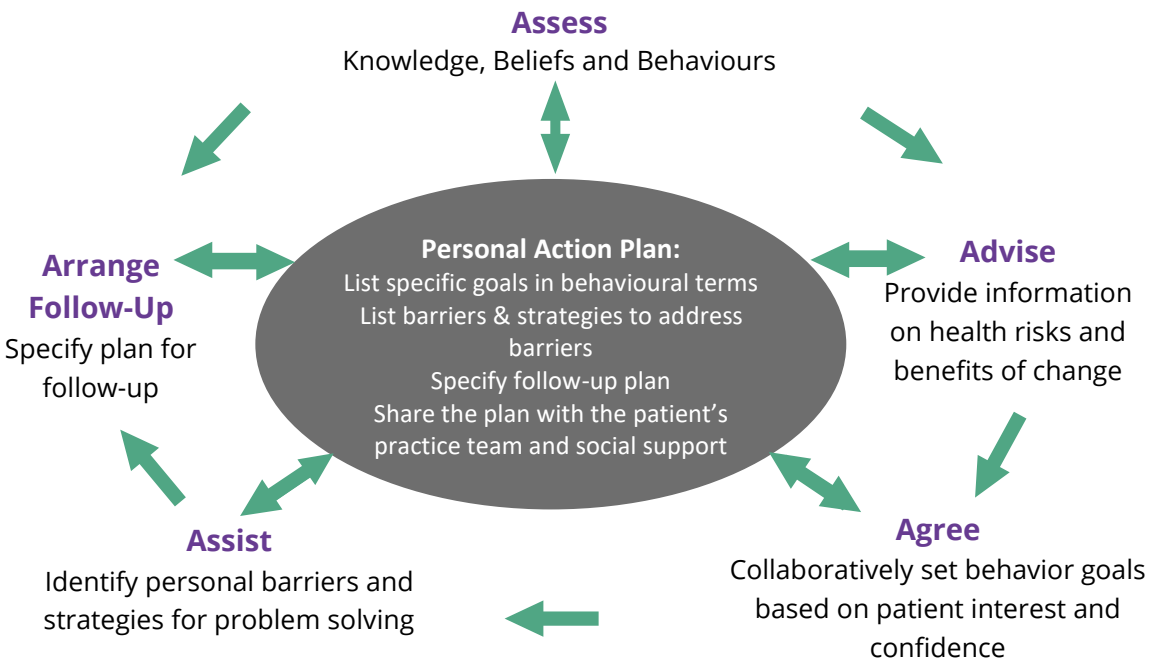
Hypertension Management Program
The 5As Provider Intervention Tool for Patient Self-Management Support in Chronic Care



This approach facilitates partnering with the patient to achieve improved management of the patient's chronic condition through:

- Problem identification
- Setting a goal
- Developing an action plan with a confidence level
- Reporting back on the plan
- Problem solving to move forward

The steps in the self-management process are not necessarily linear; each step does not necessarily follow the other sequentially. When you are seeing a new patient, or working with a current patient on a new area of behaviour change, you will probably use the self-management process sequentially, starting with "Assess" and moving clockwise around the circle. In a follow-up session, the self-management session may go counter-clockwise if the goal is not met. In this situation you would assist the patient to problem solve on how to reach the goal, and may revise the goal ("Agree") and then arrange follow-up. The self-management process is captured in the patient's personal action plan which aids in supporting the patient as they work towards their goal and is used for the review at the time of follow-up.

To be successful in supporting patient self-management, the healthcare provider must:

- Give up the agenda
- Let the patient feel in control of some aspect of self-care he/she can control
- Help the patient feel success

Furthermore, healthcare provider support for patient self-management is dependent on the healthcare provider:

1. Having a relationship with the patient
2. Maintaining continuity of care for the patient; seeing the patient on a consistent basis
3. Finding an opening to the patient, that portal of openness, concern, and real need that allows the partnership and the support to occur
4. Letting the patient guide the process, take control
5. Tailoring the advice, making the advice relevant to the patient
6. Collaborating with the patient to identify and agree on a patient-identified goal
7. Supporting the development of behavioural goals that are realistic, specific and measurable for the patient
8. Helping the patient develop self-efficacy through the setting and meeting of small goals that build self-confidence and the feeling of some ability to manage his/her condition
9. Assisting the patient in problem solving for goal success
10. Showing that the behaviour change is important to both of you by writing it down and following it up

Reference sources:

Adapted from "*Self-Management and Self-Management Support*", Dr. Chris Rauscher http://www.impactbc.ca/ files/documents/selfmanagement_designtemplate.pdf

Glasgow, R. et al. "*Self-management aspects of the improving chronic illness care breakthrough series: Implementation with diabetes and heart failure teams*." Ann Behav Med 2002;24(2):80-87