National RN Case Manager Certificate Program
Health Behavior Change

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, or in the ability to make choices to maintain health."

Self- Management Tasks in Chronic Illness (Corbin & Straus):

- To understand the physical illness and management of symptoms and pain
- To maintain roles and relationships
- To carry out routine and self-care activities
- To manage emotional changes

Self-Management Support = Health Behavior Change

5 As Framework – Evidence Based Strategy for Supporting Self-Management/Health Behavior Change in Practice

5 As		Modified 5 As	
		ASK	Ask permission to discuss the health problem; explore readiness for change
ASSESS	Beliefs, behaviors and knowledge of the health problem; confidence and importance	**ASSESS**	Objective data (i.e. lab/diagnostic test results, severity of chronic illness); explore drivers (confidence and importance); complications of the health problem
ADVISE	Provide specific information about health risks and benefits of change	**ADVISE**	On health risks of the chronic illness, benefits of health behavior change, need for long term health strategy and treatment options
AGREE	Collaboratively set goals based on patient's interest and confidence in their ability to change behavior	**AGREE**	On realistic expectations and targets, behavioral changes using the SMART* framework and specific details of the treatment options
ASSIST	Identify personal barriers, strategies and problem-solving techniques and social/environmental support	**ASSIST**	In identifying and addressing barriers; provide resources and assist in identifying and consulting with appropriate providers; arrange regular follow up
ARRANGE	Specify plans for follow up (e.g. visits, phone calls, secured messaging, mailed reminders)	**ARRANGE**	Specify plans for follow up (e.g. visits, phone calls, secured messaging, mailed reminders)

***SMART:** **S**pecific, **M**easurable, **A**chievable, **R**elevant, **T**imely

Application of the Chronic Illness Model in Practice Using the Modified 5 As to Obesity

	"A" Definition	Rationale
ASK	Ask permission to discuss weight; be non-judgmental; explore readiness for change	Weight is a sensitive issues; avoid verbal cues that imply judgement; indication of readiness might predict outcomes
ASSESS	Assess BMI, WC, obesity stage; explore drivers and complications of excess weight	BMI alone should never serve as an indicator for obesity interventions; obesity is a complex and heterogeneous disorder with multiple causes – drivers and complications of obesity will vary among individuals
ADVISE	Advise on health risks of obesity, benefits of modest weight loss, the need for a long-term strategy and treatment options	Health risks of excess weight can vary; avoidance of weight gain or modest weight loss can have health benefits; considerations of treatment options should account for risks
AGREE	Agree on realistic weight loss expectations and targets, behavioral changes using the SMART framework and specific details of the treatment options	Most patients and many providers have unrealistic expectations; interventions should focus on changing behavior; providers should seek patients "buy in" to proposed treatment
ASSIST	Assist in identifying and addressing barriers; provider resources and assist in identifying and consulting with appropriate providers; arrange regular follow-up	Most patients have substantial barriers to weight management; patients are confused and cannot distinguish credible and non-credible sources of information; follow-up is an essential principle of chronic disease management

BMI – Body Mass Index; WC – waist circumference

SMART – Specific, Measurable, Achievable, Relevant, Timely

Source: Vallis, M. et al (2013) – Clinical Review: Modified 5 As – Minimal intervention for obesity counseling in primary care. *Canadian Family Physician,* 59:27-31.