The Flinders Care Planning Model

Summary of Comments from Workshop Evaluations and Initial Care Plans

October 2009

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This information is gathered from a review of post-workshop evaluations from 20 Flinders Care Planning workshops conducted from April 2008 through to June 2009. Comments from 103 cover pages attached to care plans submissions from April 2008 to October 2009 are appended. These are important for the Team Based Complex Care Working group to understand the benefits of this process for both client and health professional.

All evaluation comments were complied under specific issue themes listed below.

Themes

- time
- buy-in and support from management and colleagues
- logistics
- target groups and selecting the appropriate patients
- the experience of patients
- team roles
- resources
- Alberta focus
- support

Issue: Time Comments

Unrealistic time required to conduct the interview

Time that patient needs to dedicate

Training time

Patient time too long but I know it will save time in the long run

I can't use it all, I will take some of the tools and use them.

Hard to listen well and stay on task with the process.

Pre-workshop prep too time consuming.

Issue: Management/Colleagues Buy-in Comments

Buy-in of co-workers

Buy-in of MDs

How to get MDs to realize it is the patient's plan and goals, not what they think the patient's goals should be

Other health team members not having the same training

Not sure I can get PCNs on board

Need help to promote with PCNs, I can't do it myself.

Not sure if it will be accepted by management

How do we sell the value to others – co-workers, clients?

All colleagues should attend

What about other practitioners who are not trained?

Need appreciation/recognition/support from others

Need clear AHS guidelines about expectations from management

Need to hear a unified voice top to bottom

Be clear on what we are trying to achieve

Cost of personnel is a barrier

Need more information on fee codes, don't understand the fee code

How will this be implemented, when will the funding be provided and for whom, how will it fit in with existing practice.

Need be better communication of the need, the how, and the why of Flinders within Alberta health care system

What is the provincial direction, the possibility of this becoming mandatory for nurses (esp. CDM) to do

There is an overload of the region introducing too many new models i.e. advanced care planning along with Flinders.

Change and the impact on the individual workload don't seem to be acknowledged.

Issue: Logistics Comments

Where to keep paper copies

How to organize forms on chart

Too many forms!

Too tedious to use forms.

These get easier to complete with practice.

Not enough room to write.

Need more room on forms, they need to be workable

Needs to be electronic

How to make changes to the care plan and Problem and Goals sheets? Who does it? Where?

Each time I can complete it more thoroughly. Still feels rigid and doesn't flow well.

Is there a way to make this more efficient? It is somewhat impractical in a busy setting.

Physical environment not conducive to this discussion

How do we communicate about this to team members?

Need a clear process of follow up on care plans

Need to update Flinders tools to include AHS logo and relevant identification info i.e. insurance numbers, and required clinical indicators on care plan i.e. blood pressure

Can we adapt or modify the process and forms to suit my practice?

How do we determine the most important chronic disease if person has more than one?

Issue: Target groups and Selecting Appropriate Patients

Need the right patients

How to identify appropriate clients

Patients with language, cultural, literacy barriers

What about patient with impaired cognitive function?

What about the unwilling client?

Who follows- up in acute care?

Doesn't fit my patient population (stroke, short term care, 2- 6 weeks)

Need to know clear value for the various health professionals and client groups: acute care, long term care, rehab, palliative care, social work, mental health, prenatal, physicians

Issue: Experience of Patients Comments

Patients not wanting to depart from being “managed”

MDs not wanting patients to depart from being “managed”

The process is too long for patients

How can we ensure they get the follow-up the need?

Inappropriate for acute care

Too restrictive, too processed, doesn’t allow for variability

Need family involvement

Issue: Team Roles Comments

Who on team is best to conduct the plan?

Where does it fit in with the other disciplines?

Current role definitions

Understanding each other’s role

Issue: Resources Comments

How do we liaise with the community?

Need more research and information

Rural – how to link to others

Will there be standardized list of interventions and resources under all headings and specialty areas for the province?

Issue: Alberta Focus Comments

The Australian model may not fit Alberta needs

Dislike the Australian model! We need to Alberta-ize it

Look forward to the Canadian version

Scoring is backwards and confusing

What’s the plan for professional education and the marketing strategy?

Issue: Support Comments

Would like regular correspondence, maybe a newsletter for support

Provide contact list of other trained colleagues

Plan for ongoing contact if we have questions for health professionals

Building skills and confidence

How to stay connected to others who are using this model?

Apathy and burnout due to workloads and change

Comments from Cover Sheet for Care Plan Submissions n= 103

What did you learn from the process? (Direct quotes)

- This process builds a long and strong relationship between the HCP and the patient. It also makes them feel like they matter and are listened to.
- Patients often know how to mange, just need to get into a routine of doing so.
- Patient contacted me for follow-up after making the plan (result is weight loss of 6 lbs in two weeks and her energy level has increased).
- For this high functioning individual, it is more about finding a manner in being consistent with behaviour.
- Process clarified a lack of key communication about taking medications.
- Teaching can occur quickly and directly at time of discussing intervention.
- Sometimes the model is not conducive to getting to know a patient. Sometimes a relationship needs to be build first and then Flinders can be more successful.
- Not every patient would like the support of a team to assist with goal setting and motivation, but perhaps will be in the future if made aware of opportunities that exist.
- The theme emerging from the three care plans is that the impact on the health of the patient outweighs the actual medical condition.
- It was very exciting to see the patient more excited to change!
- I am slow at it, but it is very thorough and I think it is a positive change for CDM.
- That the real issues aren't discussed at the beginning of the interview process. That it takes time, and working through the process for the client to trust the interviewer enough to discuss the actual issues.
- Again, that people can be very good at ignoring/not acknowledging diagnoses, and this is a huge barrier to effective treatment and prevention of complications.
- Not everyone is ready to make changes.
- Mental health is a huge elephant in the room that a lot of people are not willing to see.
- This is a bit frustrating that the patient presents wanting help, but doesn't want to do anything.
- Could be very helpful to help patient to take charge of their own health but difficult time-wise to really implement.
- I wasn't aware of her feelings of being left out because she is seen as sick.
- I had Mr. X brainstorm, and this is how he was able to come up with a possible solution.
- Interesting to see patient come in with no expectations/contemplation stage and leave in the preparation stage, "I am going to do this."
- Hard to get the patient to identify a problem. Word "problem" was an issue so I had to reframe and reword it to get patient to come on board.
- How the client can learn through their own self-reflection on the issue.
- The process gave more insight to the patient although it took time to come to something concrete.
- That practice makes closer to perfect. The third attempt really ran smoothly for me, and that the patient got a great deal of benefit out of it. She felt it really helped to clarify for herself what the underlying issues were, and how she could address them. Her problem and goal statements were profound, and theses were areas I had struggled with getting patients to express specifically before.

- The importance of empowering the clients, and the importance of positive feedback to increase confidence.
- Patient has expressed an appreciation for the respect and questioning from professional group because she feels the previous physician only wanted to handout drugs. I learned that the client is looking to be asked and to become more involved their health care.
- Patients appreciate the inquiry and understanding about their difficulty and efforts made to cope.
- There were underlying issues such as transportation and visual difficulties that became more apparent during assessment.
- Unexpected issues surface.
- Picking the right patient for care plan completion is tricky. It's not always related to the number of diagnoses. It's more related to coping behaviours and how well developed they are.
- Learned more about my patient.
- I was surprised at the end result! I thought the process would have ended with different goals.
- By the third care plan, much easier to facilitate.
- That the patient may have some emotional issues that she is not really ready to deal with.
- This program is about patient centred care.
- Great tool for building a trusting relationship with the patient.
- Patient is the main provider of information and changes can only be made through themselves.
- Importance of honouring the philosophy of client self-management. Important for client health as well as the healthcare system.
- That the patient does not have the same thinking that I do.
- That patients can be doing better than we think.
- I was very surprised when she expressed her "main concern". It very much shows that patient problems/concerns are not always related to their disease and how this model brings their issues to the forefront.
- It is also is very relevant how the patient really identifies their understanding of the disease and how "other aspects" impact the disease.
- How to improve communication with clients and assist them in self-managed care.
- By jointly creating goals, the client seems to better be able to put things in perspective.
- Using the Flinders makes me feel that I empowered the client to take ownership of his chronic condition.
- The client identified his need to begin counselling…. Very helpful to him.
- Better to have client accountable for his own health.
- My patient found the "negotiation piece" (scoring) most interesting.
- I learned that the Flinders care plan has some extremely challenging questions to ask a patient with an incurable and degenerating illness, especially at his young age.
- By deeper probing, one can identify with the patient one salient point or problem. This skill can be honed over time. Through repetition, the health practitioner can be better at coaching and perhaps directing and supporting the patient.
- The patient has vague ideas of the directions he would like to go but needs directions and coaching.
- I truly believe that the patient needs to be thoroughly involved and has to make decisions for himself about his care.
- The importance of allowing the patient time to reflect, and negotiating realistic goals.

- I learned that under the surface of diagnosis or disease issues, lies issues that may be more relevant to quality of life, such as for example socialization.
- I think we are on the right track in addressing what is important to the client versus what we as health professionals see as a concern.
- Patient stated she enjoyed the process.
- This can be difficult if the patient is not all that willing to participate fully as he doesn't really see a problem.
- Patients take much more ownership and pride in the goals set in Flinders versus traditional counselling/interview.
- Patients see that "preventive" action is directly related to meeting their goals.
- Patients surprise themselves with their answers in PIH and C&R.
- You see how the person "ticks", their values.
- Sometimes difficult to keep the person on track.
- I learned the importance of probing while interviewing – sometimes it may not be apparent on initial interview and scoring.
- How important it is to "hear" the patient and discuss their perception of the issues.
- Not to assume that I know what is important.
- Being supportive without being intrusive.
- How much more effective it is to follow a format that has a structure.
- Some clients need a bit of prodding to answer more fully.
- Try to probe deeper for answers.
- The interview process is definitely more in-depth and really draws the client into being an active partner in their health.
- We both discovered that he did not understand the relationship between CAD and hypertension/diabetes. It also brought out how committed he felt.
- Rather than focusing on weight loss we focused on her feelings and how to deal with them to help her cope and improve her daily life.
- This patient showed me how the care plan can be very useful and beneficial to both the patient and the healthcare professional.
- The care plan can actually bring out emotions or issues the patients have never thought about or realized.
- What he initially felt was a small issue, was actually a bigger issue than he thought (more important).
- I loved it! I just don't know how this can be done with my workload.
- Depression affects this client more than I realized.
- RD developed a better understanding of reasons for client's difficulty in past endeavours.
- A more systematic process to establish patient-centred goals/care plan.
- I learned that the real issues may not always be discussed if the appropriate questions aren't asked.
- I feel inspired!