Program: Evidence-Based Disease Prevention: Disease Self-Management

Organization: Philadelphia Corporation for the Aging (PCA)

Project Title: Chronic Disease Self-Management for African American Urban Elders

Project Period: September 30, 2003 TO September 29, 2006

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Evidence Base

The intervention will use the Chronic Disease Self-Management Program (CDSMP), a model developed by K. Lorig *et.al* at Stanford University. This program is a 6-week workshop designed for people with various chronic diseases. Course leaders are non-health professionals who have chronic disease and are trained by CDSMP representatives. Course topics include coping strategies, such as action planning and feedback, behavior modeling, problem-solving techniques, and decision-making. Participants are taught how to cope with frustration, fatigue, and pain. They also learn how to exercise appropriately, use medications appropriately, and communicate effectively with family, friends, and health professionals.

Original Research Evidence

The original research, led by Kate Lorig at Stanford, was published in 1996. The study evaluated the effectiveness of a chronic disease self-management program on changes in health behavior, health status, and health service utilization.

A group of 952 participants age 40 or older, all with chronic disease (heart disease, lung disease, stroke or arthritis), were randomly selected for a treatment group or a control group.

Health behaviors, health status and health service utilization were measured by questionnaire.

After 6 months, results showed that those in the treatment group had improvements in weekly minutes of exercise, frequency of cognitive symptom

management, communications with physicians, self-reported health, health distress, fatigue, disability, and social/role activities limitations. Hospitalizations and days in the hospital were also less for the treatment group.

Adaptation of Model

Whereas the original study focused on white, middle income, older adults through a healthcare organization, the Philadelphia Corporation for Aging will be testing the utility of the program on a low income, primarily African American older population, who are served through the aging network.

Other modifications to the original program include: the use of a community outreach worker, an initial health profile, linking participants to other health promotion activities at the senior center and a discounted fitness membership at the senior center upon completion of the program.

Project's Overall Design

PCA and its partners will demonstrate how an evidence-based disease prevention program can be translated into community programs in the Aging Services Network. They propose to demonstrate a team approach among 4 organizations that can be replicated within the Network. The overall goal is to enable participants to assume a major role maintaining their health and managing their chronic health conditions.

The objectives are:

- To increase lifestyle skills that assist in managing chronic conditions
- To increase knowledge of personal risk factors associated with chronic disease
- To increase personal responsibility in the management of chronic disease

PCA will implement the 6-8 weeks CDSMP courses in a senior center with experience in health promotion activities. Outreach will be conducted using a lay community outreach worker who will spread the word about the program. Various means will be used to recruit participants including newsletters and weekly senior radio programs. Referrals will be generated from both outreach activities and the health care partner.

Target Population

The target population is elderly African American persons with at least one chronic disease. The geographic focus will be the area surrounding the CASP. Of the older persons who reside in this area, more than 85% have at least one chronic condition. Common conditions reported include 62.3% with high blood pressure, 55.6% with arthritis, 29.3% with diabetes, and 19.3% with a heart condition.

Anticipated Outcomes

- Improved self efficacy

- Improved health behaviors
- Improved self-reported health status and symptom management
- Reduced visits to physician, reduced use of ER, and fewer hospitalizations

Evaluation Design

The Process Evaluation will provide Philadelphia Corporation on Aging with a basis from which to monitor and improve the program's efficiency and effectiveness over the span of the project through continuous feedback. Measures for this evaluation will include program attendance, session evaluation questionnaires, and direct observations and interviews of partner staff to provide feedback on the team process.

The Impact Evaluation will use similar outcome measures as used in the original study by Lorig *et al*. Four main areas will be assessed: health status, health behaviors, self-efficacy, and health care utilization. Outcome measures for each respective are include:

- Health Status - chronic conditions, self-rated health, energy/fatigue, symptoms, coping with symptoms, and the illness intrusion scale
- Health Behaviors - physical activity and communication with doctor
- Self-Efficacy – confidence in managing chronic disease symptoms
- Health Care Utilization - physician visits, hospitalizations, ER visits, and skilled nursing facility/intermediate care

Partnerships

- PCA is the Area Agency on Aging (AAA) and grantee for this project. PCA will have the overall administrative responsibility for the project, including monitoring the project progress and making reports to the AoA.
- The Community Aging Service Provider (CASP) is the Center in the Park, a multi-service senior center with more than 5,000 members. As the primary site for this CDSMP intervention, they will lead educational workshops, administer evaluations, and oversee the data collection and transfer to the research organization.
- The research organization is the Community and Homecare Research Division in the Jefferson College of Health Professions, Thomas Jefferson University. Their responsibilities include completing the evaluation of the intervention and the team functioning.
- Albert Einstein Health Care Network is the healthcare provider for this program. They will assure the quality and appropriateness of the health components of the program by making sure information adheres to national standards for chronic diseases. Additional tasks include providing support for health screening events, as well as support from appropriate hospital departments that deal with the identified chronic diseases.