



## Summary of key points

### Module Two: Care planning and coordination with the Flinders Program™

#### Section 1 - Care planning and coordination

- The Coordinated Veterans' Care (CVC) Program:
  - uses a proactive approach to improve the management of veterans' chronic diseases and quality of care
  - involves a care team of a general practitioner (GP) and a care coordinator who work with the veteran (and their carer if applicable) to manage their ongoing care
  - provides new payments to GPs for initial and ongoing care.
- GPs and nurse coordinators that complete this training package will receive points or hours to contribute to their continuing professional development (CPD) as required by Australian Health Practitioner Regulation Agency (AHPRA).
- GPs who are involved in the CVC Program are required to prepare for the program, enrol veterans in the program and provide ongoing care.
- The model of care for the CVC Program is based on the core team, which includes the veteran, the veteran's carer (if applicable), the GP and the care coordinator, who is a practice nurse, Aboriginal health worker or community nurse.
- The team uses care planning, coordination and review as the tools to focus on better management and self-management of the veterans' health and to incorporate the multidisciplinary team.
- The Flinders Chronic Condition Management Program™ (the Flinders Program™), enables clinicians and patients to undertake a structured process that allows for assessment of self-management behaviours, collaborative identification of problems and goal setting leading to the development of a collaborative Care Plan that incorporates self-management.
- The process of needs assessment may include the use of the Partners in Health Scale and Kessler 10.
- The CVC Program allows nurse coordinators to consolidate and build on their prior knowledge of care planning and introduces a way to assess and address self-management issues.
- While the practice and community nurse play different roles in the CVC Program, both need to utilise two-way communication skills and practice care coordination.

## Section 2 - Care planning process

- The Flinders Program™ is a set of generic tools and processes enabling clinicians and veterans to undertake a structured process that allows for assessment of self-management behaviours, collaborative identification of problems and goal setting, leading to the development of individualised Care Plans.
- The Partners in Health Scale measures the veteran's perception of their own self-management capacity. It contains 12 questions, covering the principles of self-management, and takes 5-10 minutes for the veteran to complete. It can be used to record progress over time.
- The Cue and Response Interview is a tool that allows GPs and health professionals to assess the self-management capacity of the veteran. It covers the same 12 questions as the Partners in Health Scale, but uses open-ended questions that enable issues to be further explored. Answers are scored. It highlights self-management issues that are then recorded on the Care Plan and provides an opportunity for the veteran to be heard.
- The Cue and Response Interview encourages the veteran to see that the health professional understands all of the factors that contribute to their chronic condition.
- The Kessler Psychological Distress Scale (K 10) is a simple measure of psychological distress. The K 10 scale comprises 10 questions about emotional state.
- When conducting an assessment in someone's home, there are many aspects that the practice nurse needs to take into account:
  - Issues of confidentiality and consent
  - General observations about the home
  - Issues around professional conduct
  - The business process
  - Occupational Health & Safety / Workplace Health & Safety.
- Becoming accomplished in interviewing techniques will enable you to work more effectively with veterans using the Flinders Program™ tools.
- The Problem and Goals Statements are motivational tools that focus on the biggest problem for the veteran, as they see it, and what steps they can make towards minimising this problem.
- S.M.A.R.T. goals are specific, measurable, action-based, and realistic and have timeframes applied to them. Goal Statements should be written in the first person by the veteran.
- The Flinders Program™ Care Plan identifies health care needs, goals and effective interventions. It is vital for communication and is informed by evidence-based guidelines. It includes planned services and medication lists.

### **Section 3 - Identifying and arranging access to interventions**

- When arranging interventions arising from the Care Plan, give veterans all the options and allow them to decide their next step
- If you try to force the veteran to do what you want they may agree during the consultation, but chances are they won't follow up.
- Use active listening skills to determine each veteran's learning style. This allows you to target interventions from which the veteran will get the most benefit.
- The Symptom Action Plan, Symptom Monitoring Diary and Visit Checklist are tools to assist veterans to self-manage and become more actively involved in managing their health as well as the plan for clinical signs that require immediate action.
- It is necessary to employ inter-professional, multi-agency and multi-disciplinary team work in the development of care planning and coordination for veterans with chronic conditions.
- The VAK (Visual, Auditory, Kinaesthetic) learning model describes learning styles as visual, auditory, kinaesthetic and combination.

### **Section 4 - Ongoing coordination, coaching and monitoring**

- An important part of the nurse coordinator's role is facilitating medication management and referring to appropriate services such as a pharmacist.
- Nurse coordinators need to regularly review the effectiveness of the veteran's Care Plan and assist the veteran with problem solving issues that arise from it.
- Coaching and assisting veterans with their self-management goals can be accomplished using strategies such as Motivational Interviewing and Structured Problem Solving.
- An essential part of the CVC Program is communication between health professionals, which can be established in a number of ways.
- The nurse coordinator must regularly be in contact with the veteran and must provide feedback to the GP in regards to the veteran's conditions and concerns.
- Health professionals need to be aware that their beliefs, values and culture may differ from those of the veteran and should recognise the influence this may have on their provision of care.