"I'm taking Charge of My Arthritis": a Targeted Self-Management Programme for Frail Seniors

Category	*Description*
Title of intervention	"I'm Taking Charge of My Arthritis": a Targeted Self-Management Programme for Frail Seniors
Objectives	**Objectives IROHLA taxonomy** ✓ To inform and educate older adults ✓ Improving skills of older adults ✓ To support behaviour change and maintenance ✓ To strengthen contextual social support **Short description of the objectives of the intervention** Encouraging and coaching frail house-bound seniors with arthritis how to manage their conditions better, including emotional aspects of dealing with their disease (which could interfere with maintenance). It aims to empower and activate the social life of these frail seniors as well. The intervention was undertaken for 6 weeks. Social networks is the focus of one of the program sessions. During this session, participants are guided to ways they can identify concrete actions and strategies that will serve to reinforce their social network. Unlike the other self-management programs, I'm Taking Charge of My Arthritis! was first designed to be offered on a one-to-one basis. Support and feedback initially came from health professionals, but participants were also invited to share their self-management progress with peers.
Target groups	**Target groups** ✓ older adults (50+) ✓ young seniors: 50-60 ✓ pensioners: 65-80 ✓ oldest group: 80+ **Short description of the target groups** • Frail older adult over 50 years old (mean 77), receiving home care services, with Rheumatoid arthritis or Osteoarthritis, who are house bound (did not leave home more than twice a month) with moderate to severe pain. • Spoke French or English. • 17% low income/very low income

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	• 70.2% living alone • Education years mean 9.3 (average for Canada 11.6)
Problem of focus	**Consequences for individual and/or society** Frail seniors with arthritis experience disengagement from life, poverty, social isolation, depression, pain, stiffness and fatigue plus sensory impairment, functional limitations and fewer resources and support networks. **Distribution of the problem** It is a common chronic disorders in Canada which affect more than 47% of adults aged 65 and over. **Perception of target groups (of the problem)** Individuals make a number of changes to their lives and use a variety of coping and self-management strategies
Short description of the modifiable determinants of older adults with respect to this intervention.	**Modifiable determinants of older adults are:** • knowledge of older people • skills of older people • behaviour change and maintenance • self-efficacy
Short description of the modifiable determinants of professionals.	**Modifiable determinants of professionals** The intervention did not target professionals, but skills required of professionals directly in contact with targets were 6 x 1 hour visits over a 6 week period to undertake: a. evaluation of the previous personal action plan and development of a new one, b. review of the topics from the previous meeting and discussion of a new topic related to self-management (e.g., exercise, relaxation, emotions, partnership with health practitioners, medication, distraction, problem solving), c. exploration of available resources, d. encouraging a coaching relationship rather than a pedagogical approach.
Components of the intervention	**Components** ✓ Individual counselling/coaching by professionals **Description of components** Within the project "I'm Taking Charge of My Arthritis!" weekly information is provided. Also the target group is encouraged to change health behaviour that is known to help manage arthritis symptoms. These included trying physical

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	exercise and relaxation techniques, energy management practices, use of assistive devices and aids, and management of emotions and maintenance of a positive attitude.
Approach	**Theoretical models used** 1. Theoretical Model are used for the development of the Programme (Taal, Rasker & Weigmah (1997) • TABLE 1. Standards for Self-Management Programs • Standard #1 Analyse the problem and the context • Standard #2 Use a robust conceptual model • Standard #3 Set program goals related to knowledge, behaviour, and health status • Standard #4 Use effective methods to reinforce self-efficacy • Standard #5 Teach management strategies • Standard #6 Consider the individual social environment • Standard #7 Evaluate the program Adapted from Taal, Rasker, & Weigman (1997). 2. Theoretical Model used to inspire content and format was Lorig's Self-Management Program (Lorig, Chasteain, Ung, Shoor, & Holman, 1989), but this study is unique in that it targets a different population, frail older adults. **Didactics used** Cognitive-behavioural principles were used. Personalised self-management Programme draws on Bandura's social cognitive Stages of Change model to look theoretically at self-efficacy using Lorig et al's work on motivating and maintaining healthy behaviours (Lorig, Ritter, Laurent, & Fries, 2004). Theory states that self-efficacy plays an essential role in behaviour change and involves two elements 1) efficacy expectations affect ability to resource or change behaviour, and 2) outcome expectations lead to a given result. The Health Care Professionals involved, are encouraged to coach and use personalised goal setting based on participant knowledge, behaviour and health status rather than pure pedagogy. For this purpose the intervention sets programme goals to maintain lifestyle change to improve quality of life. Some 'teaching' of self-management strategies was done by combining knowledge of the impact of the disease (arthritis) with new health behaviours each week e.g. physical exercise, relaxation, management of emotions etc. **Contexts** Frail older adults who experience disengagement from life, co-morbidities poverty, social isolation, depression, pain, stiffness and fatigue plus sensory impairment, functional limitations, who have fewer resources and support networks. Less likely to attend community Programmes due to physical limitations and psychological distress thus housebound &

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	isolated. **Stakeholders involved** Frail seniors, Health Care Professionals including physiotherapist & occupational therapists, kinesiologists, nurses and social workers **Type of professionals involved** Physiotherapists & occupational therapists, kinesiologists, nurses and social workers
Resources and qualifications	**Duration of the intervention** 6 weeks **Financial costs for the implementing organisation** In addition to administrative and recruitment costs, payment required to health professionals for 1.5 hour initial session, plus 4-6 more further coaching 1 hour sessions. Plus travel and training costs (1/2 day per professional), and 2 hour final interview (evaluation). Minimum 7.5 hours of contact time per target individual. **Financial costs for the target groups** Retired or unemployed, administered in own home, so minimal **Required competencies of professionals** • Counselling skills • Understanding of disease process However authors state that professionals were chosen due to the physically and psychologically frail state of participants' health rather than need for fully qualified expertise.
Implementation	**Implementation strategy** Individual counselling/coaching by professionals **Conditions for effective implementation** Good personal skills communicating with socially isolated and vulnerable people.

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	Stakeholders involved Frail seniors, HCPs including physio- & occupational therapists, kinesiologists, nurses and social workers
Transferability	Most Health professionals should have some previous training in consultation skills, so time to familiarise themselves with the programme's specific materials might be all that was required. There is a Coaches Guide (a training manual for professionals), although topics were included modified during the Programme. Also, A Participants Manual is available. For course materials register at http://www.monarthrite.ca/en/Programme.aspx?sortcode=2.18
Evaluation	**Methods used** • *Sophisticated process evaluation* as well as short and long term impact on participants knowledge, behaviour and health status measured. • *Telephone interview* administered at start and end and *questionnaires* administered to evaluate Programme – detail not reported here but self-efficacy questionnaires included (see Nour et al., 2005 and 2006). • *Shortened version of Gignac's Programme Expectation Scale* was used to see if expectations were met at start and end of the Programme. 80% ranked Programme as beneficial or extremely beneficial. Confidence in self, practical advice on dealing with emotions and coping with stress all rated more highly than at start. • *Monitoring:* Coaches kept details of meetings, length topics covered, etc. and 6 took part in 2 meetings midterm and at end of study of express opinions on Programme.
Effectiveness	**Main results** • 191 screened and 94 older adults participated and referred by case managers from 15 local community centres. Randomly allocated to intervention/control. • Intervention demonstrated significantly more exercise and relaxation activities among seniors than in control group. High retention level. • Participants reported less helplessness, coping better with arthritis, fewer perceived functional limitations.
Key elements/components of the intervention that must stay intact in order to have an effective intervention	**Key elements** • Individual counselling/coaching by professionals • Weekly review and development of Action plans
Level of evidence	✓ Randomised clinical trials

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Category	*Description*
Sector	Health sector
Country of development	Canada
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