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Cincinnati Children's Hospital Medical Center

Evidence-based care Guideline Highlights

Chronic Care: Self-Management

Focus Population: Children with chronic conditions and their families.

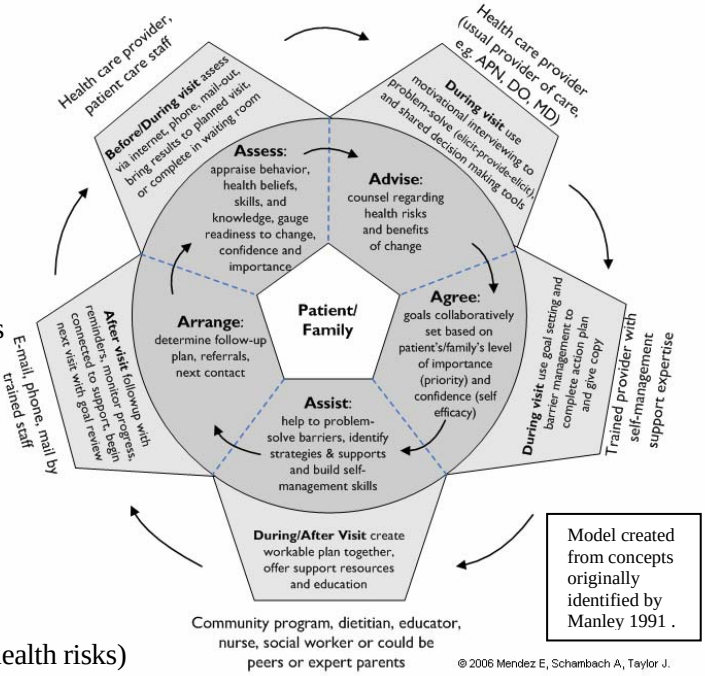
Goal: Through promoting self-management, achieve optimal health status and quality of life.

Recommendations

FOUNDATIONAL CARE PRINCIPLES

1. Include components of comprehensive chronic care management
   - self-management in the home/community
   - case/care management
   - disease management
2. Use a collaborative style of communication that promotes patient/family-centered care
3. Provide care grounded in cultural competence
4. Staff should be trained in self-management strategies

Model of 5 A's Cycle to Integrate Self-Management Into Patient Care



Model created from concepts originally identified by Manley 1991 .

THE 5 A'S CYCLE

Using the following tools / strategies:

5. ***Assess***
   - comprehensive assessments (upon initial diagnosis or early in care management) and reassessments, using validated tools when available, to evaluate: health related quality of life, disease manifestation, knowledge of disease, treatment plan, & prognosis, family functioning, social/environmental context (health risks)
   - document assessments of the following self-management capabilities: health beliefs, motivation, and
   - use a visual numeric scale to measure and document readiness to change, confidence and importance
6. ***Advise/Counsel***
   - use motivational interviewing to counsel patients/families on health behavior change
   - the "elicit-provide-elicit" method is a technique to structure the counseling process during a brief office visit
   - use shared decision-making and decision aid tools regarding intervention options
7. ***Agree***
   - use written action plans to assist patients/families in planning for behavioral change, customizing them to address: needs, patient characteristics, developmental level of the child, patient preferences, and available resources
8. ***Assist***
   - stratify the intensity of self-management interventions based on individual patient/family needs and risks
   - customize self-management education and skill-building using the following principles:
     - o design to match the developmentally appropriate level
     - o recognize that patient education alone is not to be relied on by itself to promote healthy behavior
     - o include tailored education based on individual patient/family needs, risks, and readiness to change
     - o group-based education sessions with patients / families experiencing same condition or different chronic conditions
     - o include a variety of community settings
     - o involve peers (parents, patients, or lay experts) in the delivery of self-management education programs
   - use computer-based information packages and systematic mailings
   - empower "experienced" patients/families to help provide family-to-family support
   - use other self-management support interventions:
     - o self-monitoring (diaries, journals)
     - o written action plan includes: goal-setting and barrier identification/management
     - o collaborative problem-solving
     - o regular practitioner review/follow-up
   - use any of the following techniques: family therapy, stress management, coping skills training, relaxation, cognitive behavioral therapy, and behavioral incentives
9. ***Arrange***
   - use, on a regular basis, structured reassessments along with other self-management interventions

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