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Feasibility of a Chronic Disease Self-Management Program in an Underserved Population

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Feasibility of a Chronic Disease Self-Management Program in an Underserved Population

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As Americans continue to age, programs that maintain functional independence are increasingly important. Up to 87.6% of persons over age 65 have at least one chronic medical condition, such as hypertension, diabetes, or arthritis. Two-thirds of these individuals have two or more chronic conditions. Outcomes from chronic disease are worse for low income and minority seniors.[1] The Stanford Patient Education Research Center has developed and validated a Chronic Disease Self-Management Program (CDSMP) that trains lay and professional leaders to provide a six-week, weekly workshop to small groups of individuals with varying chronic conditions. The aim is to teach self-care skills common to many chronic conditions. Classes focus on attitudes and self-efficacy for change, including group problem solving (i.e., How do I exercise more in the next week?). Specific knowledge around nutrition, diet, medication compliance issues, and strategies to communicate with health care providers are also taught. This program was previously tested with a comparatively well-educated and largely white population.[2]

The purpose of this study was to evaluate the feasibility of CDSMP with low-income, older African-American adults in an urban setting. Data collected included recruitment experiences, attendance, satisfaction ratings of the workshop sessions, and outcome tools. A one-group pretest-posttest design was used to measure outcomes related to health status, self-efficacy, health behaviors, and health service utilization. Two CDSMP classes were conducted with African-American co-leaders (a health educator and an older adult community member). Subjects were recruited by the staff and lay leaders at the senior adult residence and senior center where the groups were held. A focus group followed each course to explore potential culturally appropriate changes that might be needed in the program.

A total of 33 individuals were recruited for the CDSMP. Each class was over subscribed, and90% of participants completed all aspects of the program and the evaluation. Ninety-four percent were African-American, and 84.8% were women. The participants had a mean age of 72 years and a mean education of 10.9 years. Most (78.8%) reported more than one chronic disease; 64% had three or more chronic conditions. Subjects reported very high satisfaction with the program. Short-term (two month) follow-up suggests that subjects have incorporated increased healthy behaviors, and they believe they will be able to sustain these behaviors.

A key finding of this project was the success of our recruitment and retention strategies. Professional and lay group leaders, as well as the project research assistant, were all African-Americans and were accepted as members of the community. At the end of the program, participants received a gift certificate from a local grocery store, an incentive selected by our community lay leaders.

In summary, the CDSMP was well received by the study population and was found to be culturally relevant as delivered by ethnically concordant staff. These results are similar to Lorig's findings among a younger, middle-class, majority population in California. The next important step is to follow a large sample of CDSMP participants over time to evaluate impact on health status and healthcare utilization.

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References

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