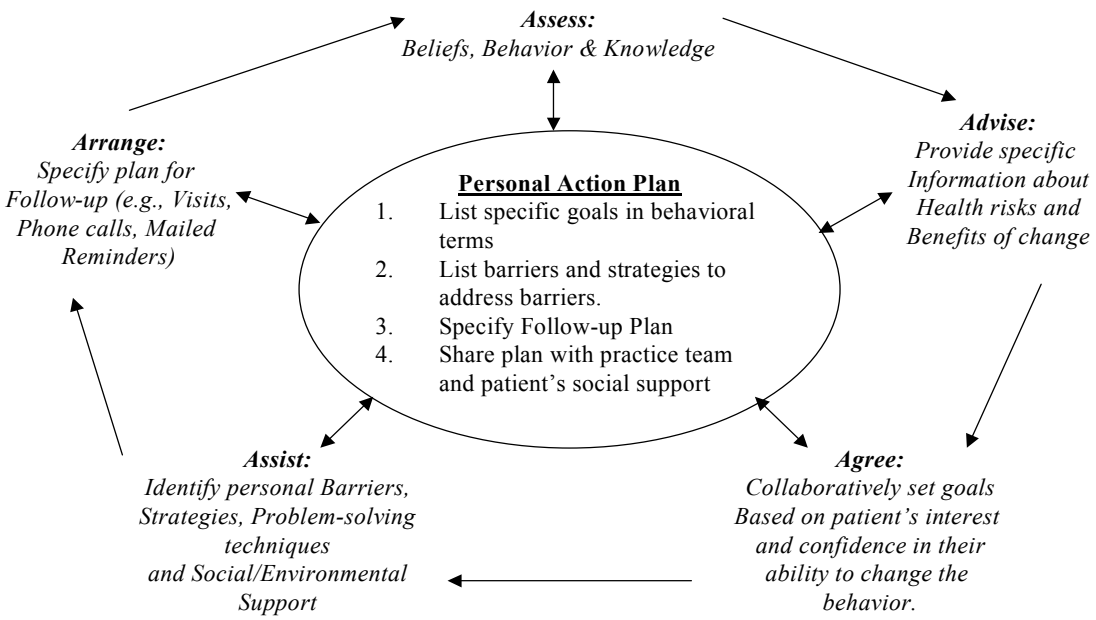
5 A's Behavior Change Model
Adapted for Self-Management Support Improvement

Self-Management Model with 5 A's (Glasgow, et al, 2002; Whitlock, et al, 2002)



Improvement Goal: All chronic illness patients will have a Self-Management (SM) Action Plan informed by and including all the 5 A's elements (Assess, Advise, Agree, Assist, Arrange). The 5 A's Behavior Change Model is intended for use with the Improving Chronic Illness Care Chronic Care Model (CCM).

Ideas are for teams to test in their own setting. Add to this list as you experiment with PDSA cycles and hear about strategies that have worked well for other teams.

Five A's Change Concept	**Patient Level (patient-provider interaction)**	**Office Environment (standard operating procedure)**	**Community/Policy (community org. and both internal system and external community policy)**
Assess <u>CCM element</u>: Have patient periodically complete valid health behavior surveys and provide them with feedback.	- Try brief behavior survey in a) waiting room, b) on computer. - Assess patient knowledge about their chronic condition. - Ask patient, "what about Self-Management (SM) is most important to talk about today?" - Ask patient, "what are your most challenging barriers?", recognizing physical, social and economic barriers. - Provide patient with personalized feedback and results. - Assess conviction and confidence regarding target behaviors.	- Select or develop HRA survey. - Employ conviction and confidence rulers. - Revise self-care surveys to make appropriate. - Add fields to the medical record to record behavior status for smoking; weight, exercise. -Add behaviors to the problem list for patient. - Prompt staff to collect or update key behaviors status at each visit. - Have computer in waiting room for HRA assessment with print outs for providers and/or patients. - Employ outreach and population-based approach to assess all patients across multiple chronic illnesses. -Pilot approaches to providing feedback to patients--check for understanding.	<u>Community:</u> - Conduct needs assessment in partnership with community groups (eg. include formative eval with potential users and non-users, small-scale recruitment studies to enhance methods.) - Work on state health dept or other coalition to develop community health behavior survey or assess barriers to change. - Share data on BRFSS items or other behaviors with other organizations. <u>Internal system policy</u> - Employ longitudinal patient assessment system (eg. using interactive computer technology). - Make screening on all 4 health behaviors a vital sign; and require reporting on all patients at some frequency.

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Advise <u>CCM element:</u> Provide personally relevant, specific recommendations for behavior change.	- Relate patient symptoms or lab results to their behavior, recognizing patient's culture or personal illness model. - Inform patient that behavioral issues are as important as taking medications. - Provide specific, documented behavior change advice in the form of a prescription. -Share evidence-based guidelines with patients to encourage their participation.	- Develop list of benefits of behavior change/risk reduction. - Develop list of common symptoms that exercise, losing weight or stopping smoking can improve. - Arrange prompt system to remind physicians to advise behavior change. - Provide prompt to have physician advise on importance of calling if any trouble taking medication as prescribed.	<u>Internal system policy:</u> - Reinforce/ Recognize/ Reward staff for documented advice to change behavior. <u>External policy:</u> -Recommend or lobby purchasers, health plan, and government to reimburse 5 A's/SM Action Planning.

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Agree <u>CCM element:</u> Use shared decision-making strategies that include collaborative goal setting.	- Have patient develop specific, measurable, feasible SM goal for behavior change. - Provide options and choices among possible SM goals. - Do above with input from family or spouse, and with support/assistance from caregiver. -Share perspectives with patient on what is most important short -term goal--agree on a specific target. - Present evidence on benefits and harms to patient and let them decide on course.	- Make sure patient SM goals are in chart and all team members refer to them. - Provide staff with training in patient-centered counseling or empowerment training, which may include videos on motivational interviewing or goal setting. - Have in-service from expert on shared decision making. - Incorporate videos on patient role or choice into practice, and have patients see prior to consultation. - Develop multi-modal intervention to promote practice change rather than one utilizing single strategy. .	<u>Community</u> -Meet with organizations to identify agreed upon self-management support (patient education) priorities for coming year. <u>Internal system policy:</u> - Create field or permanent space in medical record for behavioral goals. - Develop assessment method to determine that goals were set in a collaborative fashion. - Require peer observation and feedback on real or simulated patients at a minimum of every 4 months. <u>External policy:</u> - Require or reimburse documentation of collaboratively set goals in medical records. - Recognize providers who have completed training in motivational interviewing; Bayer course on collaboration; etc.

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Assist <u>CCM element</u>: Use effective self-management support strategies that include action planning and problem solving. Help patients create specific strategies to address issues of concern to them.	- Help patient develop strategies to address barriers to change (write on Action Plan form). -Implement patient discussion of SM Action Plan a) during PCP visit, b) immediately before or after with nurse. -Refer patient to evidence based education or behavioral counseling--individual or group. -Elicit patient's views and plans regarding potential resources and support within family and community. - Use planned interactions to support evidence-based care. -Give care that patients understand and that fits with their cultural background. - during follow-up visits, review progress, experience, concerns; renegotiate goals and revise action plan.	- Select/develop SM Action Plan form. - Adapt SM Action Plan for your setting, specifically focusing on the 4 s' (size, scope, scalability and sustainability) in planning any office restructuring. -Develop specific plan to enhance SM resources--by addressing the REAIM dimensions--to make sure you are addressing all key issues for panel wide or community impact. - Make sure blank action plan forms are in each exam room.	<u>Community:</u> - Work with community groups and referrals to develop Action Plans and communication avenues. -Get list of your patients who have used resources--get their feedback. <u>Internal system policy:</u> - Compile list of recommended quality resources that can be shared with staff and patients. -Evaluate adverse outcomes and quality of life for program revision and cost-benefit analysis. -Recognize/reward teams that have higher levels of documented action plans. <u>External policy:</u> -Add behavior change counseling to HEDIS criteria for each behavior for adult patients who receive such counseling. -Also, make problem-solving, shared decision-making, or approved SM support programs a HEDIS criteria.

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Arrange <u>CCM elements:</u> Follow-up on action plans. Follow-up on referrals. Establish two-way communication and partner with community groups to improve services and linkages.	- Give patient copy of SM Action Plan. - Follow-up call to patient within a week after visit as "booster shot" for SM Action Plan. - E-mail follow-up or brief letter restating plan and inviting questions. - Arrange for patient to contact specific community resources that could support their goals. - Follow-up with goals set in action plan at each non-acute visit.	-Develop collaborative process that can facilitate communications and support with other practices. -Develop follow-up checklist/prompt to make sure follow-up is provided. -Include blank on action plan form for follow-up date.	<u>Community:</u> - Invite community program representatives to present at patient group visit, diabetes class, or health fair. - Follow-up with community programs to see how many patients attended and to get information on their progress. <u>Internal system policy</u>: - Employ longitudinal patient monitoring and feedback systems related to their SM goals. - Provide time or incentives for follow-up contacts. <u>External policy:</u> -Recognize/Reward social and economic environment in which these health systems interventions occur. -Reimburse follow-up phone calls, e-mail contacts, etc., outside of face-to-face visit.