The Chronic Disease Self-Management Program: A Resource for Use with Older CKD Patients

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This commentary will briefly highlight the importance of promoting chronic disease self-management among older adults who are disproportionately affected by chronic kidney disease (CKD) stage 5. Older adults represent the fastest-growing segment of the CKD stage 5 population. Undoubtedly, the rapidly aging population will present new challenges and demands for the CKD health care community. The Chronic Disease Self-Management Program (CDSMP) is one existing intervention that has been recognized as potentially having utility for use with the CKD population. In this paper, we highlight opportunities for expanding the CDSMP to the population of older adults undergoing hemodialysis. The CDSMP is a six-week, lay-led, evidence-based program that includes interactive activities, such as behavior-specific action plans to improve chronic disease self-management behaviors. The CDSMP covers a wide range of health-related topics, including dealing with emotional struggles, effective communication, exercise, and nutrition. Special considerations for effective implementation of the CDSMP in hemodialysis settings are emphasized.

INTRODUCTION

Living with a chronic disease can be burdensome, often resulting in high levels of depression and low levels of quality of life (Centers for Disease Control and Prevention, 2007; Kimmel & Peterson, 2006). Patient-centered health promotion strategies, such as chronic disease self-management, can lessen the burden of chronic disease (Beattie, Whitelaw, Mettler, & Turner, 2003). Chronic disease self-management refers to an individual's ability to manage the symptoms associated with a disease, and perform daily tasks to reduce the impact of a disease on one's physical status (Lorig & Holman, 2003). The concept of self-management is important for many chronic conditions, and chronic kidney disease (CKD) is no exception. Self-management of CKD, like other chronic conditions, requires long-term behavior change and attention to dietary and medication management (Browne & Merighi, 2010; Kammerer, Garry, Hartigan, Carter, & Erlich, 2007). Other aspects of CKD self-management include regulation of fluid intake, blood pressure and electrolytes, and vascular access care (Mason, Khunti, Stone, Farooqui, & Carr, 2008; Richard, 2006). Currently, comprehensive self-management programs to reduce the health-related burdens and improve quality of life experienced by older CKD stage 5 patients in particular, are limited (Curtin, Mapes, Schatell, & Burrows-Hudson, 2005). While some interventions show promise, others lack rigor and are not always guided by theory (Chodosh et al., 2005; Mason et al., 2008). Furthermore, self-management programs targeting socially disadvantaged CKD stage 5 subgroups who may experience difficulties accessing low-cost, community-based resources are scarce (Becker, Gates, & Newsom, 2004). This commentary will briefly highlight the importance of promoting chronic disease self-management among older adults who are disproportionately affected by CKD stage 5, and discuss the potential applicability of one existing, accessible program that is designed to help people living with chronic disease manage their conditions successfully.

CKD IN THE AGING POPULATION

CKD is a serious chronic condition with significant health and health care cost implications for aging populations who have poorer clinical outcomes when compared to other subgroups (Nzerue, Demissachew, & Tucker, 2002). Older adults with CKD are at increased risk for cardiovascular disease morbidity and mortality (Stevens et al., 2010). Forty years ago, people with CKD stage 5 were younger and healthier than individuals in stages 1-4 (Stevens, Viswanathan, & Weiner, 2010). Today, older adults are the fastest growing segment of the CKD stage 5 population. The 2010 United States Renal Data System Annual Data Report identified an important and emerging issue with regard to the aging population; that is, aging baby boomers will greatly contribute to the growth of the CKD stage 5 population (USRDS, 2010). In recent years, the adjusted incident rate has increased by nearly 10% for adults age 75 and older, and between 1978 and 1999, the incident rate of patients age 65 and older has risen from 27% to 48%, respectively (Silva, 2005). This is a cause for concern, particularly given that older adults are already at risk for chronic diseases, such as diabetes and arthritis (Centers for Disease Control and Prevention, 2007).

It is no surprise, then, that the Centers for Disease Control and Prevention's State of Aging and Health in America report (2007) identified seven top priority calls to action, six of which are related to self-management behaviors among older

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adults. Nephrology professionals may consider introducing new programs that emphasize greater patient involvement to reduce the overwhelming impact of CKD stage 5 on the lives of older adults. Introducing new programs that teach chronic disease self-management is timely and relevant, especially given the recent changes to the Conditions for Coverage for End-Stage Renal Disease facilities, in which the Centers for Medicare and Medicaid Services (CMS) places great emphasis on increased patient participation in their health care through better engagement of patients, or their designees, as active members of the interdisciplinary treatment team (Alt & Schatell, 2009; Federal Register, 2008 [§ 494.80]). This declaration promotes self-management by requiring facilities to educate patients about treatment options (V458), vascular access care (V550), dietary and fluid management (V562, V545, and V546), the dialysis experience, dialysis management, infection prevention, quality of life, rehabilitation, and coping (V562) (Alt & Schatell, 2009; Federal Register, 2008). Self-management programs are useful tools for educating patients about the various aspects of care, and empowering them to be more involved in their health care. This recognition by CMS is noteworthy, and provides an opportunity for nephrology professionals to encourage older patients to be active self-managers.

THE CHRONIC DISEASE SELF-MANAGEMENT PROGRAM

In light of the benefits of successful chronic disease self-management, one such program that shows promise when used with chronically ill older adults is the Chronic Disease Self-Management Program (CDSMP). Developed by Lorig and colleagues at Stanford University, the CDSMP was designed to promote successful self-management behaviors by empowering participants to take an active role in their health and health care, and is based on the assumptions that people with different chronic conditions will have similar self-management tasks, and will experience improved health by learning these tasks (Lorig et al., 1999; Lorig et al., 2001; Stanford Patient Education Center, 2012). This evidence-based intervention was evaluated in a randomized study of 952 patients with a mean age of 65 representing a variety of disease categories, and has been adapted for use with minority groups (Gitlin, Chernett, Harris, Palmer, Hopkins, & Dennis, 2008).

The program is offered in six lay-led two-and-a-half hour sessions consisting of interactive activities and homework assignments that address symptom management, exercise, nutrition, medications, and other important self-management topics (**Table 1.**). Participants receive a patient-friendly text that provides an overview of chronic disease and self-management, and offers useful tips and strategies for improving one's health status. For example, participants are guided through activities that promote positive and healthy self-talk as a way to use the mind to manage unpleasant symptoms (Lorig, Holman, Sobel, Laurent, Gonzalez, & Minor 2006). A diabetes version of the program also exists, which covers additional topics, including preventing hypoglycemia and reading nutrition labels. Guided by Social Cognitive Theory (Bandura, 1986), the program aims to increase self-efficacy through modeling (i.e., skill-building through observation) and

Table 1. *CDSMP Session Topics*

Session	Topics
Session 1	Overview of self-management
	Action plans (ongoing)
	Symptom management
Session 2	Problem solving (ongoing)
	Dealing with difficult emotions
	Exercise
Session 3	Pain management
	Nutrition
Session 4	Future plans for health care
	Effective communication
Session 5	Medications
	Making treatment decisions
	Managing depression
Session 6	Working with health care professionals
	Working with the health care system

Table 2: *Basics of a Successful Action Plan*

Action Plan Basics	Rationale
Something you want to do	The "self" in self-management implies that the patient (or designee) is the primary manager of his or her chronic condition.
Reasonable	The plan must be something you can expect to accomplish in a specified time period.
Behavior-specific	Being behavior-specific is the difference between "I want to avoid fluid overload" and "I will not drink more than 64 ounces of fluids daily."
Answers the question: What?	Exactly what is the behavior the patient desires to achieve?
Answers the question: How much?	How much of the behavior will the patient perform? For example, walk for 10 minutes.
Answers the question: When?	When will the behavior take place? For example, walk for 10 minutes after dinner.
Answers the question: How often?	How often will the behavior occur? For example, walk for 10 minutes after dinner for one week.
Confidence level	On a scale from 1 to 10, a confidence level of at least 7 indicates the behavior is likely to occur.

Adapted from Lorig et al., 2006, p. 23.

mastery (i.e., skill-building through repeat performance of a task). Also, the program emphasizes short-term planning through the development of an action plan, an essential self-management tool (Lorig, et al., 2006). Action plans are behavior-specific, allowing participants to identify tasks that must be performed. The basics of a successful action plan are listed in **Table 2**.

Funding from the Administration on Aging to 45 states, the District of Columbia, and Puerto Rico has increased CDSMP offerings in a variety of community settings, including senior centers, churches, and libraries in the United States (Administration on Aging, 2011). In North Carolina, for example, the Division of Aging and Adult Services and the Division of Public Health have enacted a campaign to offer the CDSMP throughout the state to reduce the impact of chronic disease on older adults. Health care professionals and people living with a chronic disease who have completed the program can receive training to offer the program in their respective clinics and facilities, complete with program materials. Social workers, physicians, and other health care professionals may refer their patients to participate in the CDSMP at no cost, or work with their local Area Agency on Aging (AAA) that is licensed to offer the program in their facilities and clinics. Some businesses are working with their AAA to offer the CDSMP to their employees. Other states are implementing the program using this or a similar model of dissemination. Dialysis facility social workers can find out about statewide CDSMP offerings, licensing, and training to offer the program in their facilities by contacting their local AAA or by visiting the Administration on Aging website at **www.aoa.gov**.

The CDSMP is recognized as having utility with the CKD stage 5 population (Curtain et al., 2005) because the workshops have been successful at increasing patients' confidence in their ability to successfully manage their disease. The CDSMP is an established program that offers an array of educational materials easily adaptable for the CKD stage 5 population. Most hemodialysis patients visit a dialysis facility three times per week for three to five or more hours each visit (NKUDIC, 2011); this substantial and consistent amount of contact with nephrology professionals lends itself to increased opportunities for engaging patients in disease self-management. Further, the camaraderie that often builds among CKD stage 5 patients due to their frequent and consistent interactions in the dialysis facility is yet another factor that may contribute to the success of disease self-management programs in CKD stage 5 settings.

OPPORTUNITIES FOR ADVANCING SELF-MANAGEMENT INTERVENTIONS

Among Older Adults with CKD Stage 5

Why is it important to advocate for improved self-management behaviors for older CKD stage 5 patients? The answer is simple—because they, too, can benefit from greater involvement in their health and health care. Older adults are at an increased risk for experiencing age-related physiological changes, such as visual and hearing impairment, declined physical functioning, malnutrition, and cognitive impairment (Falvo, 2009). These and related conditions increase the likelihood of poor psychosocial outcomes, such as economic hardships, depression, and isolation (Falvo, 2009). These same negative outcomes are exacerbated among older adults with CKD stage 5

(Silva, 2005). Thus, promoting disease self-management among older patients should become a priority due to its potential to improve quality of life, decrease health care utilization, and mitigate functional impairments. Disease self-management programs have proven useful for older adults with other serious illnesses (Lorig et al., 1999). Older CKD stage 5 patients may benefit from interactive self-management programs that are needs-focused and underscored by enhanced self-efficacy (Richard, 2006). The increasing demands that a rapidly aging population present on the health care system are inevitable. Therefore, it is in the field's best interest to promote self-management behaviors for older patients to lessen the impact of this growth on nephrology care.

Implementation Considerations

Special considerations are needed when implementing the CDSMP with any chronic disease population. First, issues such as high staff turnover, patient attrition, changes in corporate ownership, and regulatory changes act as barriers to successful implementation of interventions in health care settings (Buckwalter et al., 2009). When implementing the CDSMP, social workers should take into account these barriers, and develop strategies for overcoming them while maintaining fidelity to the program (Washington et al., in press). Second, given that there are marked disparities in both the incidence and prevalence of this disease among minority groups (e.g., the incidence rate among African Americans is 3.6 times greater than whites, (USRDS, 2010)), cultural considerations must be taken into account when implementing the CDSMP in this patient population. Social workers must consider adaptations that align with cultural values and practices such as the use of culturally appropriate language and marketing tools (Gitlin et al., 2008; Mingo, McIlvane, Jefferson, Edwards, & Haley, 2012). Third, although the CDSMP was designed for people living with many types of chronic disease, social workers might consider additional topics, such as vascular access care and fluid management when implementing this program with older adults in hemodialysis settings. Nonetheless, the CDSMP is one example of an effective self-management program that has proven useful for older persons living with chronic diseases.

CONCLUSION

With a core commitment to assisting patients in improving their self-management behaviors, health care professionals can help to ensure that all CKD stage 5 patients receive the high quality of care they deserve by implementing programs, such as the CDSMP. To achieve this, Browne & Merighi (2010) recommend a patient-centered approach in which the dialysis facility health care team works in collaboration with the patient to overcome barriers to successful self-management. Nephrology social workers are tasked with helping patients reduce psychosocial stressors and maximize their rehabilitation potential, and the CDSMP offers patients the opportunity to learn better self-management strategies to accomplish these goals. By increasing patient control over their own health, patients become more cognizant of any changes that occur, and more knowledgeable about the steps needed to return to their baseline level of health faster than they would without this type of self-awareness. Also, patients who can accurately assess their condition can better aid their health care providers by succinctly and efficiently relaying changes in their health. While more research is needed about the potential benefits of improved self-management behaviors among older CKD stage 5 patients, it is evident from the existing literature that programs like the CDSMP have positive potential with this population.

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