**Literature Review: Assisting Older People with Chronic Conditions through Self-Management Support**

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Nurses and other health professionals can support older people with a chronic disease by employing self-management support programs and techniques. Current evidence suggests that patients with effective self-management skills make better use of health professionals’ time, have enhanced self-care skills and improved quality of life. There are a number of self-management programs that are offered in community health settings in Australia, in particular the Stanford University and Flinders University programs. Lack of engagement and referral by GPs are cited as common barriers to effective self-management, and questions have recently arisen about the efficacy of such programs.

Lawn & Schoo (2010) and Gallagher et al (2008) outline the difference between acute and chronic care. While acute care is often episodic, with a focus on cure, chronic care is ongoing, and there may be no cure for the condition (Lawn & Schoo 2010). In acute care, the person’s quality of life depends on the short term care given by the health professional. Quality of life for people with chronic conditions is dependent on the person’s ability to self-manage their condition, and although compliance to health advice is expected, results can be variable (Gallagher et al. 2008). The person often has more knowledge of their condition than the health professional, and their care may be coordinated in a team-based arrangement (Lawn & Schoo 2010). Older people may present with comorbidities even in the acute setting, and an understanding of chronic care and self-management support and techniques will aid health professionals to assist them to keep healthy (Gallagher et al. 2008).

Self-management interventions and support aim to develop a person’s self-efficacy (Coleman et al. 2009). Self-management involves the individual with a chronic condition working in partnership with their carers and health professionals so that they can negotiate a plan of care and review or monitor the plan (Lake & Staiger 2010). The health professional assists the person to engage in activities that protect and promote health, and aid the person to monitor and manage the symptoms and signs of their condition (Coleman et al. 2009). The person becomes equipped to
be able to confidently deal with all that a chronic condition entails, including symptoms and treatment and their physical, mental, emotional and social consequences (Lake & Staiger 2010).

Self-management support interventions can be brief, such as a quick discussion with a person while they’re in the emergency department, or they can be a long term commitment, such as 1-2 years of health coaching, with visits reducing in frequency (Lake & Staiger 2010; Lawn & Schoo 2010).

While a Cochrane systematic review conducted in 2007 concluded that “supported self-management”, that is, a combination of self-management training and ongoing support, shows benefit for people with COPD, a recent randomised controlled trial conducted on COPD patients in Glasgow, Scotland, concluded that participation in a self-management support program had not effect on either time to first readmission to hospital or mortality (Effing et al. 2007; Bucknall et al. 2012). While there remains some contention about the effectiveness of self-management support programs, an increasing amount of evidence is now contextualising self-management support programs and investigating beyond the economic benefits into temporal and environmental dimensions (Lawn & Schoo 2010; Sonntag et al. 2011).

The Stanford University School of Medicine Chronic Disease Self-Management program, also known as ‘Lorig’ (after its founder) or ‘Better Health Self-Management’ program, developed by Stanford University, is a six week group program of weekly 2½ hour sessions led by a trained health professional leader and a peer co-leader (Lawn & Schoo 2010). People with different conditions can complete the same generic programs, and they are encouraged to attend with a carer or family members. The Better Health Self-management program has a strong research base, indicating that participants experience reduced hospital stays, improved health status and increased healthy behaviours. Lake & Staiger (2010) argue that group-based sessions are more beneficial than one-on-one sessions, as the presenter can cover a topic comprehensively over a couple of hours, rather than squeezing the information into a 20-minute appointment. The group environment also encourages peer support (Lawn & Schoo 2010).

The Flinders Model of Chronic Condition Self-Management is a one–on–one model developed by Flinders University (Lawn & Schoo 2010). It consists of a generic set of processes and tools where the interventions and actions in the care plan are personalised to the identified needs and priorities of the individual. The model enables health professionals and
their client to undertake a structured process to develop a 12-month care plan for medical and self-management actions and interventions.

Aside from formal programs, there are other self-management support tools and interventions that health professionals can use to help people manage their chronic conditions. Motivational interviewing and health coaching are techniques that are widely employed to promote behaviour change in people with chronic conditions (Lawn & Schoo 2010). Motivational interviewing is a client-centred method which works through the person’s existing ambivalence to behaviour change and provoke enthusiasm for change (Linden, Butterworth & Prochaska 2010). Based broadly on the work of Miller & Rollnick (1991; 2008), it is highly flexible and be incorporated into a variety of settings and allows interventions to be targeted to clients at different stages of readiness (Sonntag et al. 2011).

Motivational interviewing is part of a broader range of techniques known as health coaching. Health coaching involves the application of principles and techniques from health psychology to support people to achieve positive health and lifestyle outcomes through attitude and behaviour change (Lawn & Schoo 2010). This approach is more flexible than a standardised model, and emphasises the importance of working with the individual person (Lake & Staiger 2010).

There are a broad range of other self-management support programs, including the 5A model, which was developed in the United States for smoking intervention and the Expert Patients Programme, developed by the National Health Service in 2002 and used extensively in the United Kingdom (Lake & Staiger 2010; Lawn & Schoo 2010). These programs are not widely developed in Australia (Lawn & Schoo 2010).

Compliance with self-management support programs can be variable. Gallagher (2008) describes the reluctance of some older people to change habits that they have developed over a lifetime, and that they may have reduced motivation. Health professionals need to take up a partnership model with older people to ensure their engagement with the program to ensure that self-management goals are realistic and achievable (Lake & Staiger 2010).

Self-management support approaches can be strengthened by continuity of approach across the health service, and there is a significant risk of undermining self-management attempts by non-supportive philosophies (Gallagher et al. 2008). Lawn & Schoo (2010) describe how programs can fail if they are not supported by the health care organisation. The widely-adopted Wagner Chronic Care Model acknowledges the importance of adopting system-wide change as well as individual practitioner training.
(Coleman et al. 2009). A supportive system is more effective than any single practitioner in helping older people with chronic conditions remain healthy.

Sunaert et al (2011) describes the reluctance of GPs to refer older clients to a self-management support program. Older people may have been living with their condition for a long time, and may have reasonable existing levels of self-management skills (Sunaert et al. 2011). Having experienced and managed several exacerbations over the period of their illness, older people were more likely to feel able to manage their conditions (Sunaert et al. 2011). Gallagher (2008) noted that ‘experienced’ older people were likely to have a higher level of self-efficacy than a younger person who had completed a formal self-management support program. The reluctance described by Sunaert et al (2011) may be somewhat justified, however older people should be treated individually, and care should be exercised that older people aren’t excluded from programs on the basis of their age.

Experience in Australia and the UK (who have attempted to integrate the Stanford program into their National Health Service) highlight that uptake of these programs is also limited particularly by CALD (culturally and linguistically diverse) and low socioeconomic groups (Redman 2011). Low health literacy may also contribute to poor uptake and participation in both the programs and interventions (Redman 2011). Wang & Matthews (2010) describe the reluctance of older adults of Chinese descent to participate in self-management support programs, preferring instead to use traditional Chinese medicine, and citing communication difficulties. Unfamiliarity of the health system was also cited as a barrier to effective self-management support and health practitioners could aid such people more effectively by assisting them to navigate the system (Wang & Matthews 2010).

In conclusion, health professionals can use self-management support techniques and programs to support older people with chronic conditions, even in the acute setting. Care should be exercised when determining appropriate methods and techniques in low uptake groups such as those with low health literacy and those of low socioeconomic status. A single program or intervention will not work with all people, and creativity is required to engage people from diverse backgrounds. A wide evidence base continues to be developed to ensure the efficacy of programs and to build confidence to adopt the techniques more extensively.
References


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