Efficacy of the Self-Mutual-Group model targeting quality of life improvement among empty-nest elderly: An intervention study

Chichen Zhang (zhangchichen@sina.com)
Southern Medical University  https://orcid.org/0000-0003-1095-9939

Yaqing Xue
Southern Medical University

Yuan Cai
Shanxi Medical University

Jiao Lu
Shanxi Medical University

Xiao Zheng
Southern Medical University

Wenpei Yuan
Shanxi Medical University

Yi Qian
Southern Medical University

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Abstract

Background

The “empty nest” family is becoming the main family pattern in China. Meanwhile, the health-related quality of life of empty-nest elderly is an increasing public health concern. This research aims to examine the effectiveness of Self-Mutual-Group (SMG) model in improving quality of life of the empty-nest elderly to provide a scientific evidence for improving their health.

Methods

A prospective intervention study was conducted among empty-nest elderly in Taiyuan, Shanxi. Participants who met the inclusion criteria were assigned randomly to the intervention or control group. The intervention group received a seven-month SMG-based intervention. A participant's quality of life was measured at the baseline and seven months after using the Short Form 36-Item Health Survey (SF-36).

Results

No significant difference was found between the intervention and control groups in terms of participant characteristics at baseline ($P > 0.05$). After the intervention, participants’ scores on Mental Component Summary (MCS), Physical Component Summary (PCS), role emotional (RE), vitality (VT), social function (SF), mental health (MH) and general health (GH) increased significantly in the intervention group. Additionally, these scores differed significantly from those in the control group ($P < 0.05$).

Conclusion

This study showed that the SMG-based health management is effective in improving quality of life among empty-nest elderly after seven months.

Trial registration

Study on the ‘SMG’ Health Management Model Based on Community Organization Theory among empty-nest elderly (ChiCTR1800015884). Registration date: 26-04-2018. Retrospectively registered.

Background

With rapid economic development, the extension of average life expectancy, and the decrease in fertility rate, China has entered a period of accelerated population aging. Currently, on the mainland China, approximately one fifth of the total population is aged 60 years and older, accounting for more than 200 million people. At the same time, more older people have encountered a situation called “empty nest.” In 2015, the China family development report (2015) released by the National Health and Family Planning Commission showed that empty nesters accounted for half of all the elderly in 2015, of which 10% lived alone and 41.9% lived only with their spouses. By 2020, the number of empty nesters will grow to 118 million, indicating that the empty-nest problem will certainly become a serious public health issue. In China, an empty-nest family refers to an older adult living alone or with his or her spouse. In the traditional family pattern, which is influenced by the Confucian filial piety culture, children usually take care of their parents when the latter get older. In recent years, however, because of
practical problems, such as work and family, an increasing number of children choose not to live with their parents. This phenomenon means that often no adult children is around when older adults need help.

Shrinking social resources and a lack of emotional support for empty nesters could lead to a greater risk of health problems. This situation is contrary to the “healthy aging” advocated by the World Health Organization (WHO). Healthy aging is manifested in not only the extension of the life of the elderly but also, more importantly, the improvement of their quality of life. Previous research on quality of life in the general population has assumed that quality of life decreases as people age. Indeed, as age increases, the physiological function in the elderly declines gradually, making them more susceptible to various diseases and health problems. A systematic review demonstrated that among older Chinese adults (aged ≥ 60 years), the overall prevalence of multimorbidity was up to 87.0% in urban residents. As a vulnerable group, the empty-nest elderly have also been given great concern. Many studies that have been conducted in China have demonstrated that the social supports, quality of life, and mental health were poor in empty-nest elderly. A research found that in Xiamen City, empty nesters had lower values on a range of indicators relating to physical and mental health and social adaptation; moreover, older adults living alone had a significantly worse quality of life than others. A significant association was also found among empty nesters, noting that they are more sensitive to chronic conditions. Some studies also found that empty-nest elderly may experience more discomfort, anxiety, and depression. Gao et al. found that an empty nest had a significant adverse influence on elderly individuals’ physical health, cognitive ability, and psychological health. In fact, empty nesters have experienced not only the restructuring of their lifecycle but also the transformation of the family cycle. When children move out of their homes, the elderly usually feel abandoned by their children and become more frustrated, depressed, and anxious. Therefore, it is necessary to find effective ways to improve the quality of life of empty-nest elderly.

Previous studies have proposed various interventions to improve the quality of life of the elderly but showed limited effectiveness. Van Uffelen et al. conducted a randomized, placebo controlled intervention trial to examine the effect of walking and vitamin B supplements on quality of life. The results showed that the walking program and vitamin B supplements were not effective in improving quality of life in community-dwelling older adults. Taguchi et al. found that although several studies have shown beneficial effects of exercise on health-related quality of life (HRQOL) in the elderly, their intervention trial failed to demonstrate such an effect for any measure of HRQOL, except for the Falls Efficacy Scale. The limited effectiveness of interventions in these studies may be related to participants’ compliance and motivation. A few researchers also found that participants’ motivation was not high during the intervention process, and the interventions were only maintained until the end of the study. Thus, some researchers have tried to conduct group interventions. Wu et al. conducted a group psychological intervention to improve quality of life among cancer patients, showing significant changes in quality of life. Wang et al. found that a community comprehensive health management intervention can improve the quality of life of the elderly with hypertension. The group intervention can take measures against common goals and ensure that participants maintain a high level of participation. However, this intervention cannot meet all specific individual requirements. Therefore, effective interventions should not only consider individual needs but also help participants maintain long-term behavioral changes to achieve long-term benefits.

Based on the above, we focused on improving individuals’ awareness of health management and ability in self-management, mutual-management, and group-management by increasing their self-efficacy, and then constructed a Self-Mutual-Group (SMG) model. Considering the particularity of the empty-nest elderly, we
divided SMG-based health management into three stages and designed a set of interventions for individuals and groups. The first stage involves the provision of individual health management guidance according to the health needs of each participant. In the next two stages, peers and team members play a major role. Encouragement from peers and members can inspire participants’ confidence and determination for continuous participation. We hypothesized that the SMG-based intervention is effective in improving quality of life of the empty-nest elderly. The purpose of this study was to conduct an empirical study of the empty nesters in Shanxi Province to evaluate the effects of the SMG-based health management model on quality of life.

### Methods

#### Study design and participants

We conducted a randomized controlled trial in Taiyuan, which is the capital of the Shanxi Province and has six districts (Yingze, Xiaodian, Xinghualing, Wanbailin, Jinyuan, and Jiancaoping). A multi-stage stratified random cluster sampling method was used to select participants for the intervention from the six districts. First, the six districts were divided into three economic levels using their gross domestic product (GDP) based on government data taken from the website: high (Yingze, Xiaodian), medium (Xinghualing, Jiancaoping), and low (Wanbailin, Jinyuan). Then one district was selected randomly at each level by drawing lots. Second, each community in the three selected districts was numbered according to the order of communities in the government website, then two communities were selected randomly in each district using a random-number table. All the empty-nest elderly living in the selected communities were considered candidates for participation in the study. The empty-nest elderly, who were aged 60 years and above, had no cognitive disorder or other mental illnesses, provided informed consent, were willing and able to complete the investigation, and were residing in the community for at least a year before the study, were eligible for the study. The exclusion criterion was having cognitive disorders or serious diseases, such as deafness, psychiatric disorders, or Alzheimer's disease.

The sample size was estimated according to the following formula

$$N_1 = N_2 = \frac{2(Z_a + Z_p)^2 \times \sigma^2}{d^2}.$$  

A total of 396 empty nesters were enrolled as participants, of which 204 and 192 were in the intervention and control group, respectively. Figure 1 presents the details of participant involvement. The study was approved by the institutional review boards of Shanxi Medical University. A written informed consent was obtained from all participants.

#### Interventions

From October 2016 to May 2017, the intervention group participated in a seven-month SMG-based intervention, which consisted of three stages: self-management (1–2 months), mutual-management (3–4 months), and group-management (5–7 months). The first stage was aimed at the empty-nest elderly individuals to develop their self-health management awareness and ability, such as self-care awareness, active medical awareness, self-health assessment ability, and self-service medical equipment use ability. At the mutual-management stage, the empty nesters in the same community were paired according to their age, gender, relationship status, home distance, and other factors to form mutual-management; if necessary, volunteers or study staff members were introduced to participate in the pairing. The third stage involved the implementation of group health management based on the first two levels. Groups were categorized by disease type and residential area. For the former, because the empty-nest elderly often face common health problems, there is a common interest in implementing certain
goals. For the latter, the principle of proximity was considered; participants were expected not to drop out of the intervention because of distance problems. Details of the intervention are shown in Figure 2. In the entire intervention process, researchers and community workers played the role of health management instructors to assist in the implementation and development of the three types of management. The control group received a routine follow-up without any intervention. Finally, 350 empty-nest elderly completed the study continuously, of which 167 and 183 completed the seven-month SMG-based intervention and seven-month routine follow-up, respectively. Attrition rate was 11.6%.

**Instruments**

The general information questionnaire was used to assess the participants’ demographic information, including age, gender, education, marital status, frequency of children visit, employment status, monthly income, social activity participation, self-care ability, and chronic disease.

The primary outcome variable, that is, quality of life of the empty-nest elderly, was measured using the Short Form 36-Item Health Survey (SF-36), which was developed in the United States and designed to allow self-evaluation of quality of life. It made up of 36 questions and two summary scores, namely, Physical and Mental Component Summary (PCS and MCS, respectively). The PCS encompassed the following dimensions: physical function (PF), role physical (RP), bodily pain (BP), and general health (GH). The MCS contained the following dimensions: vitality (VT), social function (SF), mental health (MH), and role emotional (RE). Individual item scores were summed up and transformed into a 0–100 scale, ranging from the worst to the best possible quality of life. At present, the SF-36 has been used widely in evaluating quality of life, including both the physical and mental health of the empty nest elderly in China. In this study, the scale’s Cronbach’s α was 0.751.

Questionnaires were administered at baseline and post-intervention (seven months). The questionnaire was completed following a face-to-face interview between an interviewer and a participant and collected on the spot. To ensure quality, completed questionnaires were checked carefully by quality supervisors after the interview. The response rate was 100%.

**Statistical analysis**

EpiData was used for entering and checking the validity of data, and SPSS 22.0 software for statistical analysis. Data were expressed as mean ± SD (standard deviation). Difference between groups in terms of baseline characteristics was tested using chi-square test. The effect of the intervention versus control conditions was examined using ANCOVA analysis on post-intervention measurement values, controlling for pre-intervention scores. Cohen’s d was provided to evaluate the effect size with a guideline: trivial (<0.20), small (0.20 to <0.50), moderate (0.50 to <0.80), and large (≥0.80). P value was statistically significant at (P < 0.05).

**Results**

**Participants’ sociodemographic**

Participants’ sociodemographic characteristics are shown in Table 1. Of the 350 participants, 190 (54.3%) were male and 160 (45.7%) were female; 244 (69.7%) were married and 16 (4.6%) had never been married; the age range was 60–88 years with a mean age of 69.96±6.43 years. Meanwhile, 238 (68%) participants had a certain
income every month, such as retirement pensions and supply from children or spouse, whereas 112 (32%) did not have a steady income. In addition, most participants graduated from secondary school or below (77.4%), were living with their spouse (60.9%), and completely self-cared (80.6%). No significant differences were found between intervention and control groups in terms of participant characteristics at baseline ($P > 0.05$).

**Effects of the SMG-based intervention**

The mean scores on the SF-36 for intervention and control groups at baseline and after the seven-month follow up are shown in Table 2. After controlling for pre-intervention assessment values, the post-intervention scores on MCS ($F = 105.146, P < 0.001, \text{Cohen's } d = 0.62$), PCS ($F = 73.922, P = 0.011, \text{Cohen's } d = 0.32$), RE ($F = 71.127, P < 0.001, \text{Cohen's } d = 0.62$), VT ($F = 35.404, P < 0.001, \text{Cohen's } d = 0.35$), SF ($F = 112.945, P < 0.001, \text{Cohen's } d = 0.53$), MH ($F = 76.223, P < 0.001, \text{Cohen's } d = 0.48$), and GH ($F = 20.150, P < 0.001, \text{Cohen's } d = 0.31$) for intervention and control groups were significantly different. However, no significant differences in the scores on PF ($F = 0.405, P = 0.525, \text{Cohen's } d = 0.05$), RP ($F = 0.736, P = 0.392, \text{Cohen's } d = 0.12$), and BP ($F = 2.429, P = 0.120, \text{Cohen's } d = 0.08$) were observed between the intervention and control groups. The effect sizes are shown in Figure 3.

**Discussion**

The main finding of this study was that in comparison to the control group, empty nesters who participated in the seven-month SMG-based intervention had significant improvement in quality of life. The mean scores for MCS, PCS, RE, VT, SF, MH, and GH among empty-nest elderly increased significantly. Moreover, these scores differed significantly from the corresponding scores in the control group.

In simplest terms, self-management describes what a person does to manage his/her disease\textsuperscript{21}. A cross-sectional study\textsuperscript{4} found that empty nesters’ awareness of self-health management is weak. Since empty nesters do not want their children to worry, they usually hide their illness and do not care about their health. They were also less likely to consult doctors\textsuperscript{9}. These findings indicate that strong awareness of health responsibility may not have been formed among them. Therefore, the first stage of intervention is to help empty nesters develop self-health management awareness and ability. At the self-management stage, health responsibility is transferred to empty nesters themselves. Empty nesters are fully empowered as owners to understand and solve their own health problems with maximum self-efficacy. Previous studies have indicated a positive and significant relationship between social support and quality of life in the elderly\textsuperscript{22--24}. Specifically, Fatemeh et al. suggested that the elderly should be encouraged to participate in activities to improve their quality of life. In this study, mutual-management and group-management training were employed fully mobilize the enthusiasm of empty nesters to participate in social activities. Encouragement from peers can also inspire confidence in their continued participation. Owing to the particularity of empty nesters, it is difficult to achieve the expected results by a single management method. Therefore, this study divided health management into three stages to implement the intervention progressively. The series of measures, from individual to team, ensured the effectiveness of the full intervention.

Several studies have found that good social relationships (including relationships with relatives, neighbors, and friends) are the most commonly reported factor influencing quality of life in the elderly\textsuperscript{25,26}. After retirement, the elderly usually return to their families and thus their professional and social roles are weakened. According to
family theory, the elderly who have stepped into the empty-nest period lose social support and emotional communication because of the absence of their children. They may doubt their existence and fall easily into a boring, helpless state. Therefore, in mutual-management and group-management stages, the emotional support provided by group members could meet their emotional needs to a certain degree. An offer of help from neighbors or friends could also alleviate their risk of being excluded from society. Moreover, study staff members conducted home visits once every two weeks to provide sufficient support and encouragement. By responding actively to their needs, study staff members ensured that the empty nesters would not feel uneasy when asking others for help because of concerns about burdening others and being rejected. These measures helped participants eliminate bad mood and maintain a healthy psychological state, which contributed to the significant increase in their scores related to psychological dimensions, including VT, SF, MH, RE, and MCS.

A cross-sectional study in Shaanxi province showed that education has a major influence on the quality of life among the elderly in China. For example, Lasheras et al. indicated that a low educational level is associated with unhappiness, poor social relationships, and poor self-assessed health among the elderly. Highly educated people usually have stronger awareness of health management and pay more attention to their health status. Overall, however, the participants of this study have a low educational level. Therefore, popularization of health-related knowledge is particularly important. In the intervention, we held a series of lectures about quality of life, grasped their actual needs, and provided the necessary help. In the second stage, a Health Management Consultation Day was held. Participants could consult about health knowledge related to their illnesses. In the third stage, we also held a meeting to share mutual-assistant experiences. At the meeting, highly educated empty nesters shared their experiences and knowledge with others and offered necessary help through life or emotional support. Based on the above, participants had comprehensive understanding of their health and began to pay attention to having a healthy lifestyle. Meanwhile, at the end of the intervention, many empty nesters became friends with each other and stated that they would later organize related activities together to make use of their spare time.

In this study, no positive main effect on PF, RP, and BP was observed among empty-nest elderly. For physical function, this study assessed mainly the impact of participants’ health on daily life, such as strenuous exercise, housework, and going up and down the stairs. For physical role, this study assessed the impact of health status on the completion of work or social activities. For bodily pain, this study assessed the extent of physical pain. The result indicated that intervention had limited effects on improving physical health, which could be attributed to the disease of empty nesters. Previous studies have showed that chronic disease is among the significant risk factors affecting quality of life in the elderly. Chronic diseases not only impair the health status of empty nesters but also affect their social activities. High medical costs may also cause a huge psychological burden. In the survey, we found that the empty nesters have one or more chronic diseases, such as hypertension, diabetes, arthritis, asthma, and cardiovascular disease. Many participants with arthritis reported having difficulty climbing stairs and some hypertensive patients had been recommended not to take strenuous exercises. According to the results, participants’ mental health improved, but the interventions had limited effect on alleviating long-term physical pain. Additionally, the intervention duration was limited given that physical health and lifestyle changes might be long-term processes. Therefore, professional medical services are needed to improve the physical health of individuals in this frail population.

Although there was no significant improvement in other dimensions of PCS, such as PF, RP, and BP, the current results indicated that the scores of GH and PCS also increased significantly after the intervention. The GH
dimension is a self-assessment of overall health, whereas the PCS encompassed physical component scores. Findings indicate that participants felt their health improved after the intervention, which could be attributed to subjectivity of their self-assessment. Therefore, in future studies, multi-point measurement should be considered to evaluate better the intervention process and outcomes.

Limitations

There are some limitations in this study that must be acknowledged. First, the low literacy level and advanced age of the study population might have caused participants to misunderstand the questions or give inaccurate responses. Second, researchers were not blinded to group allocation and the final statistical analyses. Therefore, subjective biases might have occurred inevitably when researchers conducted face-to-face interviews with participants. Moreover, although the group allocation was not actively disclosed to participants during the research process, participants in the intervention group might have guessed what the researchers wanted, the intervention effects might have been exaggerated. In addition, studies have shown the potential value of using more than one measures in a trial. However, this study used only the SF-36 to measure the main outcomes. Therefore, future studies can use different measurements to assess better the long-term effects of interventions on quality of life.

Conclusion

Our study demonstrated that the SMG-based health management has a positive effect on improving quality of life of empty-nest elderly. It provided a new perspective on bettering the quality of life of empty nesters, thereby establishing an important theoretical and practical foundation for the improvement and promotion of the model. These results should be tested further in larger samples and different settings.

Abbreviations

SMG: Self-Mutual-Group; SF-36: Short Form 36-Item Health Survey;

MCS: Mental Component Summary; PCS: Physical Component Summary;

PF: physical function; RP: role physical; BP: bodily pain; GH: general health;

RE: role emotional; VT: vitality; SF: social function; MH: mental health;

HRQOL: health-related quality of life.

Declarations

Ethics approval and consent to participate

The Ethical Committee of Shanxi Medical University approved the study protocol.

The investigation was conducted after the informed consents of all participants were obtained.

Consent for publication
Not applicable.

**Availability of data and materials**

The dataset analysed during the current study is available from the corresponding author on reasonable request.

**Competing interests**

The authors declare that they have no competing interests.

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**Author Contributions**

CCZ designed this study, participated in its implementation, and served as the lead writer. YQX did the data interpretation and co-wrote the article. YC, JL were involved in the study design and critically revised the article, XZ and WPY helped collect the data and research the literature. YQ helped with formatting of this manuscript. All authors have seen and approved the final manuscript.

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**Tables**

Table 1 Comparison of the characteristics of the intervention and control groups
| Characteristic               | Total | Intervention | Control | \( \chi^2 \) | \( P \) |
|-----------------------------|-------|--------------|---------|--------------|-------|
|                            | \( N(\%) \) | \( n(\%) \) | \( n(\%) \) |            |       |
| **Gender**                  |       |              |         |              |       |
| Male                        | 190 (54.3) | 96 (57.5) | 94 (51.4) | 1.317 | 0.251 |
| Female                      | 160 (45.7) | 71 (42.5) | 89 (48.6) |       |       |
| **Age**                     |       |              |         |              |       |
| 60–69 years                 | 175 (50.0) | 86 (51.5) | 89 (48.6) | 1.865 | 0.394 |
| 70–79 years                 | 135 (38.6) | 59 (35.3) | 76 (41.5) |       |       |
| 80 years or above           | 40 (11.4) | 22 (13.2) | 18 (9.9)  |       |       |
| **Education**               |       |              |         |              |       |
| No education                | 79 (22.6) | 36 (21.6) | 43 (23.5) | 0.986 | 0.964 |
| Primary school              | 95 (27.1) | 47 (28.1) | 48 (26.2) |       |       |
| Secondary school            | 97 (27.7) | 48 (28.7) | 49 (26.8) |       |       |
| High school                 | 54 (15.4) | 26 (15.6) | 28 (15.3) |       |       |
| Junior college              | 10 (2.9) | 4 (2.4) | 6 (3.3) |       |       |
| University or above         | 15 (4.3) | 6 (3.6) | 9 (4.9) |       |       |
| **Marital Status**          |       |              |         |              |       |
| Married                     | 244 (69.7) | 113 (67.7) | 131 (71.6) | 0.948 | 0.814 |
| Never married               | 16 (4.6) | 9 (5.4) | 7 (3.8) |       |       |
| Divorced                    | 10 (2.9) | 5 (3.0) | 5 (2.7) |       |       |
| Widowed                     | 80 (22.8) | 40 (23.9) | 40 (21.9) |       |       |
| **Living form**             |       |              |         |              |       |
| Living with spouse          | 213 (60.8) | 101 (60.5) | 112 (61.2) | 0.919 | 0.821 |
| Living alone                | 78 (22.3) | 39 (23.3) | 39 (21.3) |       |       |
| Living with parents         | 50 (14.3) | 24 (14.4) | 26 (14.2) |       |       |
| Living in a nursing home    | 9 (2.6) | 3 (1.8) | 6 (3.3) |       |       |
| **Children visit frequency**|       |              |         |              |       |
| Never visit                 | 4 (1.1) | 2 (1.2) | 2 (1.1) | 45.732 | <0.001 |
| Irregularly                 | 3 (0.9) | 1 (0.6) | 2 (1.1) |       |       |
| Once more than half a year  | 7 (2.0) | 4 (2.4) | 3 (1.6) |       |       |
| Once every six months       | 108 (30.9) | 51 (30.5) | 57 (31.2) |       |       |
| Frequency | Group 1 | Group 2 | Group 3 |
|-----------|---------|---------|---------|
| 1–2 times a month | 113 (32.3) | 52 (31.1) | 61 (33.3) |
| Once a week | 52 (14.8) | 29 (17.4) | 23 (12.6) |
| More than once a week | 63 (18.0) | 28 (16.8) | 35 (19.1) |

**Employment status**

| Status      | Group 1 | Group 2 | Group 3 |
|-------------|---------|---------|---------|
| Working     | 35 (10.0) | 18 (10.8) | 17 (9.3) |
| Not working | 315 (90.0) | 149 (89.2) | 166 (90.7) |

**Income Source**

| Source               | Group 1 | Group 2 | Group 3 |
|----------------------|---------|---------|---------|
| Retirement pensions  | 127 (36.3) | 64 (38.3) | 63 (34.4) |
| Personal labor income| 58 (16.6) | 23 (13.8) | 35 (19.1) |
| Child supply         | 108 (30.9) | 54 (32.3) | 54 (29.5) |
| Spouse supply        | 20 (5.7) | 9 (5.4) | 11 (6.0) |
| Social relief        | 32 (9.1) | 14 (8.4) | 18 (9.9) |
| Other                | 5 (1.4) | 3 (1.8) | 2 (1.1) |

**Monthly income**

| Income          | Group 1 | Group 2 | Group 3 |
|-----------------|---------|---------|---------|
| No income       | 112 (32.0) | 51 (30.5) | 61 (33.3) |
| < 1000 RMB      | 88 (25.1) | 43 (25.8) | 45 (24.6) |
| 1000–3000 RMB   | 90 (25.7) | 40 (23.9) | 50 (27.3) |
| > 3000 RMB      | 60 (17.2) | 33 (19.8) | 27 (14.8) |

**Spousal relationship**

| Relationship | Group 1 | Group 2 | Group 3 |
|--------------|---------|---------|---------|
| Perfect      | 125 (38.6) | 62 (40.5) | 63 (36.8) |
| Good         | 170 (52.5) | 79 (51.6) | 91 (53.2) |
| Bad          | 25 (7.7) | 9 (5.9) | 16 (9.4) |
| Worst        | 4 (1.2) | 3 (2.0) | 1 (0.6) |

**Relationship with their children**

| Relationship | Group 1 | Group 2 | Group 3 |
|--------------|---------|---------|---------|
| Perfect      | 119 (35.6) | 58 (36.7) | 61 (34.7) |
| Good         | 188 (56.3) | 86 (54.4) | 102 (57.9) |
| Bad          | 22 (6.6) | 12 (7.6) | 10 (5.7) |
| Worst        | 5 (1.5) | 2 (1.3) | 3 (1.7) |

**Social activity participation**

| Participation | Group 1 | Group 2 | Group 3 |
|---------------|---------|---------|---------|
| Most          | 37 (10.6) | 19 (11.4) | 18 (9.8) |
| More          | 117 (33.4) | 60 (35.9) | 57 (31.2) |
| Less          | 154 (44.0) | 69 (41.3) | 85 (46.4) |
|                | No        | 19 (11.4) | 23 (12.6) |
|----------------|-----------|-----------|-----------|
| **Self-care ability** |           |           |           |
| Completely self-care | 282 (80.6) | 136 (81.4) | 146 (79.8) |
| Partly self-care     | 68 (19.4)  | 31 (18.6)  | 37 (20.2)  |
| **Chronic disease**  |           |           |           |
| Yes               | 109 (31.1) | 44 (26.4)  | 65 (35.5)  |
| No                | 241 (68.9) | 123 (73.6) | 118 (64.5) |

**Note.** The survey of the spousal relationship did not include the participants who had never married or were divorced, and the survey of their relationships with their children did not include participants without children.

**Table 2 SF-36 scores at baseline and after 7 months with pre-intervention scores as a covariate**
| Variables | Group   | Pre-intervention | Post-intervention | $F$   | Cohen's |
|-----------|---------|------------------|-------------------|-------|---------|
|           | N       | Mean ± SD        | N                 | Unadjusted | Adjusted |
|           |         |                  |                   | Mean ± SD | Mean ± SD |
| PF        | Intervention 204 | 68.80±22.53  | 167 | 68.92±22.29 | 68.27±0.12 | 0.405 | 0.05 |
|           | Control 192 | 67.54±23.54    | 183 | 67.79±23.24 | 68.38±0.12 |
| RP        | Intervention 204 | 55.24±39.75  | 167 | 56.59±39.60 | 54.40±0.53 | 0.736 | 0.12 |
|           | Control 192 | 50.96±39.08    | 183 | 51.78±38.61 | 53.77±0.51 |
| BP        | Intervention 204 | 69.58±16.38  | 167 | 71.24±15.98 | 71.33±0.69 | 2.429 | 0.08 |
|           | Control 192 | 69.78±18.91    | 183 | 69.92±18.92 | 69.84±0.66 |
| GH        | Intervention 204 | 57.02±17.31  | 167 | 60.96±17.71 | 60.94±0.93 | 20.150* | 0.31 |
|           | Control 192 | 56.98±18.33    | 183 | 55.16±19.20 | 55.17±0.89 |
| VT        | Intervention 204 | 61.23±14.80  | 167 | 66.68±14.57 | 66.77±0.67 | 35.404* | 0.35 |
|           | Control 192 | 61.45±16.13    | 183 | 61.31±16.15 | 61.23±0.64 |
| SF        | Intervention 204 | 68.49±21.09  | 167 | 76.91±20.74 | 75.80±0.59 | 112.945* | 0.53 |
|           | Control 192 | 66.17±20.35    | 183 | 66.13±20.25 | 67.14±0.56 |
| RE        | Intervention 204 | 59.28±38.62  | 167 | 82.83±34.68 | 81.59±1.73 | 71.127* | 0.62 |
|           | Control 192 | 56.10±39.04    | 183 | 60.29±38.46 | 61.43±1.65 |
| MH        | Intervention 204 | 64.50±15.18  | 167 | 71.96±15.05 | 71.99±0.63 | 76.223* | 0.48 |
|           | Control 192 | 64.57±16.08    | 183 | 64.46±16.09 | 64.43±0.60 |
| PCS       | Intervention 204 | 62.66±17.74  | 167 | 66.68±16.44 | 66.02±0.36 | 73.922* | 0.32 |
|           | Control 192 | 61.31±18.45    | 183 | 61.16±18.39 | 61.76±0.34 |
| MCS       | Intervention 204 | 63.38±16.97  | 167 | 72.85±14.55 | 72.30±0.62 | 105.146* | 0.62 |
|           | Control 192 | 62.07±17.51    | 183 | 63.05±17.20 | 63.55±0.59 |

*Note: $^*P < .05.$*