

**Supplemental Table 1. Occupation- and Activity-Based Health Management and Maintenance Interventions for Community-Dwelling Older Adults (N = 28)**

Author/Year	Study Objectives	Level/Design/Participants	Intervention and Outcome Measures		Results	Study Limitations
			Intervention	Outcome Measures		
Alp, Kanat, & Yurtkuran (2007)	Evaluate whether a self-management program, <i>Choices for Better Bone Health</i> , is effective in promoting behavioral strategies for improving bone health, life quality, pain perception, physical function, and balance in osteoporotic participants	Level I RCT  N = 50 postmenopausal sedentary women with a diagnosis of idiopathic osteoporosis  <i>Choices</i> group n = 25 Control group n = 25	<i>Intervention</i> <i>Choices for Better Bone Health</i> : 5 sessions that incorporate education regarding osteoporosis and medication management, diet, living safely, and exercise  <i>Control</i> : Compliance with sedentary lifestyle  <i>Outcome Measures</i> • Visual Analogue Scale (VAS) • SF-36 • Sensitized Romberg Test (SRT) • Timed Sit to Stand (TSS)	Participants in the intervention group scored significantly better at 6-mo follow-up on pain intensity (VAS), balance assessment (SRT), TSS, and the following subscales of the SF-36 quality-of-life measures: physical function, physical role limitations, social function, mental health, vitality, pain, general health perceptions, and emotional role limitations.	Sample was from only one hospital.	
Bartels et al. (2004)	Assess the effectiveness of a combined skills training (ST) and health management (HM) intervention for older adults with severe mental illness	Level II Nonrandomized controlled trial  N = 24 participants ≥60 yr with a diagnosis of schizophrenia, schizoaffective disorder, bipolar disorder, other psychotic disorder, or treatment-refractory depression and persistent functional impairment requiring ongoing support  HM + ST (intervention) n = 12 HM-only (control) n = 12	<i>Intervention</i> ST: Hour-long group skills training 2×/wk  HM: Assessment and monitoring of routine and chronic health care needs and promotion of preventive health care  <i>Intervention group</i> : HM + ST <i>Control group</i> : HM  <i>Outcome Measures</i> • Independent Living Skills Survey • Social Behavior Schedule • Brief Psychiatric Rating Scale • Scale for the Assessment of Negative Symptoms • Preventive health care	After 1 yr, the HM + ST group had better functional outcomes, with medium to large effect sizes with respect to independent living skills, social skills, and health management, compared with those receiving HM alone.  After 2 yr, both groups had improved preventive health care.	Lack of randomization Pilot study had a small sample size.	
Brawley, Rejeski, & Lutes (2000)	Determine the effectiveness of a group-mediated cognitive-behavioral (GMCB) intervention in increasing adherence rates to physical activity in older adults	Level I RCT  N = 60 apparently healthy, sedentary adults; 50 at follow-up  GMCB n = 20 Standard physical activity (SPA) n = 20	<i>Interventions</i> WLC: Weekly 1-hr lecture discussion plus phone calls  SPA: Center-based and home-based physical activity  GMCB: Physical activity plus weekly cognitive-behavioral intervention	At 6 mo, compared with the WLC group, the GMCB and SPA groups were more active, had higher aerobic power, and had improved HRQOL. At 9-mo follow-up, the GMCB group had a higher frequency of weekly physical activity than the SPA group.	Small sample size Physiological data were not included.	

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Author/Year	Study Objectives	Level/Design/Participants	Intervention and Outcome Measures		Results	Study Limitations
			Intervention	Outcome Measures		
Chodosh et al. (2005)	Assess the effectiveness of self-management programs for hypertension, osteoarthritis, and diabetes	Wait-list control (WLC) <i>n</i> = 20  Level I Meta-analysis Databases searched through September 2004 include Cochrane Library, MEDLINE, PsycINFO, and Nursing and Allied Health; also searched bibliographies of reviews	<i>Interventions</i> Fifty-three studies included in the meta-analysis were RCTs of self-management programs for osteoarthritis (14), diabetes mellitus (26), and hypertension (13) compared with a control or usual care.	<i>Outcome Measures</i> • Physical Activity Recall • HRQOL	Participation in self-management interventions resulted in a minimal but statistically significant difference in pain and function. In addition, the self-management programs resulted in lowered systolic blood pressure and a reduction in hemoglobin A1c. It is not known what components of the program are most responsible for benefits.	Studies included in the meta-analysis were of variable quality.  Outcomes for osteoarthritis such as mood and quality of life were not included in the analysis.
Clark et al. (2001)	Evaluate the efficacy of preventive occupational therapy intended to reduce health-related declines among urban, multiethnic, independent-living older adults	Level I RCT  <i>N</i> = 361 participants recruited from two federally subsidized apartment complexes for older adults located in or near Los Angeles  Cohort I <i>n</i> = 143 Cohort II <i>n</i> = 218  Participants were living independently in their communities and were without marked dementia.	<i>Intervention</i> <i>Group 1:</i> Received occupational therapy treatment that focused on helping them incorporate positive changes in their lifestyles  <i>Group 2:</i> Participated in activities  <i>Group 3:</i> No intervention	<i>Outcome Measures</i> • SF-36 • FSQ • Life Satisfaction Index • Medical Outcomes Study Health Perception Scale	The results indicate statistically significant differences between the intervention and control groups on FSQ quality of interaction and 6 of 8 subscales of the SF-36 (physical functioning, role functioning, vitality, social functioning, role emotional, and general mental health). There were no differences between groups on other outcome measures.	Study is of good quality.
Clark et al. (1997)	Evaluate the efficacy of preventive occupational therapy intended to reduce health-related declines among urban, multiethnic, independent-living older adults	Level I RCT  <i>N</i> = 361 participants recruited from two federally subsidized apartment complexes for older	<i>Intervention</i> <i>Group 1:</i> Received occupational therapy treatment that focused on helping them incorporate positive changes in their lifestyles	<i>Outcome Measures</i> • SF-36 • FSQ • Life Satisfaction Index • Medical Outcomes Study Health Perception Scale	Compared with the two control groups, the occupational therapy group showed a significant benefit in quality of interaction, life satisfaction, self-perception of health, and seven dimensions of the SF-36	Study is of good quality.

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Author/Year	Study Objectives	Level/Design/Participants	Intervention and Outcome Measures	Results	Study Limitations
Dahlin Ivanoff, Sonn, & Svensson (2002)	Investigate the impact of a health education program on perceived security in the performance of daily occupations 4 mo after the intervention period	Level I RCT N = 253 participants >65 yr with diagnosed age-related macular degeneration attending a low-vision clinic in Sweden At 4-mo follow-up, 187 participants remained (93 in intervention group, 94 in control group)	adults located in or near Los Angeles Cohort I n = 143 Cohort II n = 218 Participants were living independently in their communities and were without marked dementia.  <i>Group 2:</i> Participated in activities <i>Group 3:</i> No intervention  <i>Outcome Measures</i> • SF-36 • FSQ • Life Satisfaction Index • Medical Outcomes Study Health Perception Scale	for physical and mental health (bodily pain, physical functioning, role limitations attributable to health problems, vitality, social functioning, role limitations attributable to emotional problems, and general mental health).  The study showed significant differences in change in perceived security between the health education group and the control group at the 4-mo evaluation for 13 of 28 occupations. The health education group showed changes toward an improved level of perceived security in 22 daily occupations, whereas those in the control group showed declines in perceived security in 22 specific daily occupations.	High dropout rate
Eklund, Sonn, & Dahlin-Ivanoff (2004)	Investigate the impact of a health education program on perceived security in the performance of daily occupations 28 mo after the intervention	Level I RCT N = 253 participants >65 yr with diagnosed age-related macular degeneration attending a low-vision clinic in Sweden At 28-mo follow-up, 184 participants remained (62 in intervention group, 69 in control group)	<i>Intervention</i> <i>Health education group:</i> Received medical information and instruction on glasses, optical aids, and lighting in areas of occupation, including self-care, meals, communication, orientation and mobility, food preparation, shopping, financial management, and cleaning <i>Control group:</i> Standard intervention for the target groups at the low vision clinics  <i>Outcome Measure</i> Perceived security in performing daily occupations	The values of perceived security in the health education group varied from -.09 to .47, with a median of .25. In the control group, the range of perceived security varied from -.32 to .15, with a median of -.14. The intervention group changed toward an improved level of security in 20 daily activities, whereas the control group changed toward a deteriorated level of security.	High dropout rate
			<i>Intervention</i> <i>Health education group:</i> Received medical information and instruction on glasses, optical aids, and lighting in areas of occupation, including self-care, meals, communication, orientation and mobility, food preparation, shopping, financial management, and cleaning <i>Control:</i> Standard intervention for the target groups at the low vision clinics  <i>Outcome Measure</i> Perceived security in performing daily occupations		

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**Supplemental Table 1. Occupation- and Activity-Based Health Management and Maintenance Interventions for Community-Dwelling Older Adults (N = 28) (cont.)**

Author/Year	Study Objectives	Level/Design/Participants	Intervention and Outcome Measures	Results	Study Limitations
Foster, Taylor, Eldridge, Ramsay, & Griffiths (2007)	Assess the effectiveness of lay-led self-management programs for persons with chronic conditions	Level I Meta-analysis Databases searched include Cochrane Central Register of Controlled Trials, MEDLINE, EMBASE, AMED, CINAHL, DARE, PsycInfo, and Science Citations Index through June 2006	<i>Intervention</i> Randomized controlled studies compared lay-led self-management programs to no intervention or clinician-led programs. <i>Outcome Measures</i> • Knowledge • Relaxation • Pain • Self-care maintenance	Lay-led self-management education programs led to small, short-term improvements in participants' self-efficacy, self-rated health, cognitive symptom management, and frequency of aerobic exercise but had no effect on psychological health, symptoms or health-related quality of life, or health care use.	Wide range of included conditions and outcome measures
Gitlin et al. (2008)	Evaluate the effectiveness of a CDSMP for delivery to older African-Americans at a senior center	Level III Pretest-posttest N = 519 African-Americans with a chronic condition over age 60 recruited through a senior center	<i>Intervention</i> Harvest Health (HH), a CDSMP tailored for African-American participants <i>Outcome Measures</i> • Physical activity • Cognitive symptom management • Health status • Illness • Intrusiveness • Health care utilization • Self-efficacy	There were small but significant improvements for HH participants in exercise, use of cognitive management strategies, energy/fatigue, self-efficacy, health distress, and illness intrusiveness in different life domains. There was no difference for health care utilization.	Lack of control group
Hibbard, Greene, & Tusler (2009)	Determine whether assessing patient capabilities for self-management and tailoring coaching support provide better outcomes for disease management	Level II Nonrandomized controlled study N = 6,828 patients referred to 2 call centers for health coaching Intervention group n = 4,254 Control group n = 2,574	<i>Intervention</i> <i>Intervention:</i> Health coaching for disease management based on the Patient Activation Measure (PAM) <i>Control:</i> Telephone health coaching for disease management <i>Outcome Measures</i> • PAM • Utilization rates of office visits • Clinical indicators, such as LDL cholesterol, blood pressure, medication	Activation scores increased, clinical indicators improved, and utilization rates declined significantly more in the intervention group than in the control group.	Lack of full data for any variables Cost of intervention component not included in the analysis

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Author/Year	Study Objectives	Level/Design/Participants	Intervention and Outcome Measures	Results	Study Limitations
Holland et al. (2005)	Evaluate the outcomes of the Health Matters program, a health promotion and fitness program from the California Public Employees Retirement System	Level I RCT N = 504 participants >65 yr old with one or more chronic health conditions in a managed care Medicare program Intervention group n = 255 Control group n = 249	<i>Intervention</i> <i>Health Matters</i> : Included a client-developed health action plan, health coaching, and patient education <i>Control group</i> : Contacted by the Health Matters staff at 12-mo follow-up and permitted to participate in Health Matters <i>Outcome Measures</i> Self-report of chronic health conditions, health status, physical activities, social activity, ADLs, IADLs, health and social role, depression, medications, and communication with physician	At 12 mo, participants in Health Matters took part in significantly more stretching and aerobic exercise than participants in the control group. Depressive symptoms decreased among participants with moderate or higher symptom scores.	Results may not generalize to those in a non-managed care Medicare program. Participants were aware of assignment status.
Jerant, Moore-Hill, & Franks (2009)	Evaluate the effectiveness of Homing in on Health (HIOH), a CDSMP, over a 1-yr follow-up period	Level I RCT N = 415 outpatients with 1 or more chronic illnesses plus functional impairments HIOH via home visit n = 138 HIOH via phone call n = 139 Usual care (control) n = 138	<i>Intervention</i> <i>HIOH</i> : A CDSMP delivered one-to-one either in participant's home or by telephone <i>Control group</i> : Usual care plus initial visit by nurse <i>Outcome Measures</i> • Self-efficacy • SF-36 • Functional ability • Quality of Life: EQ-5D, EQ-VAS	Compared with usual care, HIOH led to significantly higher illness management self-efficacy at 6 wk and 6 mo, but not at 1 yr. There was significant improvement on EQ-VAS through 1 yr. There were no differences for HIOH by telephone and for other outcome measures when delivered in person.	Most participants were White, female, married, and well-educated. Dropout rate was greater in intervention groups.
King et al. (2006)	Evaluate the effectiveness of a multifaceted physical activity intervention emphasizing participant choice for persons with type 2 diabetes	Level I RCT N = 335 persons recruited from primary care physician Computer-assisted tailored self-management intervention group n = 174 Health risk appraisal with feedback control group n = 161	<i>Intervention</i> <i>Intervention group</i> : Tailored self-management focused on choice of physical activity <i>Control group</i> : Participants filled out health risk appraisal and received feedback on assessment <i>Outcome Measures</i> • Community Health Activities Model Program for Seniors (CHAMPS) questionnaire • Diet • Demographics	At 2-mo follow-up, the intervention group improved in all physical activity and moderate physical activity compared with the control group.	Reliance on self-report Limited follow-up

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Author/Year	Study Objectives	Level/Design/Participants	Intervention and Outcome Measures		Results	Study Limitations
			Intervention	Outcome Measures		
Leveille et al. (1998)	Investigate the feasibility of a project risk factors for disability especially through increased physical activity, promote social activities, and enhance medical management and self-management of chronic illness	Level I RCT N = 201 patients ≥70 yr with one chronic condition Intervention group n = 101 Control group n = 100 Inclusion criteria: Nonparticipation in the senior center, self-reported ability to perform all ADLs and walk independently	<p><i>Intervention</i></p> <p><i>Intervention group:</i> Health Enhancement Project group received treatment that focused on physical activity and chronic illness self-management. Participants met with a geriatric nurse practitioner 1–8 times and were encouraged to participate in a variety of activities, including self-management.</p> <p><i>Control group:</i> Tour of the senior center</p> <p><i>Outcome Measures</i></p> <ul style="list-style-type: none"> <li>• Health Assessment Questionnaire</li> <li>• Physician-based Assessment and Counseling for Exercise (total leisure and work activity)</li> <li>• SF–36</li> <li>• Self-report (performance of ADLs)</li> <li>• Timed Up and Go</li> <li>• Chair Stand Time</li> </ul>	Those in the intervention group reported a significant increase in physical activity, fewer days in the hospital, and reduced ADL difficulty. At 1 yr, there were no differences on the SF–36 or on performance measures such as the Timed Up & Go test and the Chair Stand Time.	Study limited to 1 yr Observed baseline differences between groups may have limited the ability to demonstrate a difference.	
Lorig, Ritter, & Gonzalez (2003)	Evaluate the effectiveness of a 6-wk community-based program for Spanish speakers with heart disease, lung disease, or type 2 diabetes	Level I RCT N = 551 Spanish speakers with chronic disease Peer-led program n = 327 Wait-list control n = 224	<p><i>Intervention</i></p> <p><i>Intervention group:</i> Tomando Control de su Salud (taking care of your health), a standardized peer-led group that includes action planning</p> <p><i>Control group:</i> Wait list</p> <p><i>Outcome Measures</i></p> <ul style="list-style-type: none"> <li>• Physical activity scale</li> <li>• Self-rated health</li> <li>• Health distress and role function</li> <li>• Pain</li> <li>• Fatigue</li> </ul>	At 4 mo, the peer-led group had improved health status, health behavior, and self-efficacy and fewer emergency room visits than the control group. Improvements were maintained at 1-yr follow-up.	Study is of good quality.	
Lorig, Ritter, Laurent, & Fries (2004)	Test the effectiveness of SMART, a mail-delivered, self-management intervention for persons with arthritis	Level I RCT	<p><i>Intervention</i></p> <p><i>SMART:</i> Participants received a tailored action plan and letter based on diagnosis, pain disability,</p>	At 1 yr, participants in SMART had decreased disability, improved role functioning, and improved self-efficacy. At 2 yr, doctor visits and	Some loss of data because data collection was independent of intervention	

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Author/Year	Study Objectives	Level/Design/Participants	Intervention and Outcome Measures	Results	Study Limitations
Lorig et al. (2001)	Assess the 1- and 2-yr outcomes of a CDSMP	<p>Study 1 N = 1,090 (mean age: 62.2 yr)</p> <p>SMART n = 522 Usual care (control group) n = 568</p> <p>Study 2 N = 341 (mean age: 65.2 yr)</p> <p>SMART n = 180 Arthritis Self-Management Program (ASMP) n = 161</p> <p>Participants were recruited from a databank of several centers for patients with arthritis.</p>	<p>exercise levels, and other arthritis-related behaviors. Print materials were also provided. This was repeated every 4 mo for 1 yr</p> <p>ASMP: Small-group intervention; standardized protocol for a period of 20 hr taught by peer leaders to teach skills to improve function, increase physical activity, and improve problem solving</p> <p>Control group: Usual care</p> <p>Outcome Measures</p> <ul style="list-style-type: none"> <li>• HRQOL</li> <li>• Health care utilization</li> <li>• Perceived self-efficacy</li> </ul>	<p>global severity were decreased and self-efficacy was improved. There were no significant differences between groups at 3 yr.</p> <p>At 1 yr, participants in SMART had greater decreases in disability and increases in self-efficacy than those in ASMP. There were no differences at 2 yr, but at 3 yr, those in ASMP had improvements in role function and doctor visits compared with SMART.</p>	
			<p>Intervention</p> <p>CDSMP is based on the generic principles of the Arthritis Self-Management Program, with 20 hr of peer training that included information on exercises, medication management, problem solving, energy conservation, modeling, and social strategies to improve self-efficacy</p> <p>Outcome Measures</p> <ul style="list-style-type: none"> <li>• Health status (self-rated health, disability, social/role activities limitations, energy/fatigue, and health distress)</li> <li>• Health care utilization</li> <li>• Perceived self-efficacy</li> </ul>	<p>82% of participants completed data at 1-yr intervals, and 76% completed data at 2-yr intervals. At the end of 2 yr, ER/outpatient visits and health distress were reduced and self-efficacy was improved. There were no significant changes for other measures of health status, which may be indicative of the maintenance of health status.</p>	Lack of control group
Montgomery & Dennis (2003)	Determine the effectiveness of cognitive-behavioral interventions to improve the quality, duration, and efficiency of sleep for older adults	<p>Level I Meta-analysis</p> <p>N = 6 studies: Cochrane review that searched Medline, EMBASE, CINAHL, Psycinfo, and Cochrane Library for randomized controlled trials</p>	<p>Intervention</p> <p>Cognitive-behavioral therapy (CBT) for insomnia in older adults</p>	<p>The results of the meta-analysis indicate that CBT has a mild effect on sleep problems in older adults, particularly for insomnia related to sleep maintenance. Though there was initial improvement in total sleep duration, night waking, and</p>	<p>Overlap between types of sleep hygiene interventions</p> <p>Did not use standard criteria for diagnosing sleep problems</p>

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**Supplemental Table 1. Occupation- and Activity-Based Health Management and Maintenance Interventions for Community-Dwelling Older Adults (N = 28) (cont.)**

Author/Year	Study Objectives	Level/Design/Participants	Intervention and Outcome Measures	Results	Study Limitations
Murphy, Lyden, Smith, Dong, & Kolliba (2010)	Examine the effects of tailored activity pacing on pain and fatigue in adults with knee or hip osteoarthritis	Level I RCT N = 32 Tailored intervention n = 17 Control n = 15	<i>Intervention</i> Tailored activity pacing: Participants received education on activity pacing or alternating activity with rest, plus tailored recommendations made by an occupational therapist based on personalized report <i>Outcome Measures</i> • WOMAC–Pain • Brief Fatigue Inventory, Fatigue Severity and Fatigue Interference subscales	sleep efficiency, the effects eroded over time. Participants in the tailored group had less fatigue interference than those in the control group at 10-wk follow-up, with a large effect size for the group difference. Though there was no statistically significant difference between groups for fatigue severity, there was a moderate to large effect size for the group difference. There were no group differences for pain reduction.	Small sample size
Murphy et al. (2008)	Examine the effects of activity strategy training (AST) on teaching adaptive strategies for symptom control and engagement in physical activity (PA)	Level I Pilot RCT N = 54 older adults (mean age: 75.3 yr) with hip or knee osteoarthritis at senior centers/housing facilities Exercise + AST n = 28 Exercise + health education n = 26	<i>Intervention</i> Exercise + AST: Exercise plus group discussion, activity pacing, and occupational therapy session at home to individualize program <i>Exercise + health education:</i> Education program from Arthritis Foundation <i>Outcome Measures</i> • WOMAC • Pain • CHAMPS questionnaire • Physical activity • Accelerometer	Those in Exercise + AST had significantly higher levels of objective peak PA compared with those receiving Exercise + health education. There were no differences for other outcomes.	Small sample size Study group was primarily White, well-educated women, which may limit generalizability.
Newbould, Taylor, & Bury (2006)	Evaluate the effectiveness of lay-led chronic disease self-management programs	Level I Systematic review 12 databases searched	<i>Intervention</i> Lay-led chronic disease self-management programs, both disease specific and generic, were investigated. Seventeen articles and two conference papers met the criteria.	The evidence to date indicates short-term rather than long-term benefits of lay-led self-management programs.	Study is of good quality.
Ostaszkievicz, Chestney, & Roe (2004)	Assess the effectiveness of habit retraining for the management of urinary incontinence in adults	Level I Systematic review	<i>Intervention</i> Habit retraining is a form of toilet assistance by caregivers for	There is limited evidence from the 4 trials included in the review that habit retraining is effective for the	Varied features of programs

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Author/Year	Study Objectives	Level/Design/Participants	Intervention and Outcome Measures	Results	Study Limitations
Phelan, Williams, Penninx, LoGerfo, & Leveille (2004)	Evaluate the efficacy of the Health Enhancement Program (HEP) in preventing and reducing disability in ADLs in community-dwelling older adults	This Cochrane review included all randomized or quasi-randomized trials of habit retraining for the management of urinary incontinence in adults.  Level I RCT  N = 201 participants >70 yr, independent in ADLs with one or more chronic conditions and not participating in senior center activities  Intervention group n = 101 Control group n = 100	persons with incontinence. It is individualized to the routines of each person.  <i>Outcome Measures</i> <ul style="list-style-type: none"> <li>• Incidence and/or severity of incontinence</li> <li>• Cost, role strain, role burden</li> <li>• Incidence of skin rash, urinary tract infection, skin breakdown</li> </ul>	management of urinary incontinence in older adults. The results also indicate that habit retraining may be problematic for carers.  Each trial had missing data and high attrition.  Analyses did not use intention to treat.	The quality of the trials was modest, with poor reporting on levels of concealment to allocation, interventions, and outcome assessment.  Small sample size  No information provided on level of participation in HEP programs
Reid et al. (2008)	Synthesize the scientific literature regarding self-management strategies for pain caused by musculoskeletal disorders, with a particular emphasis on studies that examine program outcomes among older adults with chronic pain and programs and strategies appropriate for use in community settings	Level I Systematic review N = 27 articles  Articles published between 1980 and 2007 in English found using the following key words: <i>self-care, patient education, arthritis, osteoarthritis, pain, yoga, massage, Tai Chi, aged, chronic pain, self-management, and Arthritis Foundation</i>	<i>Intervention</i> Articles evaluated the following self-management programs designed to reduce pain and improve function among older adults with chronic noncancer pain or arthritis: Arthritis Foundation Self-Help Program, Arthritis Foundation Aquatic Program, yoga, massage therapy, and tai chi.  <i>Outcome Measures</i> <ul style="list-style-type: none"> <li>• Pain</li> <li>• Disability</li> <li>• Self-efficacy</li> <li>• Depression</li> <li>• bothersome anxiety</li> <li>• Sleep</li> </ul>	Those in HEP with any ADL disability at baseline demonstrated greater improvement in ADL function over 12 mo than those in the control group. There was no difference between groups in the development of new ADL disability or worsening of ADL function.  Researchers found that in 96% (26 of 27) of studies examined, positive outcomes resulted. The outcome for pain ranged from an increase of 18% to a decrease of 85%, with a median 23% reduction. The changes in disability scores ranged from an increase of 2% to a 70% reduction, with a median 19% reduction.	Limited enrollment of ethnic minority older adults  Psychoinfo not included in search strategy

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Author/Year	Study Objectives	Level/Design/Participants	Intervention and Outcome Measures	Results	Study Limitations
Rejeski et al. (2003)	Compare the effects of a traditional cardiac rehabilitation program (CRP) involving exercise training and a group-mediated cognitive-behavioral (GMCB) intervention targeting change in older adults' physical activity and fitness	Level I RCT  N = 147 adults ages 50–80 yr (mean age: 65) who either were at high risk for CVD or had documented evidence of CVD. Participants also had a self-reported disability.  CRP n = 37 men, 37 women GMCB n = 40 men, 33 women	<i>Intervention</i> CRP: Center-based training that included walking and upper body strength training  GMCB: Exercise therapy plus 20–25 min period of instruction and counseling with homework regarding self-regulatory tools to maintain long-term physical activity and functional independence  <i>Outcome Measures</i> • MET level: symptom-limited maximal graded exercise test • Self-efficacy • Self-reported physical activity • Physical Activity Recall	Though participants in each treatment arm made positive change from baseline on all three outcome variables at both the 3- and 12-mo assessment, those in the GMCB group had significantly better outcomes than those in the CRP group.	Study is of good quality.
Wallace et al. (1998)	Evaluate the effectiveness of a multicomponent disability prevention program	Level I RCT  N = 100 participants >65 yr and ambulatory  Intervention group n = 53  Control group n = 47	<i>Intervention</i> <i>Intervention group:</i> All members of the intervention group received an exercise intervention, nutrition counseling, and a home safety assessment. Smoking and alcohol interventions were delivered to at-risk participants.  <i>Control group:</i> No treatment  <i>Outcome Measures</i> • SF-36 • Center for Epidemiologic Studies–Depression scale • Self-reported physical disability	6-mo adjusted scores indicate that the intervention group had fewer depressive symptoms than the control group and higher scores on the following SF-36 subscales: role limitations—physical, role limitations—emotional, social functioning, mental health, energy/fatigue, and general health perceptions. There were no differences in number of restricted activities or bed days and scores on the bodily pain and physical functioning subscales of the SF-36.	The control group did not receive attention similar to intervention group.  Difficulty generalizing due to the composition of the study population—predominantly White, relatively well educated and healthy

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Warsi, Wang, LaValley, Avorn, & Solomon (2004)	Evaluate the effectiveness of patient programs for chronic disease self-management	Level I Systematic review MEDLINE and HealthSTAR search for 1964–1999; 71 trials included	<i>Intervention</i> Studies were included in the review if they had a self-management education intervention and a control group and evaluated clinical outcomes. Chronic conditions examined were arthritis, asthma, diabetes, hypertension, and miscellaneous.	Small to moderate positive effects were found for diabetes and asthma. No difference was found for arthritis. The results of a meta-regression indicated that face-to-face contact resulted in better outcomes.	Wide variation in trial methods and types of chronic illness

*Note.* ADLs = activities of daily living; CDSMP = chronic disease self-management program; CVD = cardiovascular disease; ER = emergency room; FSQ = Functional Status Questionnaire; HROOL = health-related quality of life; IADLs = instrumental activities of daily living; LDL = low-density lipoprotein; RCT = randomized controlled trial; SF-36 = 36-item Short Form Health Survey; WOMAC = Western Ontario & McMaster Universities Osteoarthritis Index.

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