Health Promotion & Self-Management in Chronic Care: Community Programs in the United States and Thailand

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Abstract

The sustenance of health promotion for those with chronic conditions is a major objective in Community Health Nursing throughout the world. Averting death and gaining healthy years are both measureable indicators of success in this endeavor. In this account of community health nurse-led programs in the United States and Thailand, the authors provide an overview of evidence-based program development and nursing interventions associated to positive client outcomes such as risk-reduction and adherence to treatment recommendations. As disease management worldwide shifts from episodic and fragmented experiences to those more coordinated and comprehensive in nature, nursing's role in self-managed care within a chronicity model becomes more salient.

Key Words: Health Promotion, Self Management, Chronic Care and Community

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Disease management has become an identified way to improve health status and control of chronic conditions through risk stratification, targeted nurse outreach, telemedicine, telenursing, care coordination and evidence-based illness-management (Roby, Kominski & Pourat 2008). Improving outcomes within chronic disease has become a health care system imperative in the United States and throughout the world. In fact, a global goal for the management of the chronic disease burden is to sustain individual actions necessary to increase the quality and years of a healthy life (Institute of Medicine, 2011). A target for this proposed goal is an additional 2% reduction in chronic disease death rates annually by 2015 (WHO, 2011). The indicators for the measurement of success towards this goal are the number of chronic disease deaths averted and the number of healthy life years gained.

To that end, the Chronic Care Model (CCM), developed by Wagner (1998), then, Wagner et al. (2001) provides an approach to the improvement of health care on many levels. The necessary elements are the community, the health system, self-management support, delivery system design, decision support and clinical information systems. Evidence-based change concepts under each element, in combination, foster productive interactions between informed patients who
take an active part in their care and providers with resources and expertise. The CCM can be applied to a variety of chronic illnesses, health care settings and target populations. The bottom line is healthier patients, more satisfied providers, and cost savings. Within the CCM, it is self-management support that is of particular interest to nursing given that nurses can provide care that is holistic and continuous, not fragmented or episodic as is the case in the current acute-care model for health care in the United States and many other countries.

The purpose of this paper is to discuss nursing’s role in promoting patient self-management and health promotion processes within the context of chronic disease. The design and nursing care processes of a self-management program for chronic cerebrovascular community health clients in a Northern Thailand village is discussed. Similar care management practices are identified in a San Francisco (United States) area public health department in another common and costly chronic and vulnerable population, those with type 2 diabetes (T2DM). A case for evidence-based self-care management programs designed and led by nurses is made.

**Self-Management and Chronic Care**

Self-management, a theme within chronic care, was defined by Redman (2004) as follows: training that people with chronic health conditions need to be able to deal with taking medicines and maintaining therapeutic regimes, maintaining everyday life such as employment and family, and dealing with the future, including changing life plans and the frustration, anger and depression. (p. 2)

The role of nursing reported in studies of self-managed programs in chronic disease tends to be one of empowering followers to find and use resources, fostering the development of coping skills as well as designing educational programs based on the best available scientific evidence of disease management. Further, the crucial role of nursing in risk reduction and the promotion of healthy behaviors is also commonly acknowledged (Moriyama et al., 2009). Studies of the importance of self-management programs in health promotion for a variety of chronic diseases exists. These studies have identified the vital function of the generalist nurse in evidence-based program design and care management in a many common and costly conditions throughout the world, including cerebrovascular disease (CVD) (Suntayakorn, C. Somsak & Kanthapang, 2011), T2DM (Handley, Shumway & Schillinger, 2008; Moriyama et al., 2009) Inflammatory Bowel Disease (IBD) (Stansfield & Robinson, 2008) and Congestive Heart Failure (CHF) (Smeulders et al., 2011).

Targeted outreach and program design, as two key functions nursing fulfills in self-managed care, are illustrated in the clinical scenarios below. Two programs of targeted nurse outreach in community health, one in rural Thailand and one outside of San Francisco, are examined to illustrate how nurse-led self-care management impacted self-care behavior and patient outcomes. Each is discussed, in turn, below.

**Risk-Reduction and Self-Management in At-Risk Clients in Northern Thailand**

In a quasi-experimental study aimed at examining the effects of a self-care management program on CVD risk and prevention of CVD within an at-risk group of residents of a rural village in Northern Thailand, Suntayakorn, Tojampa, & Kanthapang (2011) reported that the self-managed group (N=30)
had significantly better risk-reduction behaviors, lower systolic blood pressure, lower body mass index and lower diastolic blood pressure than their control-group (N=30) counterparts. The findings were attributed to the self-management strategies designed to equip the residents with a better understanding of self-management and knowledge and skills for self-monitoring, self-evaluation and self-reinforcement.

Taught to the experimental group in a one-day workshop by nurses and the researchers, the content included the importance of food selection, exercise and weight control as well as meditation. Health volunteers also attended and they were deployed to visit clients every two weeks to motivate them and reinforce the importance of keeping records of their healthy lifestyles. Clients followed for 12 weeks reported significant lifestyle changes in a questionnaire designed by the investigators. The content of the educational program was evidence-derived.

Automatic Telephone Self-Management in San Francisco Public Health

In a randomized controlled trial of self-management support among diverse clients with T2DM in a safety-net system within the Community Health Network of San Francisco (California, United, States), Handley, Shumway and Schillinger (2008) reported the cost-effectiveness of an intervention program of telephone self-management support from nursing. Specifically, the per patient cost estimate for achievement of a 10% increase in the proportion of intervention patients meeting the exercise guidelines of the American Diabetes Association (ADA) was $558. Based on self-reports of the duration and frequency of exercise and the use of standard cost estimate procedures, the findings were attributed to the addition of Automated Telephone Support Management (ATSM) with nursing advice (in addition to treatment as usual) for the experimental group (N=112) versus the control group (N=114) who experienced only treatment as usual.

The venue of ATSM (phone support) is thought to be most useful when participants have a range of language differences and literacy levels and or have geographic or mobility issues with access to care. An obvious advantage is also that with the ATSM comes the phone support of a nurse-provider which has been reported to be a factor associated to patient satisfaction (Pierre, 2000). The researchers stated that because a considerable proportion of costs were fixed, cost-utility and cost-effectiveness estimates would likely be substantially improved in a scaled-up ATSM program.

Conclusion

As disease management shifts from incomplete scattered episodes of care to a more comprehensive approach such as CCM (Dancer & Courtney, 2010), the role of the nurse in targeted outreach and evidence-based program design will be crucial. As new interventions become available in the nursing care of patients with chronic diseases such as CVD and T2DM the nurse will be well-positioned to effectively improve the care of these patients through targeted outreach and planned self-management program re-design.

The multifaceted role of the nurse in chronic care management is well documented: expert, health coach, teacher, facilitator and motivator. Yet self-management is thought to be carried out in a limited way by patients and providers (Johnston, Liddy & Ives, 2011). As nurses and other providers fully realize the impact that self-management can have on health
outcomes, disease outcomes and cost-savings to a health care system, it is likely they will become more engaged in those care management processes irrespective of their current practice configuration and goals. In industrialized countries such as the United States as well as in developing nations like Thailand, it is hoped that a meaningful shift from the disease-based and revolving-door approach in chronicity to self-management in vulnerable populations of people who tend to have multiple chronic states will occur. If providers focus on the engagement of consumer-patients in critical elements of their care, a very positive impact on specific indicators necessary to improve the health of a nation should occur.

References
