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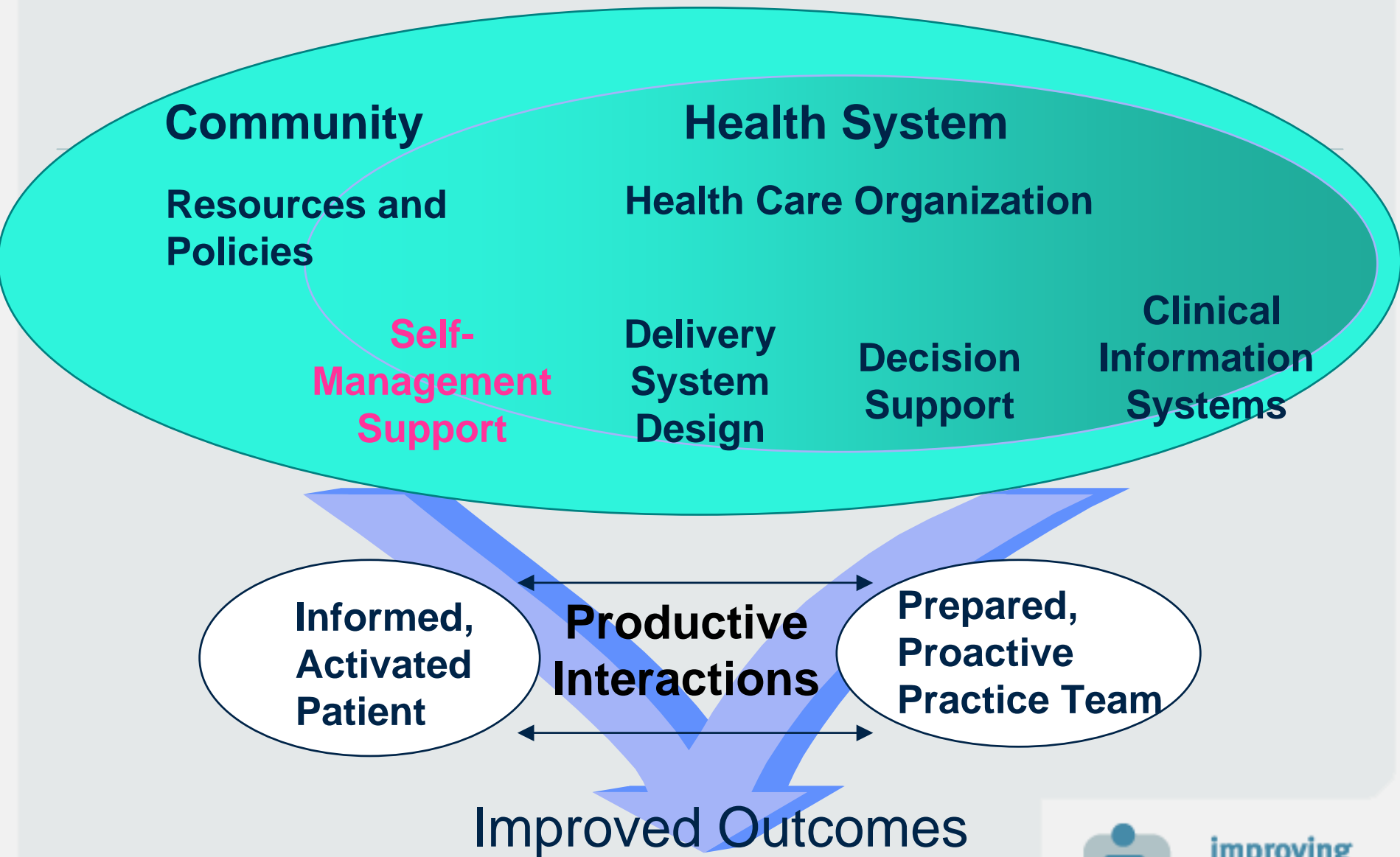
Supporting Self- management with the 5 A's

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Care Model



Self-Management Support

- Emphasize the patient's central role in managing their illness
- Use effective self-management support strategies that include assessment, goal-setting, action planning, problem-solving and follow-up.
- Organize internal and community resources to provide ongoing self-management support to patients.

What is self-management?

“The individual’s ability to manage the symptoms, treatment, physical and social consequences and lifestyle changes inherent in living with a chronic condition.”

Barlow et al, Patient Educ Couns 2002;48:177



What is self-management support?

Making and refining the health care system to facilitate patient self-management. This includes at the level of patient-provider, patient-health care team, patient-health care system and the community.

Glasgow et al, 2003



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SMS needs vary across the spectrum of health care targets

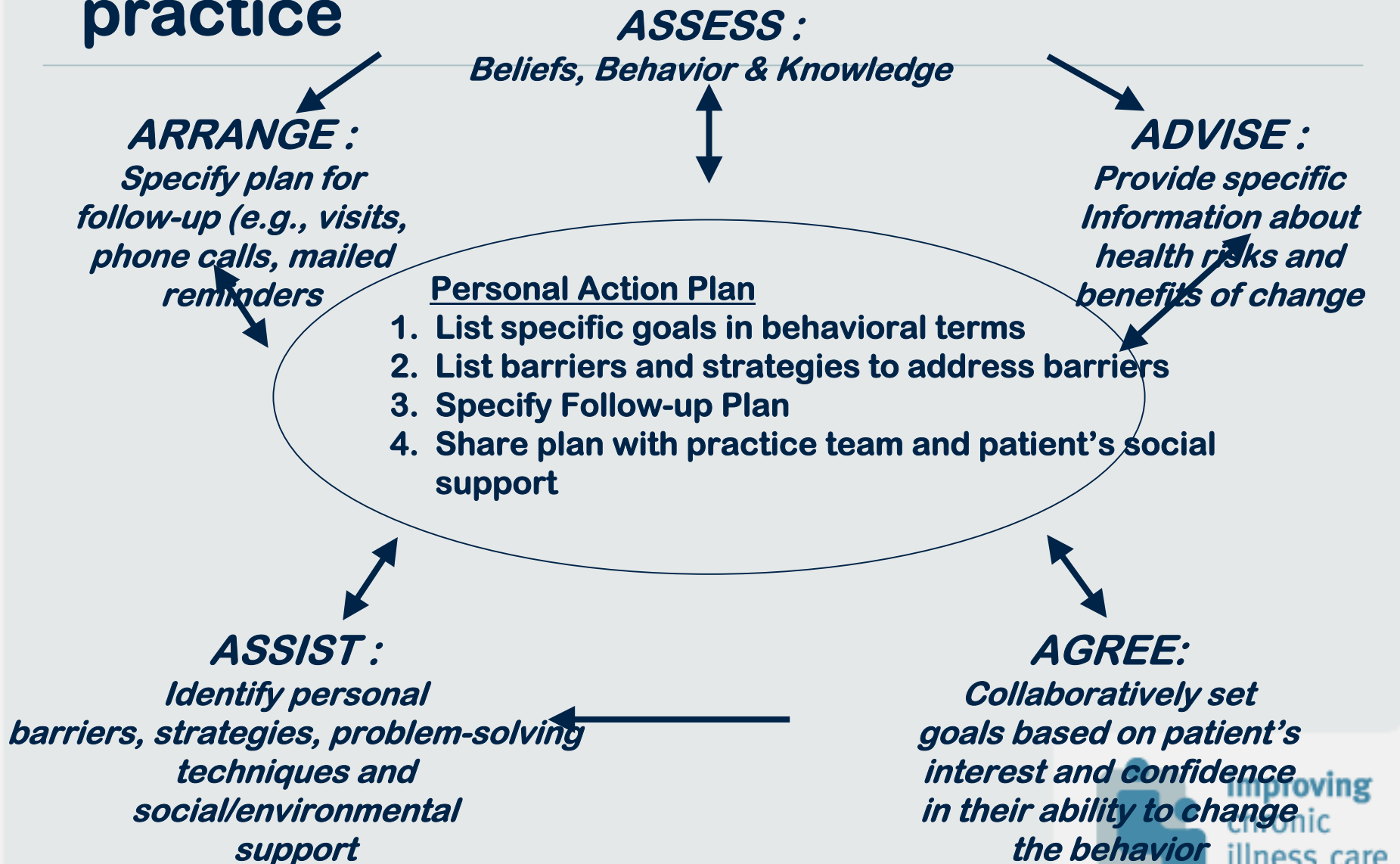


↑ **Doing a food diary**

↑ **Routine exercise**

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Self-management support in office practice



ASSESS

Risk factors, Beliefs, Behavior and
Knowledge

Standardizing Assessment

- Knowledge
- Skills
- Confidence
- Importance
- Supports
- Barriers
- Risk Factors

Tips on assessing patients

- Use brief standardized assessments
- Provide feedback to patient and care team
- Assess patient's view of progress and how choices relate to goals

Assessing Conviction

“How convinced are you that it is important to have a mammogram at least every other year?”

Not at all
convinced

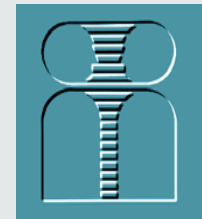
0 1 2 3 4 5 6 7 8 9 10

Totally
convinced

“What makes you say 4?”

“Why 4 and not zero?”

“What would it take to move it to a 6?”



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(From Keller and White, 1997; Rollnick, Mason and Butler, 1999)

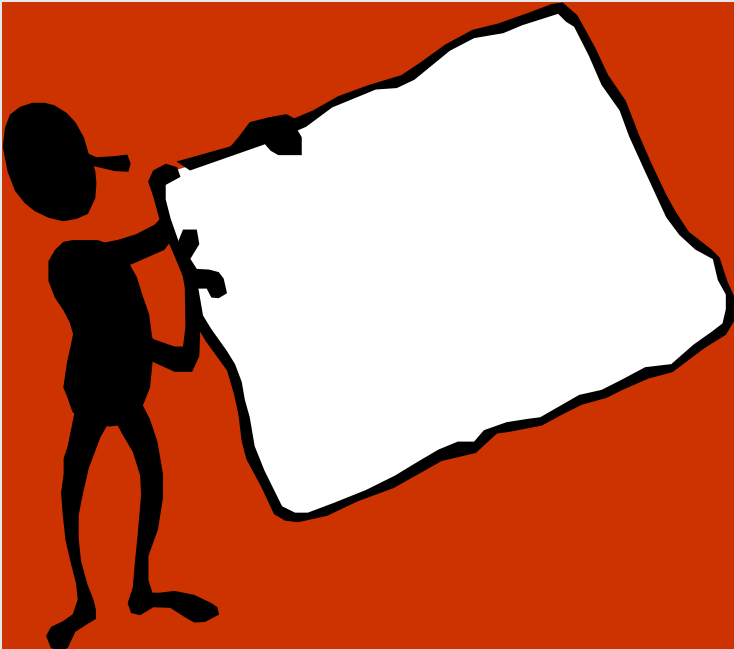
Helpful phrases during assess

- “What’s the biggest worry you have right now?”
- “Tell me what you hoped to get out of the visit today.”
- “I know about screening and diagnosing illness but you know yourself best. What should I know about how you...” (make decisions, like to get information)

ADVISE

Provide specific personalized information about health risks and benefits of change

Advise - Give information



Ask Permission

Ask understanding

Tell

Ask understanding



Tips on providing advice

- Make the source of advice clear (medical knowledge or from similar patients)
- Personalize lab values, health status and how choices affect outcomes
- Provide patient-determined level of information to make decisions

Tips on providing advice (cont.)

- Tailor information to person and their environment
- Listen more than you talk
- Have a key message for each condition or symptom

Helpful phrases during advise

- “What do you think caused....?”
- “Can you tell me more about...?”
- “What do you know about...?”
- “If I understand you correctly...”

More helpful phrases for advise

- “I think you have.....”
- “May I tell you more about....”
- “Can you review for me what we just discussed so I know that I made it understandable?”

AGREE

Collaboratively select goals and treatment methods based on patient's interest and confidence in their ability to change the behavior

Tips to create agreement

- Base goals on patient priorities
- Goals are something to achieve in 3-6 months
- Plans are specific steps to help achieve goals
- Plans must be behavior-specific

Helpful phrases for agree

- “Is there something you have been thinking about that you would like to do to improve your health?”
- “We’ve been talking about several things. Which one is most important to you right now?”
- “Where would you like to be with _____ 6 months from now?”

ASSIST

Using behavior change techniques (self-help, counseling, etc.) aid the patient in achieving agreed-upon goals by acquiring skills, confidence, and developing social/environmental supports.

Personal Action Plan

1. Something you WANT to do

2. Describe

How

Where

What

Frequency

When

3. Barriers

4. Plans to overcome barriers

5. Confidence rating (1-10)

6. Follow-Up plan

Lorig et al, 2001



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Problem Solving

1. Identify the problem.
2. List all possible solutions.
3. Pick one.
4. Try it for 2 weeks.
5. If it doesn't work, try another.
6. If that doesn't work, find a resource for ideas.
7. If that doesn't work, accept that the problem may not be solvable now.

Lorig et al, 2001



Helpful phrases for assist

- “Goals are large and typically achieved over several months. What is a first step you could take towards your goal of ____?”
- “Most of the people I work with have problems with _____. What problems are you having?”

ARRANGE

Schedule follow-up contacts to provide ongoing assistance and support to adjust the plan as needed, including referral to more intensive treatment

Tips for follow-up

- Try a wide variety of methods, whichever patient prefers (in person, phone, email)
- Make sure follow-up happens, patient trust can be destroyed by missed follow-up
- Use outreach and community opportunities

ASSIST

No success with plan

- What got in the way?
- Has goal changed?
- Problem-solve
- Keep in touch
- Referral to an expert

Helpful phrases for Follow-up

- “I’m calling today to follow-up on the plan you made to _____. How is it going?”
- “What is your next step?”

Using Stages of Change

With the 5 A's

Not ready to change: precontemplation

Assess, Advise,
Arrange

- Raise awareness
- Provide personalized information
- Indicate readiness to help
- Be aware of emotional issues
- Tickler file to follow-up in future

Contemplation (thinking about changing)

Assess, Advise &
Arrange

- Increase confidence in patient's ability to change
- Identify benefits of change
- Encourage support networks
- Tickler file to follow-up on next contact

Ready to Change: Preparation and Action

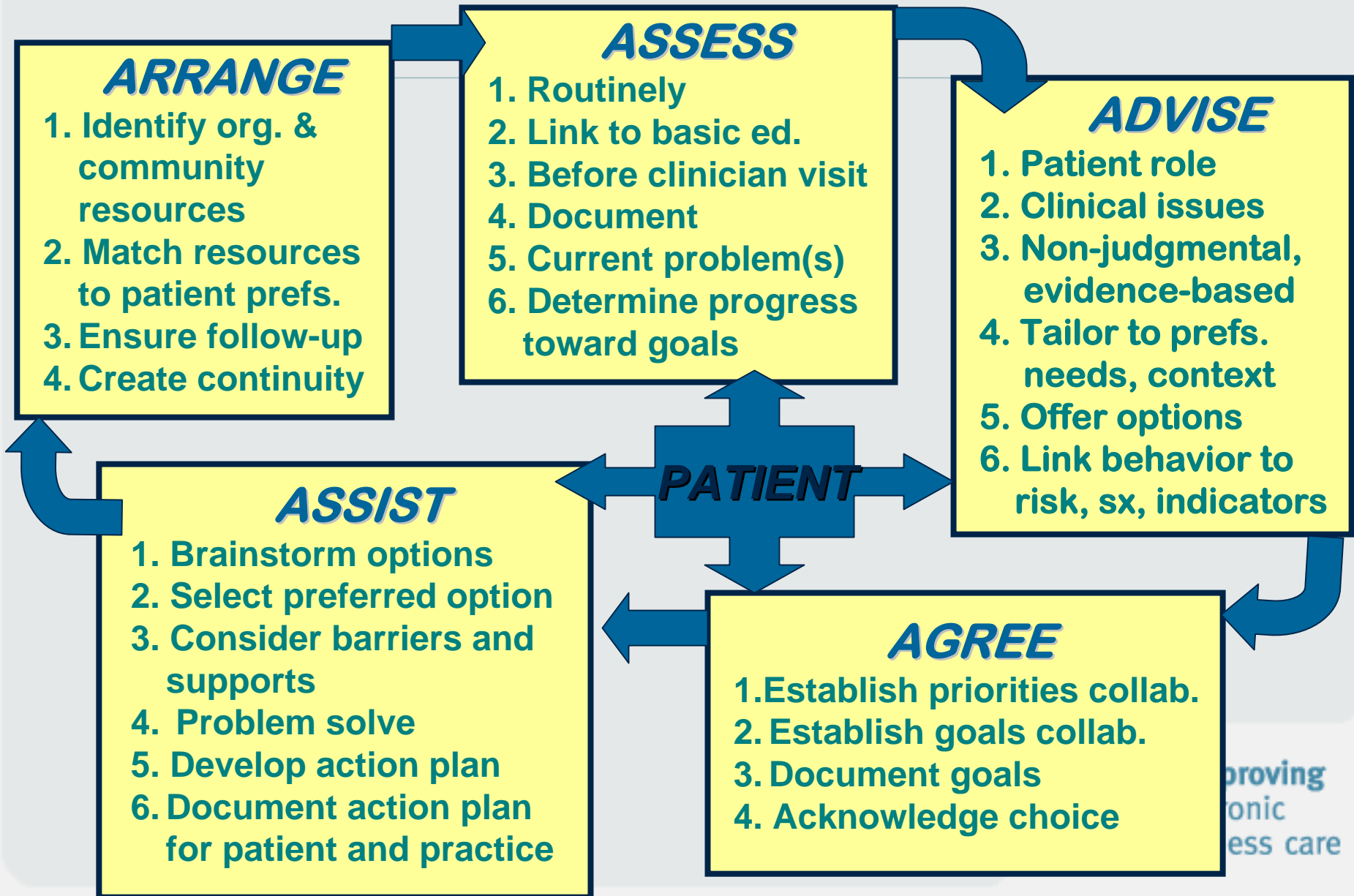
All 5 A's

- Resolve ambivalence
- Develop action plan
- Identify & reward small steps
- Problem-solve barriers
- Identify support
- Do follow-up



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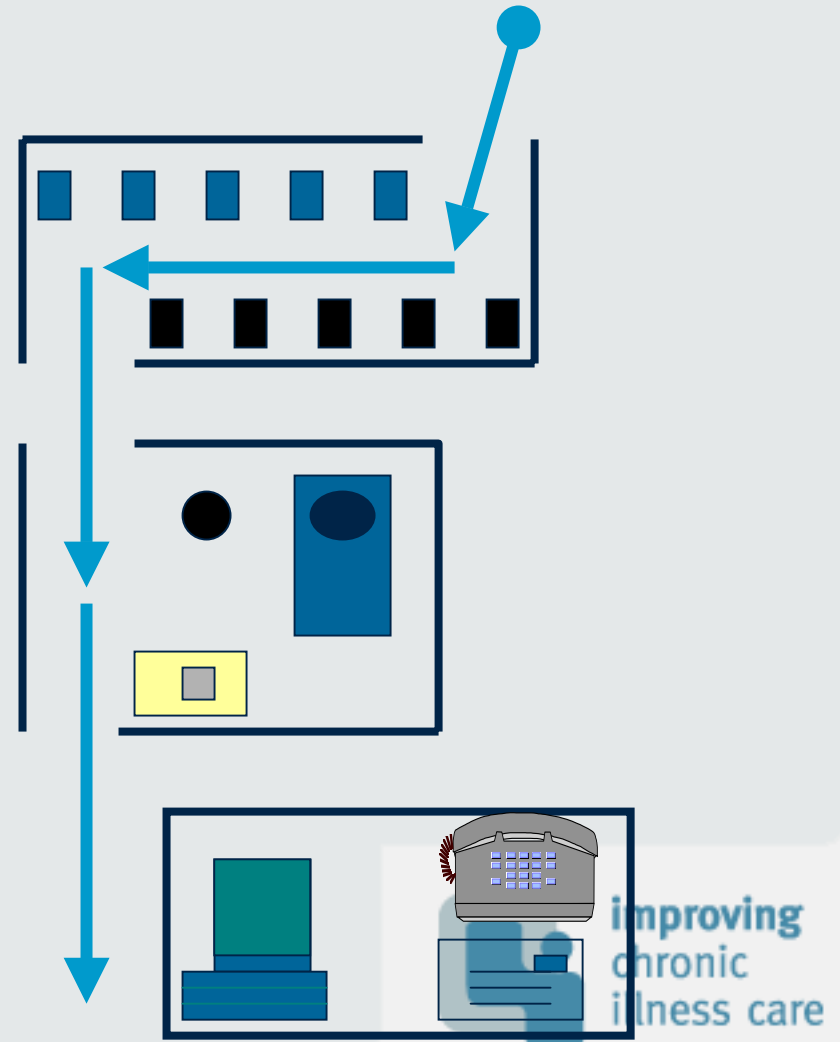
5 As Delivery Model



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Opportunities for SMS

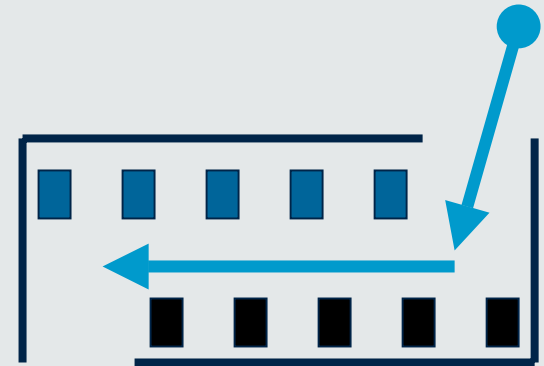
- Before the Encounter
- During the Encounter
- After the Encounter



Opportunities for SMS

Before the Encounter

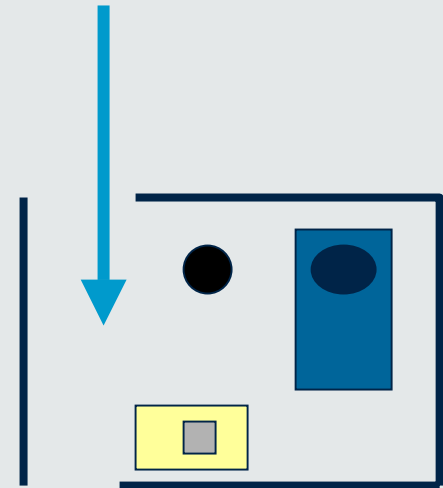
- Waiting room assessment
- Patient education material
- Posters
- Pamphlets on “Talking to your provider”



Opportunities for SMS

During the Encounter

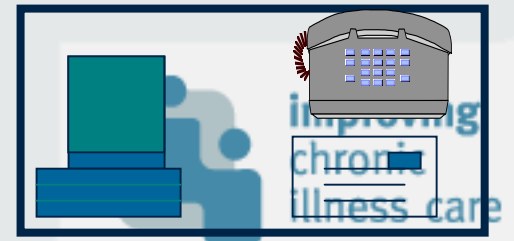
- Review assessments
- Feedback on achievements vs. goals
- Identifies priorities for visit
- Use motivational skills
- Targeted patient educ. materials
- Referral for more SMS



Opportunities for SMS

After the Encounter

- Referrals (Health Education, etc)
- Further use of MI skills
- Phone calls follow-up
- Mailed patient education
- Peer support
- Newsletters
- Follow-up visits



Who can do this?

- Natural helpers
- Trained peers
- Health educators
- Nurses
- Physicians
- Any caring person...

Resources

- Book: Rollnick et al “Health Behavior Change” 1999.
- Bibliography on self-management:
www.improvingchroniccare.org

Web resources

- www.bayerinstitute.com provides provider training in “Choices and Changes”
- www.motivationalinterview.org has books, videos and training
- www.stanford.edu/group/perc home of Chronic Disease Self-Management Program

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