementation, respondents indicated that a special interest group (40), an Internet support group (34) and ongoing contact with the course trainer (29) would be useful.

Discussion

Flinders training is relatively new in NZ, with the majority of training completed by nurses

since 2007. Many of these nurses will not yet have reached a confident level of practice, with 298 nurses undertaking their training in conjunction with a postgraduate academic programme between 2007 and 2009. An advantage of an approach which embeds training in an academic programme is achieving a high completion rate for the Certificate of Competence and therefore completion of three client assessments and care plans. Becoming confident, efficient and gaining competence in the use of the Flinders tools requires, however, experience beyond the three client assessments and care plans needed to fulfil the requirements for the Certificate. Anecdotally a minimum of six client assessments may be required before a health professional is fully confident in the use of the tools.

While there were limitations in the survey reported (43% response rate), with only 100 respondents achieving a Certificate of Competence, together with the short time frame since the Flinders Program™ has been implemented in NZ, the findings are of interest. Although 82 (55%) of the health professionals surveyed were using some or all of the Flinders tools and processes, the low survey response rate may indicate that a greater number of health professionals who have trained in the Flinders Program™ are not using the Flinders tools and therefore may have ignored the survey.

The majority of respondents in the survey were also still relatively inexperienced (77% had completed six or fewer assessments) suggesting there may be a large gap between training and implementation in clinical client care. The resources required to train nurses are considerable and ongoing education and support for the nurses completing self-management training is essential if they are to develop confidence and maintain their competence.[14]

Comments from the nurses who responded to the survey indicate value gained in learning to develop a collaborative approach to client care planning with active participation of clients. The Flinders Program™ specifically ensures that a collaborative approach to decision-making occurs between the client and health professional. While the tool most frequently used is that related to goal setting, there is the possibility that goals may not be client-centred or client-determined without use of the Flinders problem identification process. Identifying which clients will benefit most from self-management support[15] may enable prioritising and tailoring of support to client needs.[16]

The evidence for the effectiveness of various models of self-management on long-term health outcomes is variable.[17–19] Nevertheless, there is likely to be an ongoing and increasing focus on self-management programmes in NZ primary care, particularly with a nurse role. The Flinders Program™ is one approach to structured long-term condition management that has been available in NZ since 2005. The survey findings suggest that while training has been predominately with primary care nurses, the uptake and implementation of the full Flinders Program™ is limited. Barriers to implementation are reported as including time for one-hour structured appointments, resistance from colleagues, lack of space and insufficient ongoing support. Consideration

Table 4. Barriers

Barrier	Number	Percentage
Time	126	85
Lack of funding	39	26
No electronic version	37	25
Resistance from clients to pay	36	24
Client reluctance for long visit	31	21
No space or spare room	25	17
Resistance from GPs	21	14
Resistance from nurses	18	12
Resistance from management	18	12
Lack of mentoring	12	8
Language—not a Maori framework; clients do not have English as first language	5	3
Repeats questions; not user-friendly	3	2
Lack of confidence	2	1
Other	8	5

Table 5. Enablers

Enabler	Number	Percentage
Strong leadership in practice	29	35
Ongoing contact with trainer	27	33
Funding for programme	20	24
Support from nurses	18	22
Support from GPs	17	21
Newsletters/conferences	3	4

should be given to implementation of complex interventions before extensive training resources are committed. Without structured support for quality improvement initiatives and long-term condition programmes such as the Flinders Program™, the ability to implement learned skills is difficult. The identification of ongoing support from the trainer cannot be considered a sustainable option other than in the short term. Further research is needed to both provide evidence for the value of the Flinders Program™ in NZ primary care and also to determine how complex interventions and new models of care can best be introduced into primary care.

NZ general practice has access to funding streams such as Care Plus which can provide for long-term condition management programmes. There is however great variability in how Primary Health Organisations (PHOs) and general practices utilise funding streams, highlighting a need for support for overall change in general practice. Some PHOs have utilised the Flinders Program™ as a structured assessment for Care Plus enrolment.[20] If self-management support is to work, there is a need to better understand the infrastructure, systems and training needed for clients, health professionals, policy makers and health care organisations.[19] Several authors[21,22] consider that new models of practice are needed, with policy makers appreciating that support is needed not only at a client level, but also a practice level. Harris et al.[3] argue that while implementing self-management support in general practice is challenging, there are difficulties not only in the context of work pressures, but also in the traditional, more directive, approach of general practice.

Practices most successful with long-term condition programmes in general are recognised as practices that have systematically assessed their chronic care systems and apply client-centred goal setting and action planning, have established long-term condition clinics and provide dedicated nursing time.[6,23] Without addressing barriers such as infrastructure, adherence to funding streams, delivery systems and resistance from managers and some health professionals, the introduction of new and complex patient interventions in primary care remains difficult.

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COMPETING INTERESTS
Dr Janine Bycroft is a Flinders accredited trainer.