



Self-Management

Key Points

- 1) Chronic diseases require new responsibilities for patients and physicians

Patients have many new behaviors that they must consider adopting. Physicians are no longer in control but must share in a treatment/disease management partnership with patients. Optimal disease management requires support of patients in self-care.

- 2) Chronic disease self-management provides the patient and health care team with strategies to improve the patient's knowledge, skills and confidence in chronic disease care

Self-management support is what health care providers do to assist and encourage patients to become good self-managers.

- 3) The five A's guide providers in assisting patients in behavior change

The five A's include Assessing the patient's interest in behavior change, Advising about the disease or about the intended action plan, Agreeing on an action plan, Assisting the patient in strategies and skills and Arranging follow-up to see how the plan is going.

- 4) Action plans (goals) and steps (subgoals) must be specific and achievable

Goals should be specific and realistic. Short-term subgoals make the reward of success come sooner. Action plans are more likely to be successful if the patient is confident that the agreed upon goal can be achieved.

- 5) Action steps are most effective when supplemented with follow-up

Arrange follow-up for the action plan agreed by you and the patient. This follow-up can be made by you, other clinical staff, or by fellow patients. Follow-up provides an accountability mechanism for action plans and increases their likelihood for success.