Managing chronic diseases to reduce health disparities

By: Stephanie Fallcreek

SUMMARY

Increasing community members' knowledge and skills about how to manage chronic conditions is a key component in reducing health disparities. In Greater Cleveland, Health Improvement Partnership – Cuyahoga (HIP-Cuyahoga) leveraged Racial and Ethnic Approaches to Community Health (REACH) funding from the Centers for Disease Control and Prevention (CDC) to expand availability of evidence-based chronic disease self-management programs designed to increase participant success in taking control of their health. The specific programs offered included the Chronic Disease Self-Management Program (CDSMP) and Diabetes Self-Management Program (DSMP) developed by Stanford University and licensed by the Self-Management Resource Center (SMERC), and the Diabetes Empowerment Education Program (DEEP) developed at the University of Illinois, Chicago. Each of these programs can be implemented by training lay health leaders from the community to lead workshops within their own neighborhoods. Focused on 7 high poverty neighborhoods, our team implemented strategies to recruit and train leaders for, and connect residents to, the self-management workshops, to support those with chronic disease and build ongoing sustainability for self-management skill-building in the communities. Resident leaders and other lay leaders successfully facilitated workshops in the target neighborhoods, empowering residents, improving health, and building a base to continue offering workshops after REACH.

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CHALLENGE

Chronic conditions such as heart disease, stroke, and diabetes are among the leading causes of death in the US. According to the Centers for Disease Control and Prevention (CDC), these chronic conditions impact quality of life and drive 2.7 trillion in annual health care costs in the US. Despite the presence of renowned healthcare facilities in Cleveland, residents of the city and surrounding inner-ring suburbs face disproportionately high rates of chronic disease. According to the County Health Rankings, Cuyahoga County is ranked 60th out of 88 counties in Ohio for health outcomes.

Risk behaviors including tobacco use, poor nutrition, lack of physical activity, excessive alcohol use, and chronic stress contribute to chronic disease onset and progression. In addition, social and environmental determinants such as economic instability, deteriorating and limited affordable housing, and geographically-limited access to healthy food may affect one's ability to manage their chronic conditions. It is important to acknowledge and address these behaviors and barriers and equip residents with tools and resources to better manage their own health in order to address the high burden of chronic disease in under-resourced neighborhoods.

YOUR INVOLVEMENT IS KEY

HIP-Cuyahoga partners offer chronic disease self-management classes on an ongoing basis. Visit fairhillpartners.org for the program schedule, so you can take charge or your health, or become a health leader in your community.

"I had the opportunity to facilitate a Chronic Disease Self-Management workshop at Stephanie Tubbs Jones Health Center… I saw the residents change right before my eyes, they stopped saying what they can't do [and they started to say] I'll try… they went from looking depressed to being excited to report about what they had accomplished that week. The participants began to realize that the self-management techniques they learned about could really make a difference in their lives."

Delores Collins (Ms. D), community member, advocate, and REACH project trained Chronic Disease Self-Management Leader and Master Trainer

SOLUTION

Active participation by individuals in promoting their own health is critical for prevention, risk-reduction, and management of chronic diseases. Chronic disease self-management programs have been shown to improve health and communication with doctors, while reducing stress and helping manage symptoms like fatigue, pain, and depression. These programs focus on meeting challenges that are common to individuals suffering from diverse chronic conditions, such as pain management, nutrition, exercise, medication use, emotions, and communicating with family, health care providers, and employers.
Our REACH Chronic Disease Management (CDM) team focused on implementing CDSMP, DSMP, and DEEP workshops by recruiting and training lay health leaders from the community to lead these workshops within community-based organizations and neighborhood clinics. Each of these models can be delivered by trained lay leaders, deploying residents of the community to build neighborhood capacity for this work and the potential for long term sustainability and cost effectiveness. The neighborhood peer leader model also can help to overcome some of the fear and trust barriers that limit participation. These programs also have been demonstrated to be effective when the workshops are delivered by health care and social service providers in partnership with lay leaders, acting as co-facilitators.

RESULTS

Since January 2015 the REACH project has supported training for 101 lay leaders to implement CDSMP and DSMP in priority neighborhoods. 7 Master Trainers also have completed training through the REACH project. This resulted in 14 workshops being held to date within the seven targeted neighborhoods and four clinics in those neighborhoods, including 3 this year. Of 133 workshop participants, 88 (66%) fully engaged and "graduated" as defined by fidelity to the model (attended at least 4 of 6 sessions). Pre and post survey of completing participants revealed a significant increase in general health (pre 51.5%, post 75%), decrease in depression severity (pre 6.4%, post 4.9%) and decrease in difficulty sleeping (pre 4.5%, post 3.3%). Further by increasing the number of lay leaders trained to deliver CDSMP, DSMP, and DEEP workshops, a neighborhood resource was created for delivering local, affordable, and effective chronic disease self-management programming.

Graduates from the CDSMP lay leader program

SUSTAINING SUCCESS

A major success of our chronic disease self-management programs work, in terms of a sustainability mechanism, was connecting to the Community Health Worker (CHW) program at Cleveland State University (CSU). A few of the initial residents that were trained as lay leaders later enrolled in the CSU CHW program. They saw an organic connection between the role of CHWs and the CDSMP/DSMP/DEEP workshops in the community. CDSMP leader training currently is incorporated as a part of the curriculum for CSU CHW students. Part of their field experience hours for certification can include supporting or delivering CDSMP workshops. Since 2015, 32 CHWs successfully completed Leader Training for CDSMP, with several implementing workshops since the training. In addition to this community-based success, there has been progress within area clinics in regards to program sustainability. For example, a Pharmacist, Mike Shreshta, from one of the Federally Qualified Health Centers, has completed both Leader Training and Master Training in CDSMP (as well as cross-trainings in other workshop programs including Pain Self-Management and Matter of Balance). As a staff leader at the clinic, Mike promotes referrals to community workshops and has held clinic-based workshops for his clients.

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