



Partnering in Primary Care  
– Flinders Feasibility Study

# Practice Nurses use the Flinders Model with Older People

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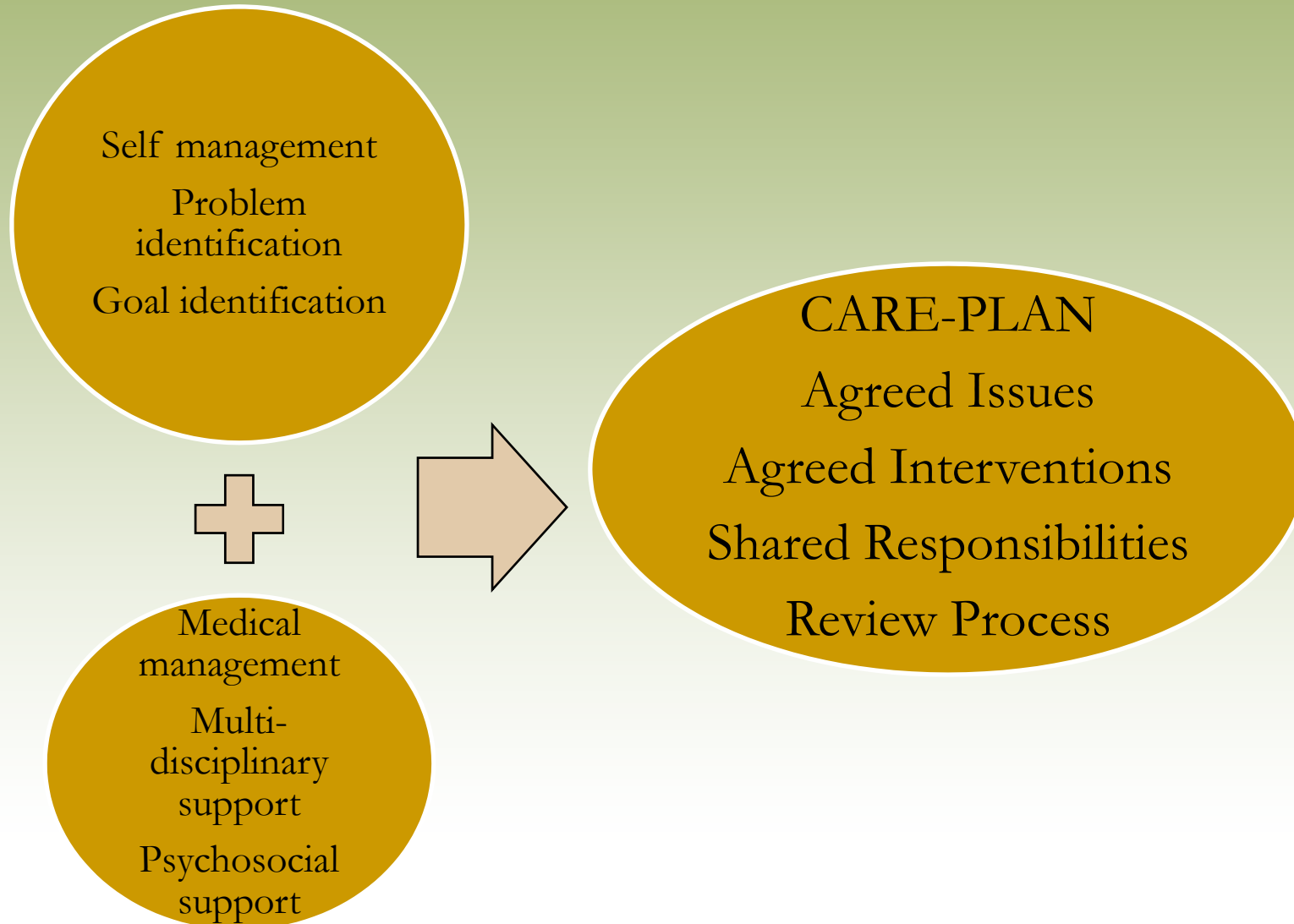
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# Presentation Overview

- Flinders Model overview
- Feasibility Study overview
- Older Peoples perspectives
- Practice Nurse perspectives



# Flinders Model Overview



# The Six Principles of Self-management

- Have knowledge of their condition
- Follow a treatment/care plan agreed with their health professionals
- Actively share in decision making with health professionals
- Monitor and manage signs and symptoms of their condition
- Manage the impact of the condition on their physical, emotional and social life
- Adopt lifestyles that promote health.



# The Flinders Model - aim

For people living with chronic disease;

- To raise their Quality of Life
- To improve their effective use of health care system
- To collaboratively identify problems with their health professional
- To increase their engagement in their own care



# Flinders model - health professionals

- Provides training and certification
- Assessing self-management capacity
- Facilitating care planning
- Using a generic set of evidence based tools



# Flinders Tools - Partners in Health (PIH) questionnaire

Knowledge of:

- Condition(s)
- Treatment(s)

Understanding of:

- Monitoring and recording
- Symptom management

Progress towards a healthy lifestyle

Ability to:

- Take medications
- Share in decisions
- Arrange & attend appointments
- Monitor and record
- Manage symptoms
- Manage physical impact
- Manage social impact
- Manage emotional impact



# Flinders Tools

- Cue and response questions
  - Explore PIH responses in depth
  - Enables exploration of barriers to self management
  - Checks clinician /client assumptions
  - Behaviour change prompt
  - Reflection opportunity
  - Clarification of common set of problems
- SMART goal setting
  - Identifies a goal(s) client can work towards
- Self management care plan



# The Flinders Feasibility Study

Aim:

- To assess the acceptability and usefulness of the Flinders Model when utilised by primary healthcare nurses with individuals who have long-term conditions



# Feasibility Study Method

- **20 general practices** in Central and South Auckland (Intervention /Control)
- **100 Participants**
  - Flinders assessment and care planning with primary care nurse
  - Baseline measures
- **Follow-up** as appropriate
- **At 6 months:** Repeat outcome measures
- **Interviews:** Nurses & Participants
- **Web Survey:** Flinders trained health professionals



# Demographics

		n = 100
<b>Age</b>	Average age	60.5yrs
<b>Gender</b>	Male	47%
	Female	53%
<b>Ethnicity</b>	Maori	26%
	NZ European	38%
	Pacific	20%
	Other	16%
<b>Disease</b>	CVD/Stroke/PVD	39%
	COPD/Asthma	51%
	Gout	25%
	Diabetes Mellitus	48%
	Arthritis	44%
	Other	55%
	Co-morbidities	75%



# Older people's perspectives

- Assessment
- Goal setting
- Results
- Health professional relationships



# Assessment

- Not experienced assessment before  
*It was good to have a review of my health and my condition and sort of talk about it, I've suffered with asthma for so long, it was hard to have that knowledge*
- Hadn't realised problems

*I had so many packets because I take 10 pills every morning and by the time I got them all sorted out.....I was growling 'I do take my medications'..... But when I started on blister*

- Hadn't believed situation could be different  
*packs I said 'she's right I must have been missing out on some because it feels a lot better, especially my diabetes'*

*I felt encouraged, you know, to actually have more knowledge, its sort of made me recognise things different [to] before*



*The things I struggled with, I could actually look at and go "Oh I can improve that"*

# Goal Setting

- Ownership

*No one forced me or tied my arm up behind my back or anything. I just decided I'd do it properly*

- Learning

*She helped me to understand when to take them, not when it was too late...I had to relearn my [inhaler] technique*

- Written plan

*...set some goals at the first one, I didn't meet all of them but by putting it in writing it gave you those goals to work to*



# Catalyst for behaviour change

Unused 'preventer' inhalers

*"had a drawer full of them"*

*"puffed on ventolin" all day.*

Initial goal: *"Time out for me"*

The Flinders assessment *"set me thinking"*

New goal to use preventers

After pondering

- Set another goal to reduce her cigarette smoking
- .... give up altogether

Three months on...proud of changes



# Goal examples

- One of them was my fitness, being able to play with my nieces and nephews better
- Taking my medications at the right times
- I created my extra goal of sorting my hearing out
- To try and get more sleep



# Changes

- Dramatic reduction in asthma symptoms
- Knows how to monitor and manage symptoms
- Blood sugars better controlled
- Can describe the effect smoking has on his body
- Got a hearing aid, is wearing it and continues to seek a better fitting ear mould
- Taken up a hobby previously unable to tolerate...



# Controlled asthma - Korowai weaving



# HP Relationships

- Partnership

*Anything that I didn't know we were able to work out and find ways to work on them*

*This interaction is totally new...I would just isolate myself [before]*

- Better understanding

*The two of us kept working together despite the hearing problem*

- Level relationship

*I think between the two of us ...we are on a fairly even level now*



# Practice nurse perspectives

## Enablers

- Strong leadership
- Post course trainer contact
- Funding
- Support from practice



## Barriers

- Time **96%**
- Client reluctance re cost of long / repeat visit
- Practice resistance
- Funding



# Web Survey responses

- 148 responses (37%)
- 55% using some or all of the FLINDERS tools
- Most used FLINDERS tools
  - SMART goal setting
  - Care planning
- Enablers
  - Familiarity with tools facilitated expertise
  - *The more you use it the quicker you could become at using it*
- Barriers
  - Time - *Interviews took too long to complete in the time that is usually given to appointments for chronic care*



*Funding for the length of time involved, it becomes a cost to the patient*

# Ponderings

*I find the tools have been very helpful in dealing with those that I previously thought were 'difficult' patients, as the tools have enabled me to find out what the person's agenda is.*

*Its all a process and the value comes from following the whole process despite the time it takes*

*My patients find it very personal and a means of voicing their concern, their need, and most of them stated that they are heard at last!!*



# Acknowledgements

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