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Experiences of Chronic Disease Self-Management Program Leaders

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Abstract

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Abstract

Chronic conditions are public health threats. The Chronic Disease Self-Management Program (CDSMP) is an evidence-based disease management program that addresses personal self-management of chronic conditions. The CDSMP involves peer trainers who instruct and assist with chronic disease preventive measures. Although disease management demonstrates promise to improving patient self-maintenance, previous researchers have not evaluated how the program affects program leaders. The purpose of this study was to discover how self-help leaders feel about the CDSM program. The overarching research question asked about perspectives that self-help leaders had toward the program. Through a narrative qualitative approach, the perceptions of peer leaders were examined to determine if the program was personally beneficial. Guided by the social cognitive theory, a purposeful convenience sample of 20 participants completed the study. The participants were practicing peer trainers in the CDSMP program. Data analysis included hand coding using open and axial coding and content analysis. Study findings included themes surrounding how the CDSMP program benefits health in general as well as the management of facilitators' own chronic diseases, health behaviors, and increased quality of life. The ability for chronic disease management leaders to experience positive effects of the program they administer may result in positive social change. This awareness can positively affect social change by enhancing an already established evidence-based community health program with stronger and better-equipped leaders.

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Dedication

My dissertation is dedicated to my late mother, Mary Kathryn Burris. Mere words could never express how much I miss you and thank you for all you have done for me. I will carry your spirit of love, faith, and gratitude with me forever. I thank the Lord that he thought enough of me, to allow such a wonderful person to be my mother. I know you are looking down from heaven and smiling. I love you, Mommy.

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I would like to thank my father, Paul K. Burris for loving and supporting me in all that I have sought out to do.

I would like to acknowledge Dr. Kate Lorig for her incredible work in chronic disease self-management. I am blessed to have met you and thank you for supporting me. I would like to acknowledge Dr. Cheryl Anderson and Dr. Georjean Stoodt for their unwavering commitment in my journey of becoming a scholar of change. I appreciate all of your hard work and encouragement that you have given me. I would also like to acknowledge Dr. Judith McLaughlin who cemented the foundation of research in my soul and gave me a chance to discover what public health is all about. I would like to also recognize the sacrifice and patience that my children, Quincy Hillman, II and Elijah Bryce Hillman reluctantly gave when I could not give all of my time to them. Thank you, babies!

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And lastly, but certainly not least, I recognize my Lord and Savior, Jesus Christ for blessing me yet again with another accomplishment. I am honored to serve you, ready to make more great things happen in this life you have given me and humbled by it all.

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Chapter 1: Introduction to the Study

Introduction

Many older adults are plagued with chronic conditions. Chronic conditions are ongoing, incurable, insidious, and difficult to manage; however, chronic diseases are treatable and manageable once diagnosed (Nielsen & Gron, 2012). Some examples of chronic conditions are stroke, Alzheimer's disease, heart disease, arthritis, hypertension, cancer, diabetes, and chronic respiratory diseases (Centers for Disease Control [CDC], 2013). Chronic conditions can affect people of all races, genders, and socioeconomic backgrounds. For almost a century, the leading cause of death for adults aged 65 and older has been the chronic condition of heart disease (CDC, 2013).

In addition to heart disease, health and lifestyle choices, as well as prevention measures, education, communication, diet, and the consideration of comorbid conditions, have all become important concerns of self-management programs (Redman, 2011). Lifestyle choices are a key factor in the development of a chronic condition. Lifestyle choices may include smoking, drinking excessive alcoholic beverages, poor nutrition, and a sedentary daily routine (World Health Organization [WHO], 2008). Individuals can also inherit chronic conditions, such as diabetes, heart disease, and cancer (WHO, 2008). However, multiple and varying health education programs exist to help older adults treat and manage chronic illnesses.

Various forms of disease management (DM) programs are beneficial for multiple types of chronic conditions. One such DM program, the Chronic Disease Self-

Management Program (CDSMP), uses community lay leaders to facilitate sessions that encourage strategic self-management skills training (Lorig, 2001). The use of community lay leaders to facilitate CDSMPs may be an effective method to assist older adults who live with ongoing chronic conditions. The community lay leader is a trained peer who is task-oriented, transparent, and committed to serving others in sharing personal experiences in coping with a chronic condition (Schultz & Galbraith, 2003). The influence of someone who is of similar age and who is managing his or her own chronic condition can be an advantage for both parties (Schultz & Galbraith, 2003). This influence can potentially establish trust between the facilitator and the participant relating to the management of the condition.

One of the main advantages of the CDSMP is its use of community lay leaders. An abundance of literature exists on the effects of the CDSMP on its participants, but a dearth of information exists on the effects of the CDSMP on its leaders. Lorig et al. (1999) conducted a community investigation of more than 900 participants who showed improvements in 6 months in symptom management and self-reported health. This investigation did not explore the effects the program had on the leaders who facilitated it. Lorig, Sobel, Ritter, Laurent, and Hobbs (2001) also studied more than 400 patients in a before-after cohort study who showed an improvement in self-reported health status, as well as a reduction in health care use in patients with chronic illness. The primary outcome measures included health behavior and status, self-efficacy, and health care usage (Lorig, Sobel et al., 2001). Baseline measures and post measures of 12 months were

measured (Lorig, Sobel et al., 2001). A limitation of the studies was that the researchers did not evaluate the moderators of the CDSMP (Lorig et al., 1999; Lorig, Sobel et al., 2001).

Lorig, Sobel et al. (2001) revisited an investigation by using a longitudinal design as a follow-up to their previous randomized trial. This study involved 831 participants who were analyzed for health status, health care utilization, and perceived self-efficacy. Lorig, Sobel et al. found that, in comparison to the baseline of each of the 2 years, health status improved, health care use reduced, and perceived self-efficacy marginally improved. These findings support the emphasis made in the CDSMP of sustainment; however, the leaders of the program were excluded regarding how the program affected their own health status (Lorig, Sobel et al., 2001). This exclusion represents a gap in the current literature.

Researchers have not addressed how community lay leaders are affected by facilitating the CDSMP. Previous scholars have addressed the effects of training on community lay leaders (Barlow, Wright, Turner, & Bancroft, 2005; Ritter, Lee, & Lorig, 2011), as well as supportive self-management programs (Barlow & Hainsworth, 2001, 2003). However, scholars have not investigated the perceptions of the community lay leaders who are actively facilitating CDSMP sessions, and how this work has influenced the community lay leaders' own quality of life. I addressed this gap through this research.

Chapter 1 is organized into the introduction and background of disease management programs. Next, the chapter presents the problem statement and purpose of

the study, followed by the research questions and the theoretical framework for the study. The chapters also presents the conceptual framework, nature of the study with definitions, assumptions, scope and delimitations, limitations, and significance. Finally, the chapter culminates with a summary.

Background

The CDSMP is an innovative, evidence-based program that is one of the leading self-management programs for the aging services network (Ory et al., 2013). With the rising number of older adults entering retirement, a rise has occurred in the recruitment and retention of the community lay leaders to facilitate the program. Researchers have recognized older adults as a useful and valuable teaching tool to their peers and to society (Warsi, Wang, LaValley, Avorn, & Solomon, 2004). The use of peer leaders also provides a creative approach to cost-effectiveness in the health care system. Community lay leaders have contributed to the older adult's adherence to the self-management of their health conditions (Brownstein et al., 2005). The premise of relating to another individual who has a chronic condition can enhance the self-management process by building rapport and trust between the peer leader and the peer.

Chronic conditions have increased. Traditionally, DM programs have been multidisciplinary across different health care delivery systems (Ellrodt et al., 1997). By contrast, the CDSMP depends on consistent intervention from the person diagnosed with the disease (Royal College of General Practitioners, 2004). Both programs involve components of coordination of health care, being proactive, and a focus on early

recognition of worsening signs and symptoms (Cappuccio, Kerry, Forbes, & Donald, 2004). These programs work together to benefit the older adult in managing his or her chronic condition.

Community-based disease self-management programs led by community lay leaders allow older adults to learn the necessary tools to live healthier in society. Community lay leaders are trained to administer health education programs to a peer group of older adults through lecturettes, demonstrations, and personal stories (Lorig et al., 2001). This health education strategy helps improve the participant's quality of life. Historically, medical management has included the usual practice for treating individuals with chronic conditions (Matheson, Wilkins, & Psacharopoulos, 2006). However, in newer methods, community educators focus on patient education, prevention, and the self-responsibility of the patient (Lorig et al., 2001).

Programs in self-management teach individuals how to control health symptoms and recognize the associated risk factors (Ritter et al., 2011). Self-management tasks are dependent on the effective application of knowledge. The facilitators of these tasks are an instrumental component of how effective the intervention is for participants. Moreover, the community leaders who facilitate this education are instrumental in the DM program's fidelity and effectiveness (Glasgow, Davis, Funnell, & Beck, 2003). Because of DM's popularity, a need exists to analyze the lay leaders involved in the program and to investigate how this type of advocacy also affects the quality of life for the lay leaders who facilitate the programs.

Problem Statement

Despite the growing need to assist older adults in better understanding, and managing, their chronic conditions, researchers have not addressed how community lay leaders are affected by facilitating the CDSMP in their communities. The popularity of the CDSMP has increased; therefore, a need exists to analyze the use of trained laypersons and the effect of the program on their everyday lives (Ory et al., 2013). No researchers have investigated how the effect of the CDSMP has influenced the facilitators of the program. The program must obtain new facilitating leadership, as well as retain current facilitators. Retainment is a valued factor in the work of chronic disease self-management because of the need to reinforce management skills taught in the program (Ritter et al., 2011). These skills are imperative to practice in order to effectively benefit from the program.

The Georgia Division of Aging, under the administration of the Older Americans Act, makes strides in supporting health-related programs for older adults in Georgia. In 2006, more than 80 health-minded citizens were trained to administer the Georgia CDSMP and only 10% completed the requirements to facilitate their first workshop (Administration on Aging, 2013). A need exists to investigate the potential barriers that stopped those trained facilitators from success in carrying out their duties. A closer inquiry regarding how the program has affected those facilitators who have taught provided insight to future programmatic thrusts.

Purpose of the Study

The purpose of this study was to investigate the perceptions of the CDSMP lay leaders regarding the effect the CDSMP has had on their own quality of health. The skills, concepts, and ideas introduced to the participant were the ones actually lived by the facilitator. The open dialogue in weekly sessions provided insight into the lay leader's own chronic condition. The self-management tasks taught by the lay leader were initially modeled and expected to be followed and reported on as "action plans" the following week (Lorig, 2005). I explored the effects of these self-management tasks on the facilitator. The intent of this study was to find the patterns or consistencies among Georgia CDSMP lay leaders regarding their perceptions, views, opinions, and thoughts of the program, as well as how the program has affected their own quality of life.

Research Questions

In this investigation, I addressed the lack of knowledge in the current literature through the following questions:

1. What are the perceptions of CDSMP facilitators toward the health benefits of the program?
    a. What are the perceptions of CDSMP facilitators toward their own health habits?
    b. What are the perceptions of CDSMP facilitators toward the health habits of those involved with the program?
2. How has facilitating the CDSMP changed the health habits of the facilitator?

a. What are the perspectives of CDSMP facilitators toward their own quality of life living with a chronic condition?

Theoretical Framework for the Study

The social cognitive theory and its construct of self-efficacy are beneficial to those community lay leaders tasked to instruct participants in their own self-management skills. The social cognitive theory includes a core set of determinants, the mechanism through which they work, and the optimal ways of translating this knowledge into effective health practices (Bandura, 2004). The core determinants include knowledge of health risks and benefits of different health practices, including the perceived self-efficacy that a person can exercise control of his or her health habits.

In addition, outcome expectations regarding the expected costs and benefits for different health habits, and the health goals people set for themselves. Included in the health goals are the concrete plans and strategies for realizing those goals, and the perceived facilitators and social and structural impediments to the changes they seek. Knowledge of health risks and benefits creates the precondition for change. Health behavior is also affected by the outcomes people expect their actions to produce (Bandura, 2004). The aforementioned determinants have an effect on a person's overall view and attitude towards his or her own health. In social cognitive theory, self-efficacy is a major factor because it affects lifestyle habits directly and influences other determinants. The stronger the perceived efficacy, the higher the goals people set for themselves, the more they expect their efforts to produce desired outcomes, and the more they view obstacles

and impediments to personal change as surmountable (Bandura, 2004). I used this theory to gain insight into the ability of the community lay leader to practice the health-enhancing skills taught to the participant through the CDSMP.

Community lay leaders can increase self-efficacy by helping participants in the CDSMP become motivated towards participating in health enhancing activities. This motivation should encourage healthy habits among the lay leaders themselves (Lorig, 2001). Lay leaders trained to help other senior adults to development self-regulatory capabilities are instilling a resilient sense of efficacy as well as imparting self-management skills (Jang & Yoo, 2012). These self-management skills can improve the leader's quality of life through consistency of good health practices. When individuals practice and report these good health habits to the group, the process serves as a motivator for the participants taught to model these good habits themselves.

Experiences in exercising control of the exacerbations of chronic disease symptoms serve as efficacy-builders. If people are not convinced of their personal efficacy, they abandon the skills they have learned when they fail to get results or suffer setbacks (Lorig, 2005). Efficacy beliefs affect every phase of personal change, including (a) whether or not people consider changing their health habits; (b) whether or not they have the motivation and perseverance needed to succeed; (c) whether or not they have the capacity to recover from setbacks; and (d) how well they maintain the habit changes they have achieved (Bandura, 2004). The role of the lay leader as a model can enhance the participant's own self-efficacy to achieve what has been taught in the weekly workshops.

However, the effect of the leader's own self-efficacy can distinguish if the leader is successfully executing what has been taught.

A community lay leader is someone who helps the older adult overcome some of the barriers to physical activity and unhealthy behaviors that older people face, which counter healthy living and successful aging, while emulating those steps themselves. The lay leader helps guide the older adult in the right direction, provides appropriate information, is a support mechanism for an older participant, helps the older adult understand things from his or her own point-of-view, and provides positive health promotion as a positive role model (British Health Foundation, 2010). Chapter 2 includes a detailed explanation of the role of the social cognitive theory and its relationship to the lay leader.

Conceptual Framework

The need to manage chronic conditions is a necessary component of daily living. The concept that grounded this study was the ability of community lay leaders to promote the necessity of daily chronic disease self-management to older adults, while executing the self-management skills within their own lives. Barlow, Turner, Wright, and Bancroft (2005) examined the outcome of a chronic disease self-management course influenced by the volunteer lay tutor facilitating the course. Barlow et al. found a beneficial result of the leader feeling valued and increased the lay leader's ability to perform the taught skills more efficiently in his or her own personal lives.

A core principle of promoting the health and well-being of the lay leader lies in the successful retention of the key components emphasized in weekly sessions (Lorig, 2005). Overall, sessions encourage a capacity building approach, while also encouraging a person-centered approach (Selvey, 2013). The contextual lens of this study included the community lay leader as a role model, peer mentor, and community advocate (Lorig & Sobel, 2001). Chapter 2 further details this contextual lens.

Nature of the Study

The purpose of this narrative, qualitative study was to discover the views, opinions, and beliefs of the trained lay leaders who facilitate the CDSMP on a weekly basis. Narrative research is a distinct method to understanding people's daily lives through their own interpretation. This type of research stifles abstract views and pinpoints a qualitative approach that the investigator can connect to the social change of the world (Holloway & Freshwater, 2007). I hoped that through this investigation, insight into Georgia CDSMP lay leaders and their experiences with the CDSMP would garner useful information for future studies.

The views of the CDSMP lay leaders are important to examine because of the increased growth of the dissemination of the program during the last 10 years in the aging network. Moreover, it is a cost-effective method of delivering a community-based program. Lay leaders are volunteers and are of the same demographic with whom they facilitate the program with (Lorig, 2001). The volunteers are trained; however, these volunteers may have chronic disease conditions as well.

Lay leaders are peers, and the concept of being a peer is partnered with identity, not only regarding the demographic, but experiences, attitudes, and roles as well (Shiner, 1999). This identity can influence the learner as well as the teacher. This influence is supported because of the relatability the leader has to the participant. The leader may possibly suffer from the same chronic condition, or may use the same health care resources the participant does.

Chronic Disease Self-Management Program community lay leaders influence the participant in making consistent and wise choices to manage his or her chronic condition. This occurs through the weekly sessions and follow-up phone calls when the 6-week session has ended. However, the lay leaders do not receive encouraging follow-up calls during the times they are not facilitating program, nor are these leaders actively teaching the program when it is not in session.

In order to explore the views, opinions, and beliefs of CDSMP lay leaders, this study involved collecting data from Georgia CDSMP lay leaders through intensive interviews. I analyzed the data using content analysis to identify themes following a preliminary stage of coding. Intensive interviews involved transcribing key words and highlighting significant points. A second reading helped to note emerging themes, which were grouped and titled. The organization of themes produced a master list of themes. I analyzed and compared the themes to the original transcript (Barlow et al., 2005).

Definitions

Chronic diseases: Conditions that slowly develop during a period with distinctive signs and symptoms that show their progression (author, year). The assistance of prescribed pharmaceuticals can slow down these signs and symptoms, but the condition still affects the body (WHO, 2008).

Disease management: A systematic approach to address diseases, as it relates to an individual's disease process (Ellrodt et al., 1997). Disease management incorporates organizations from all health care entities involved with the patient (Ellrodt et al., 1997). Disease management also focuses on the continuum of care during the disease process (Ellrodt et al., 1997).

Lay leaders: Specialized facilitators of the CDSMP. Lay leaders are trained for 4 half days to administer the scripted CDSMP protocol (author, year). Lay leaders must recruit individuals diagnosed with a chronic condition to participate in the 6-week CDSMP program (author, year). Lay leaders are required to conduct at least one CDSMP offering once a year, as well as attend a refresher training session once a year (Ory, 2013).

Master trainers: Highly specialized facilitators, moderators, and trainers of lay leaders of the CDSMP (author, year). Master trainers participate in training for 4 1/2 days to administer the CDSMP, as well as to train potential lay leaders to administer the CDSMP (author, year). Master trainers differ from lay leaders because they are required to train potential lay leaders, as well as administer the CDSMP program (author, year).

Training requirements are once a year and facilitating requirements are twice a year (Ory, 2013).

Self-efficacy: An individual's ability to believe they can successfully accomplish tasks (Bandura, 2004).

Self-management: An individual's effectiveness in coping with the symptoms of a chronic condition, including the physical, psychological, emotional, and psychosocial adaptations on a daily basis (Ory, 2013) .

Top trainers: Specific experts apprenticed under the auspices of the Stanford University Patient Education Research Center (Lorig, 2005). Top trainers have participated in holding the lay leader and master trainer positions and are considered versed enough to train, facilitate, and manage all aspects of the CDSMP program (Lorig, 2005). Top trainers are required to attend a 5-day training in Stanford, California, which includes evaluation on their facilitating and training skills in an actual workshop (Ory, 2013).

Assumptions

Three assumptions existed within this study. Because the CDSMP has been an entity in the aging network for the past 15 years, I assumed that it will continue to be a resource used in the operations of the aging network. I assumed that the lay leaders participating in the study were honest in answering questions related to their opinions, views, and expressions regarding the CDSMP program, relating to their role as lay leader, master trainer, or top trainer. I explained to the participants in this study that all responses

would remain anonymous and confidentiality of all responses would be held to the highest level. Responses are only available for viewing by select faculty or staff at Walden University, and me. The participants also had the option to withdraw from the study at any time without consequence or ramifications. A final assumption was that the participants were properly trained to carry out the duties of the CDSMP without fault in fidelity and succession of the 6-week program.

Scope and Delimitations

The scope of this study was a narrative, qualitative case study of lay leaders for a CDSMP program that takes place in Georgia. The study was limited to one specific DM program located in one area of the United States. The study may not be generalizable to other DM programs and other geographical areas. In narrative studies, the researcher is involved in the study, and I am a lay leader of this program, as well.

Limitations

The limitations of this study consisted of the training that the CDSMP leader participated in and how the training was delivered and received. It was not known whether all of the CDSMP facilitators were trained properly or completed the training per the protocols of the standards that Stanford University has put forth. In addition, a limitation existed regarding the process of fidelity of the program that the facilitator has conducted. This limitation is because of the strictness of the script-like sessions and the ability to follow the instructions verbatim.

Significance

This study is significant to the ongoing body of effective DM literature that is developing. This investigation was also valuable because of its uniqueness in the inquiry of the view, opinions, and beliefs of older adults diagnosed with a chronic condition. The significance of this study may enhance the facilitators who are currently coleading the CDSMP with new insight as to the views, opinions, and thoughts of their cohorts regarding the facilitation of the CDSMP.

Summary

The use of community peer leaders and trainers is becoming more popular in light of rising health care costs, the lack of community health interventions, and the decrease in health resources (Barlow et al., 2005). Community peer leadership and community lay leader trainers have played a role in the reduction of health care costs, as well as the effectiveness in reaching the general public (Whitley, Everhart, & Wright, 2006). The facilitators of these community-based programs have been successful in supporting their peers in healthy lifestyle changes to manage their chronic conditions (Lorig, 2005). However, with the increase of these leaders and trainers, a missing component exists in the views, opinions, and beliefs of the services they provide and how those perceptions affect the lay leader's own quality of health. In this study, I investigated the CDSMP leaders' opinions and views with respect to the role the leaders play and its effect on their own quality of life.

The CDSMP has experienced a surge in momentum within the last 15 years, garnering federal funding (AHRQ, 2005). This momentum has shaped the popularity of the program with an influx of community leaders willing to undertake duties as trained lay leaders, master trainers, and T-trainers (Lorig, 2005). However, this change has also ignited the need to explore the views and opinions of those trained.

In Chapter 2, I examine the current body of knowledge to review what has been accomplished as it relates to the CDSMP and its evolution as a leading public health strategy. Chapter 3 introduces the methodology of analyzing the opinions, views, and thoughts of Georgia CDSMP leaders.

Chapter 2: Literature Review

Health care providers teach chronic disease self-management as an important way for patients diagnosed with a chronic condition to improve and sustain themselves. Integration of self-management strategies can improve a patient's quality of life, as well as reduce overall dependence on the health care system (Lu, Li, & Arthur, 2014; Nielsen & Gron, 2012; Redman, 2011; Ritter et al., 2011; Schulman-Green et al., 2012). Strategies, such as providing education and increasing self-empowerment, encourage patients and present opportunities for investigators to explore new possibilities of research on chronic diseases (Lu et al., 2014; Nielsen & Gron, 2012; Redman, 2011; Ritter et al., 2011; Schulman-Green et al., 2012). Continued research regarding self-management approaches is imperative to successful outcomes.

Although a number of recent studies exist on the effectiveness of CDSMPs in health care delivery (Lu et al., 2014; Nielsen & Gron, 2012; Redman, 2011; Ritter et al., 2011; Schulman-Green et al., 2012), critical work on the effects of CDSMPs on leaders who facilitate the programs is absent within the body of research literature. Researchers have focused on the outcome of the program's intervention on the participants; however, researchers have not paid attention to how CDSMPs may affect the leaders of these programs. Research on CDSMPs, in general, is important because researchers have shown that self-management programs can assist consumers in enhancing the ability to manage their chronic conditions with a reduction in exacerbating symptoms, to assist in increasing their self-confidence and decrease their use of emergency health care services

(Lu et al., 2014). The lack of attention to CDSMP leaders and the positive effects of CDSMPs supported the need to review and synthesize the current research literature, with a focus on issues concerning self-efficacy in relation to lay leaders.

This chapter is divided into six sections. In the first section, I outline the literature search strategy used for this review. The chapter then provides a brief history of disease management (DM) and the severity of chronic disease as a global phenomenon. Then, I overview chronic disease self-management education and programs, review literature on lay leaders of self-management educational processes, and review social cognitive theory in relation to ideas of self-efficacy to set up the theoretical framework for this study. Last, I briefly outline the methodology of the study for analyzing the effects of the CDSMP on the leaders who teach it.

Search Strategy

For this study, I conducted a comprehensive search for current (2009–2014) peer-reviewed articles that focused on lay leadership, chronic disease self-management, disease management, lay leader participation, and the involvement of community-based entities (community leaders and volunteers). I conducted all searches using electronic databases, including CINAHL Plus, Academic Search Complete, MEDLINE, SocINDEX, PsycINFO, ProQuest, as well as Google Scholar. Terms used in the search included *chronic disease, chronic disease management, chronic disease self-management, chronic disease and disease management, self-care, peer leadership, peer leader, lay leadership, lay leader, master trainer, self-efficacy in disease self-management, community health*

workers, community lay leaders, Georgia community lay leaders, chronic disease self-management program, disease management, peer leaders and health programs, self-management, self-management of chronic conditions, chronic care model, chronic care programs, American Recovery Act Funding, volunteerism among older adults, and *evidence-based health programs*. Last, using a research method that reference librarians refer to as citation chaining, I searched the bibliography of selected articles to find additional current peer-reviewed studies to support this literature review.

Disease Management History

Disease management has a brief history, but its development has roots in several areas, which creates difficulty in pinpointing its precise inception (Matheson et al., 2006). However, many DM programs trace their early development to the commercial introduction of blood glucose monitoring systems for diabetics in the early 1980s (Matheson et al., 2006). The introduction of blood glucose monitoring gave rise to disease management as a trend in health care, and the idea of patients managing their own care was highly supported by the medical and pharmaceutical communities (Matheson et al., 2006). Later, pharmaceutical companies in the early 1990s contributed to the popularization of disease management by promoting the idea and practice of medication compliance in which patients were educated in the management and monitoring of their own conditions (Matheson et al., 2006; Nielson & Gron, 2012). These self-management programs required patients to keep medication management journals and to document

medications taken; essentially, patients were responsible for monitoring the effects of the medication prescribed for the symptoms patients presented (Matheson et al., 2006).

Early self-management approaches were highly dependent on factors of medical literacy, communication between health care providers and patients, and confidence in self-monitoring (Lu et al., 2014). For example, in an early study of compliance, Gallefoss and Bakke (1999) examined the self-management practices of patients with chronic asthma and obstructive pulmonary disease. Gallefoss and Bakke compared patients educated in steroid inhaler compliance to patients not educated in steroid inhaler compliance. Gallefoss and Bakke found improved compliance and correct administration of the inhaler when the subjects were educated in compliance procedures and monitored themselves properly.

Traditionally, patient education and disease management programs focused on specific groups of patients, such as those with asthma, diabetes, and heart conditions (Dunning, 2010; Lu et al., 2014; Nielson & Gron, 2012). However, by the middle of the 1990s, a second wave of disease management emerged with the advent of disease management organizations, and many of these organizations focused on a single disease (Matheson et al., 2006). While the management of a single disease produced targeted results, this singular focus failed to treat the individual as a whole or address issues related to comorbidity (Matheson et al., 2006). With the consideration of comorbidities and the steady growth of other long-term chronic conditions, a targeted focus would not be

sufficient to treat the whole person. Consequently, since the early 2000s, more holistic disease management approaches have emerged recognizing the need to treat the individual as a whole being and not to simply focus on one disease or condition. In addition, increased communication and interaction among the health educators providing education and support to patients was another advancement in disease management (Cramm & Nieboers, 2012). These advances led to the evolution of disease management from focusing on a single disease to the need to treat the individual holistically, as well as considering the accompanying comorbid conditions discovered along the span of the disease (Dunning, 2010; Nolte & Osborne, 2013).

Researchers have conduced demographic studies on participants of the CDSMP (Rose et al., 2008). Rose et al. (2008) researched the effect of the CDSMP on 153 lower-income, African American older adults. The pretest-posttest design yielded improvements in cognitive symptom management and improved communication with their physician. However, no improvements in self-efficacy or health care use occurred (Rose et al., 2008). The investigation did not include the moderators of the CDSMP who led the 6-week session program. Moreover, in a 6-month study of the Shanghai CDSMP, Dongbo et al. (2003) found improvements in aerobic exercise, symptom management, fewer hospitalizations, and self-efficacy. The researchers evaluated this investigation of the CDSMP regarding its effect on persons of Asian descent (Dongbo et al., 2003). The need for ongoing self-management skills and education required a comprehensive, integrated, and holistic approach that DM failed to accomplish in its early stages (Dunning, 2010;

Nolte & Osborne, 2013). Lorig, Ritter, and Jacquez (2005) also conducted a pretest-posttest design on 261 people and found improvements in aerobic exercise, activity limitation, health distress physician visits, and self-efficacy. These findings support the effectiveness of the CDSMP on the participants involved, as well as the activities promoted in the program, but not how it affected the leaders of the program (Lorig, Ritter, & Jacquez, 2005).

In the 21st century, health care educators and providers approach patients and their conditions holistically, and approach self-management as an integrated array of relationships among patients and various health care providers, educators, and services (Redman, 2011). Health, lifestyle, prevention measures, education, communication, diet, and the consideration of comorbid conditions have all become important concerns of self-management programs (Redman, 2011). Consequently, health care providers and educators have focused more and more on increasing effective communication and logistics relating to the integration of services and involved parties (Cramm & Nieboer, 2012; Redman, 2011).

Self-management continues to strengthen and provide benefits to both patients and the health care industry (Conn, 2011). Self-management has the potential to tap into the individual's own ability to manage a chronic illness symptomatically, psychosocially, and emotionally (Cramm & Nieboer, 2012). Additionally, with the ever-increasing prevalence of chronic conditions, health care providers are embracing effective management

involving patient participation more and more as a way to help address the needs associated with chronic conditions (Lu et al., 2014).

The Severity of Chronic Disease

The diagnosis of chronic conditions are on the rise, and this rise in chronic conditions gives cause to a deeper understanding of the need for chronic disease self-management (Dickson, Clark, Rabelo-Silva, & Buck, 2013). Chronic diseases are conditions that are usually incurable and place significant burdens on the individual's health, finances, and activities of daily life, including burdens extending to families and communities (Schulman-Green et al., 2012). The Centers for Disease Control and Prevention (CDC, 2009) defined chronic conditions as noncurable, reoccurring illnesses, and cited that chronic conditions are the leading causes of morbidity and disability globally. Chronic conditions, such as cardiovascular disease, diabetes, and cancer, are among the most costly and prevalent of global health issues (Schulman-Green et al., 2012). The diagnosis of a chronic condition entails a complex causality, with numerous co-conditions that lead to a defined reference, and these diagnoses have affected more than 100 million people in the United States alone at an annual cost of more than $650 billion dollars in the daily management of care (Savage, 2009). Chronic conditions are the main reason individuals seek health care, and these conditions represent the leading cause of disability and death in the United States (Schulman-Green et al., 2012).

Issues related to aging further complicate chronic conditions, and as generations of people age, it becomes imperative to consider and address the issues related to the

connection between aging and chronic conditions. In 2009, 80% of noninstitutionalized persons who were 70 years of age or older reported having at least one of seven of the most common chronic conditions (Chodosh et al., 2010). The most common chronic conditions for this age group included stroke, Alzheimer's disease, heart disease, arthritis, hypertension, cancer, diabetes, and chronic respiratory diseases (CDC, 2013). Among these conditions, arthritis was the most prevalent, affecting more than 48% of individuals 65 years of age and older (CDC, 2013). Hypertension affected 42% of this population, and 32% of this group had some form of heart disease, of which heart disease and history of stroke are major factors (Chodosh et al., 2010). Diabetes affects approximately 15% of persons 65 years of age and older and this increases the risk for other chronic conditions, including ischemic heart disease, renal disease, and visual impairment, as well as neuropathy (Chodosh et al., 2010). The CDC confirmed that common chronic conditions that affect people 65 and older include arthritis, hypertension, heart disease, diabetes mellitus, respiratory diseases, stroke, and cancer (CDC, 2013). Furthermore, these conditions often merge into a multisymptomatic condition with symptoms affecting one another or manifesting all at once. With the increase of people experiencing chronic illnesses and the potentiality of disability and death, a serious need exists to address comprehensive self-management efforts to help decrease these effects and sustain lives.

Lifestyle and diet can also directly contribute to chronic conditions in ways that are both modifiable by the patient and not modifiable. Lack of consistent physical activity,

regular nutritional intake of fat and sugar, and excessive alcohol and tobacco use are among the most modifiable causes of chronic illnesses (CDC, 2009). Nonmodifiable causes include genetic obtainment, environmental exposure, and age (WHO, 2005). Emerging evidence shows that psychosocial stress also plays a part in causing chronic diseases, and many symptoms manifest themselves through stress-related occurrences (WHO, 2012).

In addition, the nature of chronic conditions poses significant challenges for health care in general and for self-management approaches specifically. These challenges often include patients experiencing an acute period, which may or may not be symptomatic, and then the subtle course of the specific illness, which may lead to complications, possibly confounding injuries from impairment (Savage, 2009). Additional challenges include patients using medications ineffectively, developing ways to deal with the psychological factors of the illness, managing complex regimens, and interacting with health care providers (Schulman-Green et al., 2012). All of these challenges support the need for increased vigilance in disease management as a whole.

Chronic conditions can also lead to increased functional limitations, which can lead to the frequent use and burdening of the health care system. The CDC (2009) reported that complications from chronic conditions accounted for 81% of hospitalizations, 91% of prescribed medication usage, and 76% of physician visits. The use of health care facilities increases the need for equipment, staff, and often times specialists. This demand on the health care system stems from a range of chronic

conditions, including arthritis and musculoskeletal disease that are noncritical and noncommunicable, to heart failure and cancer, which are serious, fatal and noncommunicable, and to HIV/AIDS that is persistent and communicable (Savage, 2009). Furthermore, the wide symptomatic results of chronic conditions can often lead to an acute state of the disease if not addressed promptly.

Chronic Disease Self-Management Education and Programs

The endeavors of chronic disease self-management have the capability to improve the quality of care as well as reduce the burden of chronic condition symptoms a person may experience (Conn, 2011; Grady & Gough, 2014; Li, 2013; Nolte & Osborne, 2013; Ory et al., 2013). Chronic disease self-management may help reduce a dependence on the health care system for preventive care and thereby decrease the overall cost of that care (Nolte & Osborne, 2013). As health care costs continue to rise, the significance of cost saving strategies are conducive to the viability of the health care system. Strategies that promote education, information, tools, and resources, but allow the patient to make an informed decision are necessary to an overall state of health (Schulman-Green et al., 2012). The daily practice of using the tools and skills learned through education practices can encourage the chronic disease recipient to take an active role in health management (Schulman-Green et al., 2012).

Practitioners have developed programs to promote and facilitate the self-management of chronic conditions. For example, the Flinders Chronic Condition Management Program captures the care planning process while enhancing self-

management support. This program is a process of generic and holistic co-management in-teams of patients, health care professionals, and friends of family members. The program also includes comprehensive case management that enables an approach that defines the appropriateness of specific team interventions and self-capabilities (Battersby et al., 2010).

The Flinders Program emphasizes the collaboration of clinician and patient as team members in addressing behaviors for sustained gains in health outcomes (Battersby et al., 2010). Another program is the Expert Patient Programme, created in the United Kingdom and based on the popular Stanford CDSMP. This program is a health-professional curriculum, based on teaching that originated from skilled nurses and health care personnel. The program emphasizes an increase in knowledge and skill practice, as well as family and health care team support (Johnston, Liddy, Ives, & Soto, 2008).

One of the foremost CDSMPs is the Stanford CDSMP, also known simply as the CDSMP, developed by Kate Lorig at Stanford University in the 1990s (Neilsen & Gron, 2012; Lorig et al., 2014). The CDSMP is the program that I specifically focused on in this study. The CDSMP is a 6-week, small-group intervention training program in which peer instructors teach from a highly structured manual. The program is based on the theories and ideas of self-efficacy and emphasizes problem solving, decision-making, and confidence building in patients (Lorig et al., 2001). The CDSMP is a community-based intervention delivered by pairs of lay leaders in weekly sessions, and covers topics, such as cognitive symptom management, communication, dealing with anger and depression,

exercise, problem solving, contracting service providers, and advanced directives (Lorig et al., 2001). The overall goal is to support the participants' sense of control of their condition and develop the social and mental strategies of living with a chronic condition through problem-solving methods (Nielsen & Gron, 2012). Furthermore, the confidence in successfully completing a positive health-related goal can benefit the participant's overall quality of life (Nielsen & Gron, 2012).

In response to the global prevalence of long-term chronic conditions, researchers have begun studying chronic disease self-management programs in contexts other than the United States. For example, Stone and Packer (2010) evaluated the effects of introducing the Stanford CDSMP into the existing program in an Australian rural setting. Stone and Packer gathered information from managers, lay and professional course leaders, and patients regarding the positive and negative effects of implementing the Stanford CDSMP. The researchers evaluated outcomes using pre- and post-tests focusing on changes in activity participation and self-management skills and knowledge (Stone & Packer, 2010). Managers, course leaders, and patients identified both positive and negative aspects of the Stanford CDSMP represented by two key themes: program content and logistics of delivery. Study participants recommended enhancing content quality, improving logistics, and providing more resources. The researchers recommended that practitioners sufficiently contextualize CDSMPs (Stone & Packer, 2010). That is, future implementation of CDSMPs should involve consideration of researching local contexts, population demographics, and self-care needs in relation, specifically, to the logistical

concerns of CDSMPs. However, Stone and Packer did not address the effects of the program on lay leaders.

In another study of the use of the Stanford CDSMP outside the United States, Ritter, Lee, and Lorig (2011) examined the connections between the moderators of demographics, disease conditions, and health status and self-efficacy to determine whether certain people benefit more from CDSMP than others. Ritter et al. analyzed data from previous CDSMP sessions in England using multiple regression and found no moderating factors that could significantly and consistently predict improved outcomes. Therefore, Ritter et al. concluded that certain people could not benefit more from CDSMPs than others, and little justification exists for targeting specific populations for CDSMPs or excluding other populations. Furthermore, although CDSMPs may help to affect and possibly increase self-efficacy, the researchers also found little justification for targeting individuals with particular levels of initial self-efficacy.

Researchers have used other chronic care models in their research. In their 2012 study, Cramm and Nieboer examined the effect of the chronic care model on chronic care self-management. The chronic care model is a chronic care approach developed to change chronic disease care from being acute and reactive to being planned, proactive, and patient-based. Cramm and Nieboer surveyed health care professionals in 22 primary care practices in the Netherlands via questionnaire. The researchers found that over time, chronic illness care delivery improved significantly through use of the chronic care model (Cramm & Nieboer, 2012). These improvements resulted primarily from heightened

project coordination and from increasing the quality of communication and task integration among various patients and the various health care professionals involved in patients' chronic care self-management. Cramm and Nieboer's findings have practical implications for both chronic disease management and self-management programs. Their results suggested that various health care professionals must connect strongly to one another and to patients via effective communication and task integration to help provide effective education and holistic care.

Researchers have also studied the relationship between CDSMP outcomes and multiple chronic conditions. For example, Harrison et al. (2012) examined the connection between CDSMP and multiple long-term chronic conditions, or multimorbidity. Harrison et al. observed that patients accessing CDSMPs often reported multimorbidity, which is associated with poor outcomes. Harrison et al. analyzed data from a cost-effectiveness trial of a modified version of the Stanford CDSMP and found that multimorbidity moderated the effect of the CDSMP on mental well-being, health-related quality of life, and vitality. The researchers found individuals with multiple morbidities gained self-reported increases in vitality, health-related quality of life, and psychological well-being after participating in the 6-week course (Harrison et al., 2012). Although multimorbidity was associated with increased illness burden, these patients benefitted significantly from the CDSMP. Self-efficacy did not appear to be a factor in patients' benefitting from the CDSMP. In addition, in Harrison et al.'s study, like the ones discussed above, the researchers did not address the effect of CDSMPs on leaders of these programs.

Lay Leadership

In response to the increasing need to address the severity of chronic conditions, health education programs that emphasize the need to promote and facilitate self-management techniques are increasing in popularity (Schulman-Green et al., 2012). This popularity has given credence to the demand for more lay leaders to conduct these programs, and researchers and practitioners are beginning to see the importance of lay leadership in addressing the increasing rate of chronic conditions occurring globally, as well as for equipping individuals with the necessary tools for self-management (Nielsen & Gron, 2012). Lay leadership rests on the idea that the use of lay ways of knowing, in addition to professional approaches, can help the health care system by supporting patients in becoming better self-managers of their conditions (Nielsen & Gron, 2012). The Stanford CDSMP is partially based on the use of lay educators who were community mental health workers, as well as the use of lay health care providers who taught first aid with the American Red Cross (Nielsen & Gron, 2012). However, researchers have not inquired into the effects of chronic disease self-management on peer leadership, and what is missing in the current research is the resulting effects on the leaders' own perspectives of their chronic condition after being involved in the CDSMP, or the latent outcome of CDSMPs on its leaders. Although several recent studies exist on lay care management (Carter-Pokras et al., 2011; Catalano, Kendall, Vandenberg, & Hunter, 2009; Hayes et al., 2010; Lorig et al., 1986), no researchers have focused on how CDSMPs and lay leadership affects lay leaders themselves.

Early studies showed that lay leadership was just as significant, albeit in differing ways, to heading CDSMPs as professional leadership. Lorig et al. (1986) compared lay and professional leadership in disease specific programs, such as the Arthritis Self-Management Program. Lorig et al. found that participants in the lay-led course had the most changes in relaxation techniques, while the participants in the professional-led course had an increased gain in knowledge. The researchers concluded that both types of leaders were just as significant and necessary (Lorig et al., 1986).

In later comparative studies, researchers examined the effectiveness of lay and peer leadership vis-à-vis professional leadership (Catalano et al., 2009; Hayes et al., 2010). Catalano, Kendall, Vandenberg, and Hunter (2009) examined the differences between health professional leaders and peer leaders of the CDSMP in Australia by looking at their experiences and their opinions of leading the program jointly. What the researchers found were themes consistent with both the value and the strain of working together (Catalano et al., 2009). Concerns existed regarding the respect given to lay leaders as opposed to health care professionals, as well as about creating the right balance of a leadership among lay and professional roles (Catalano et al., 2009). In another study, Hayes et al. (2010) examined the effectiveness and feasibility of using peer health leaders in a self-management program relating to hypertension among veterans. The researchers found increased levels of health support were consistent with the sustained presence of lay leaders during the program. From state- to local-level supporters who initiated the shared commitment to establishing peer leader posts to launch the effort, the effect of lay

leadership was demonstrated through an increase in veteran's self-management skills relating to hypertension (Hayes et al., 2010).

In their 2011 study, Carter-Pokras et al. examined the barriers and best practices in the development and implementation of Latino lay health promoter programs in Maryland. The researchers conducted in-depth interviews with 10 health promoter coordinators regarding their program experiences (Carter-Pokras et al., 2011). Carter-Pokras et al. asked coordinators about issues related to their selection, recruitment, training, and supervision, as well as key program elements. The researchers used NVivo 7 to identify common themes and found that most programs focused on areas, such as awareness of healthy lifestyles and reducing risk of illness (Carter-Pokras et al., 2011). In addition, Carter-Pokras et al. found that coordinators sought lay leaders with team-building skills and an expressed commitment to help the community. Coordinators trained lay leaders through active engagement at monthly meetings, and most programs visited care sites, ran practice sessions, and conducted regular performance evaluations. Carter-Pokras et al. concluded that effective lay health promoter programs require several related factors: (a) needs assessment, (b) a target population advisory board, (c) promoters, and (d) a significant training program.

While past investigators have focused on benefits to the participants, researchers have not examined how community lay leaders are directly affected by the processes of the program from week to week during the 6-week training period. Researchers have studied CDSMPs for its effectiveness on older adults (Lorig et al., 2005), as well as on

adults in urban and rural older settings (Stone & Packer, 2010). Moreover, prior researchers have investigated comparisons between community-based and medically-based CDSMP initiatives (Lorig et al., 1986; Nolte, Elsworth, Sinclair, & Osborne, 2007). However, no inquiries were made regarding the experiences of the trained lay leaders of CDSMP programs. These leaders comprise the nucleus of how participants perceive, interpret, and receive program information (Lorig et al., 2003); in other words, the leaders of the CDSMP carry the integrity of the sessions. Ritter et al. (2011) described a leader as influential in the process of flow and sustainability between the participant and what is being taught. This relationship is valuable to the participant, as well as to the leader as it reinforces the ability of the leader to lead (Lorig et al., 2011). This reinforcement may build self-efficacy and lead to improved self-management by lay leaders as well. Through the study, I sought to examine how lay leaders are influenced by the CDSMPs they lead and how these programs build self-efficacy in lay leaders.

Social Cognitive Theory and Self-Efficacy

Bandura's work on social cognitive learning arose in response to narrow-focused previous work on cognitive learning that neglected social, motivational, and affective processes of cognitive functioning (Bandura, 1993). Bandura's social cognitive learning, particularly perceived self-efficacy, is a well-known theory for educational research, as well as research involving leadership, learning, and teaching (Nielsen & Gron, 2012). According to Bandura (1993), perceived self-efficacy involves people's beliefs about their capabilities to produce certain levels of performance that influence events that affect their

lives. Bandura also theorized that perceived self-efficacy involves one's judgment of his or her own capabilities to execute given types of performances, and that the most effective way of creating a strong sense of efficacy is through mastery experiences. Bandura found that those who are able to attain goals and skills quickly and easily often wrestle with the idea of failing because success requires sustained effort. Bandura also theorized that the stronger one's perceived self-efficacy is, the higher the goal challenges are that he or she sets, and the firmer his or her commitment becomes to achieving those goal challenges. Consequently, those with higher perceived self-efficacy seek out more challenging tasks and set higher goals for themselves (Bandura, 1993).

Self-efficacy relates to the cognitive, motivational, and affective dimensions of human agency (Bandura, 1993). Cognitively, people shape their actions initially in thought, and their behavior is purposive, regulated by forethought embodying cognized objectives (Bandura, 1993). People's self-efficacy influences the types of anticipatory scenarios they construct for themselves (Bandura, 1993). Generally, those with a high sense of efficacy visualize success, while those with a low sense of efficacy visualize failure or at least dwell on potential problems and personal shortcomings (Bandura, 1993).

Perceived self-efficacy also plays a central role in the self-regulation of motivation (Bandura, 1993). This role occurs because people are motivated to act based not only on their beliefs about the likely outcomes of their performance but on their beliefs about what they are capable of as well (Bandura, 1993). Thus, people's beliefs in their capabilities influence their motivation of outcome expectancy (Bandura, 1993). Motivation is based

on goal-setting, and by making satisfaction conditional on meeting identified goals, people direct their behavior and create reasons to persist in their efforts until they meet their goals (Bandura, 1993).

Self-efficacy affects not only people's motivations, but their affective states as well. People with high degrees of self-efficacy do not create stress for themselves by conjuring imagined challenges resulting in distressing thought patterns (Bandura, 1993). However, those with low degrees of self-efficacy who believe they cannot manage stressors, real or perceived, experience high levels of anxiety (Bandura, 1993). In short, those who hold low self-efficacy keep themselves from success; they distress themselves and impair their level of functioning through inefficacious thinking wherein they magnify the severity of possible problems and worry about negative situations that rarely occur (Bandura, 1993).

Bandura's social cognitive theory and concept of self-efficacy provide the theoretical girding to better understand the aims of CDSMPs (Nielsen & Gron, 2012). Behavior and social learning form the foundation of this theory, which encapsulates the self-efficacy needed for effective patient self-management and self-management regulation (Bandura, 2004). Researchers have linked increased patient self-efficacy to CDSMPs in a number of studies (Jang & Yoo, 2012; Lorig et al., 2014; Lu et al., 2014; Nielsen & Gron, 2012; Nolte & Osborne, 2013; Ritter et al., 2011). Patient-centered focus of CDSMPs can increase self-efficacy in patients, as well as increase self-efficacy in lay leaders. Like patients, lay leaders of CDSMPs may increase their self-efficacy by

acquiring information regarding chronic conditions and about how to manage the conditions and relate that information to their own lives. Although the effect of CDSMPs on the self-efficacy of lay leaders has not been the focus of previous studies, increasing the self-efficacy of lay leaders may be an important latent effect of CDSPMs worthy of inquiry. This increase in self-efficacy may involve CDSMP lay leaders putting into practice techniques taught, modeled, or gleaned through their leadership experiences. Lay leaders trained to help others to development self-regulatory capabilities are instilling a resilient sense of efficacy and may be imparting self-management skills in themselves as well (Jang & Yoo, 2012).

The method of evaluating leaders of the CDSMP for this study entailed intensive interviews from personal perspectives in teaching the program. The study involved examining the current perspectives of the peer leaders and trainers in the Georgia CDSMP. A list of trained CDSMP leaders maintained by the Stanford Patient Education Research Center was securely accessed to serve as the sampling frame. The current body of literature is lacking substantial evidence of the investigation of the views, opinions, and thoughts of the leaders of the CDSMP. This comprehensive program has shown its effectiveness to bring forth positive results to its participants, but it has lacked the same evidence of its effect on the leaders.

Similar Studies

In the study of lay leadership of CDSMPs, researchers have taken methodological approaches similar to the one used in this study. For example, Catalano et al. (2009) and

Stone and Packer (2010) took qualitative approaches and used in-depth, semistructured interviews to explore issues related to CDSMPs. Catalano et al. and Stone and Packer found this approach useful in gathering information on the differences between lay and professional leadership of CDSMPs. Catalano et al. (2009) examined the differences between health professional leaders and peer leaders of the CDSMP in Queensland, Australia by looking at their experiences and their opinions of leading the program jointly. The researchers observed that the model of CDSMP in Queensland is a hybrid one in which professionals and nonprofessionals often work together. The researchers found themes consistent with both the value and the strain of working together (Catalano et al., 2009). Concerns existed regarding the respect given to lay leaders as opposed to the respect given to health care professionals, as well as about creating the right balance of a leadership among lay and professional roles (Catalano et al., 2009). Catalano et al. found that a qualitative approach was the most suitable way to obtain information on the lived, experiential, inter-relational aspects of the two groups working together.

In a similar study, also conducted in Australia, Stone and Packer (2010) used semistructured interviews to explore the experiences of introducing the Stanford CDSMP into a rural setting of seven professional and three lay leaders. Stone and Packer gathered information from managers, lay and professional course leaders, and patients about the positive and negative effects of implementing the Stanford CDSMP. The researchers evaluated outcomes using pre- and post-tests focusing on changes in activity participation

and self-management skills and knowledge (Stone & Packer, 2010). Managers, course leaders, and patients identified both positive and negative aspects of the Stanford CDSMP represented by two key themes: program content and logistics of delivery. Study participants recommended enhancing content quality, improving logistics, and providing more resources. The researchers recommended that practitioners sufficiently contextualize CDSMPs (Stone & Packer, 2010); therefore, future implementation of CDSMPs should involve researching local contexts, population demographics, and self-care needs in relation, specifically, to the logistical concerns of CDSMPs. Like Catalano et al. (2009), Stone and Packer (2010) found the qualitative approach of employing interviews useful for gathering information regarding the experiences of introducing and implementing a new CDSMP. However, also like Catalano et al. (2009), Stone and Packer (2010) did not address the effects of the program on lay leaders. Although the researchers of both studies employed interviews rather than a case study approach, their results suggested that a qualitative approach was suitable for this study to capture the experiences of how CDSMPs affect the lay leaders who teach them.

Summary and Transition

In summary, Chapter 2 detailed the literature search strategy used for the study, providing a history of disease management and outlining the seriousness of chronic diseases. I then analyzed, integrated, and evaluated the current peer-reviewed literature related to CDSMPs and found that although several programs exist (i.e., the Flinders CCMP and the Expert Patient Programme), the foremost program to appear in recent

literature is the Stanford CDSMP (Lorig et al., 2014; Neilsen & Gron, 2012). Recent literature has also shown that professional leaders and lay leaders work together (Catalano et al., 2009; Stone & Packer, 2010). Prior researchers found that both tensions and benefits were related to professionals and lay leaders working together (Catalano et al., 2009). In addition, both professionals and lay leaders indicated the importance of contextualizing CDSMPs, of considering local and regional markets, trends, and client needs when selecting and implementing CDSMPs (Stone & Packer, 2010).

Current research also indicated that project coordination, communication, and task integration were key components to running effective CDSMPs (Cramm & Nieboers, 2012). In addition, researchers found CDSMPs to positively affect patients suffering from multiple conditions (Harrison et al., 2012). Harrison et al. (2012) found individuals with multiple morbidities gained self-reported increases in vitality, health-related quality of life, and psychological well-being after participating in the 6-week course. Although multi-morbidity was associated with increased illness burden, these patients benefitted significantly from the CDSMP. Carter-Pokras et al. (2011) found that CDSMP coordinators sought lay leaders with team-building skills and an expressed commitment to help the community and concluded that effective lay health promoter programs require several related factors: (a) a needs assessment, (b) a target population advisory board, (c) promoters, and (d) a significant training program.

The Social Cognitive Theory and Self-Efficacy section and the Similar Studies section of Chapter 2 provided an underpinning for the foundation of this study, including a

review of Bandura's social cognitive theory (1993), self-efficacy, and studies with similar qualitative methodological approaches. Chapter 1 introduced the study, and the following chapter, Chapter 3 details the methodology used for this study.

Chapter 3: Research Method

The purpose of this study was to investigate the perceptions of Georgia CDSMP lay leaders regarding the effect the CDSMP has had on their own quality of health. Chapter 3 outlines the research tradition used, the selection of participants, the instrumentation, and the trustworthiness and ethical procedures used.

Research Design and Rationale

The central concept of this investigation follows a narrative approach. Narratives play a role in everyday life and can help to communicate experiences of the leader through that individual's own point of view. The narrative interview can offer a comprehensive discovery of the CDSMP leaders' recollection of their experiences in coleading the 6-week session program. The research herein centered on two overarching research questions that each have one subcomponent:

1. What are the perceptions of CDSMP facilitators toward the health benefits of the program?
    a. What are the perceptions of CDSMP facilitators toward their own health habits?
    b. What are the perceptions of CDSMP facilitators toward the health habits of those involved with the program?
2. How has facilitating the CDSMP changed the health habits of the facilitator?
    a. What are the perspectives of CDSMP facilitators toward their own quality of life living with a chronic condition?

Researchers face several options when determining a research design. Supported by Swanson and Holton's (2005) statement that research is a process having a specific type of merit, the decision is viewed as an important task, one in which the researcher needs to be aware of its purpose and process to ensure an appropriate selection. Social science research encompasses many choices for an accompanying research design. Of these designs, qualitative, quantitative, and mix-methods represent the three most common research methods used in social science research.

This study followed utilization of a qualitative research method. According to Merriam (2009), the qualitative research method is useful in illuminating three primary facets of the human experience: (a) "How people interpret their experiences," (b) "How they construct their worlds," and (c) "What meaning they attribute to their experiences" (p. 23). Further, Cooper and Schindler (2008) attested to the viability of qualitative research, noting that it encompasses an "array of interpretive techniques which seek to describe, decode, translate, and otherwise come to terms with the meaning, not the frequency, of certain more or less naturally occurring phenomena in the social world" (p. 196). A qualitative research design was appropriate for this study because it enabled me to develop a broad understanding of the Georgia CDSMP lay leaders' perceptions regarding the effect the CDSMP has had on their own quality of health.

This qualitative analysis occurred using a narrative approach to interviewing the CDSMP leaders. Hermans (1995) described the narrative interview as a method of recall of the past regarding a main point of concern. Clandinin and Connelly (2000) described

narrative research as a form of inquiry wherein the researcher studies individual lived experiences or perceptions and retells the responses as a narrative chronology. In this type of interview, the researcher gathers the participants' views, opinions, and thoughts on the subject of interest. The researcher should be able to encourage the participant to recall the story consistently and concisely from start to finish (Hermans, 1995). Recollection supports the participant's unbiased opinion of the subject matter.

Role of the Researcher

The foremost role of the researcher was to set and follow systematic procedures and collect data from multiple perspectives to present an accurate depiction of the findings. These procedures included designing the study, collecting data, analyzing the data, and composing. I also maintained an open mind to interpret multiple experiences and unexpected occurrences objectively. Interviewees were encouraged to answers each interview question openly and honestly. I attempted to create a climate in which the interviewee felt comfortable and more likely to respond honestly and comprehensively (Moustakas, 1994).

I recorded interviews, and enlisted the assistance of a transcriptionist to convert data from audio recordings to textural data for further examination. I then assessed the responses to assure that transcriptions were accurate and able to capture the true essence of the responses. After examining these responses, I determined thematic commonalities among the interviewees. Additionally, I determined any discrepancies within the responses; any irregularities were presented so that all angles were accurately reported.

I did not have any personal relationships with the participants, and did not hold authority above any of the sample. As such, no issues of power differentials existed. I did not provide incentives to sampled participants, monetary or otherwise. In addition, no expected issues of conflict of interest or bias occurred, as I had no personal relationship with any participants.

Bias was managed through theoretical sensitivity. I recognized potential biases against the data and kept those biases in check. Further support of this came from the personal and professional background of the principal investigator through development and refinement of caution and preparation (Schreiber & Stern, 2001).

Methodology

Participant Selection

To gather subjects pertinent to the research, the recruitment process involved several steps. The study entailed purposeful convenience sampling to collect participants. Purposeful sampling is appropriate when a researcher wishes to identify and select individuals with salient experience relevant to the topic of interest (Coyne, 1997). After approval from the Walden Institutional Review Board, recruitment involved gathering at least 20 CDSMP facilitators trained in the CDSMP protocol since 2005 to participate in the study. Purposeful participant sampling included using the Stanford University Patient Education site, such that all participants were certified in CDSMP protocol since at least 2005 and were active CDSMP leaders in the state of Georgia. I also identified participants through the CDSMP Evidence-Based Coordinator for the Georgia Division of Aging.

Additionally, all participants were at least 18 years of age and spoke fluent English. Any individuals who did not meet the criteria specified were not eligible to participate in the study. I contacted participants through electronic correspondence and telephone inquiries. Additionally, all participants received and signed an informed consent prior to taking part in any research activities.

Instrumentation

No standard survey or instrument applied to the research questions; therefore, I developed a series of interview questions to evaluate the case studies of interest. Prior to data collection, two CDSMP facilitators with more than 15 years of combined experience in conducting leader training reviewed and further developed the researcher-produced questions (see Appendix A). After incorporating the facilitators' input, the finalized interview questions helped to uncover information and garner responses from lay leadership and master trainers of the Georgia CDSMP.

The narrative interview consisted of an introduction through general questions, followed by probing, and then balancing of these two components. I introduced general questions that motivated the participant's central chronicle of the story. The probing portion allowed me to elicit any missing pieces to the central part of the story. The last portion of the interview involved fitting all components into a centralized idea. In this aspect, the participant was the expert in the process. The participants were questioned about the why and how something occurred in the process of coleading the CDSMP

(Flick, 2014). This questioning process also brought out the participant's views and opinions regarding such events.

Open questioning is a key component to exploring opinions and allowed the study participants to express their opinions, thoughts, and views of the CDSMP. The questioning also provided evidence regarding how the lay leaders interact with the program, as a daily regimen of self-management is required (Sbaraini, Carter, Evans, & Blinkhorn, 2011). This influence was beneficial to knowing the effects of self-management on leaders.

Data Collection

Participant interviews focused on the thoughts, opinions, and views of the CDSMP lay leader. The questions followed a semistructured interview guide with open-ended questions and probes to ensure consistency as to the views, opinions, and thoughts of the participant with respect to moderating the CDSMP (Burke & Miller, 2001). An open forum format interview followed the semistructured interviews, which provided additional information.

The data collection method for this study was a telephone interview protocol. Holt (2010) stated that using the telephone interview maintains a level of consistency in data analysis. This method allows the researcher to depend on what the study participants communicate as the context from what will be analyzed (Holt, 2010).

Several practical advantages exist to using the telephone as a means of data collection. One such advantage is time efficiency. When a geographical dispersion of the

study participants occurs, collecting the data by telephone interview saves time versus a face-to-face interview with the concern of traveling to the interview (Stephens, 2007). Also, flexibility for study participants exists when offering a telephone interview. In the event of an unexpected interruption, the telephone interview allows a higher convenience of rescheduling as opposed to a face-to-face interview (Holt, 2010).

Interviews. The phone interview began by informing the participants of the purpose of the study. I then obtained the participants' views, opinions, and thoughts of being a leader of the CDSMP. Each interview lasted approximately one hour. A standard tape recorder through the phone's speaker system recorded the data. Participants were notified that they could choose to leave the study at any time. If participants would have chosen to leave the study, or in the case that a sufficiently sized final sample could not be attained, recruitment would have been expanded to outside of the state of Georgia.

Open forum. The CDSMP is a dynamic group and I used the open forum method for participants and leaders to express themselves in session. I also held an open forum via telephone through a conference call with all willing participants. In the open forum, the participants helped to stimulate the memory and thoughts of other group members. It also provided an environment that allowed participants to agree or disagree with each other. Moreover, a process of critiquing and supporting one another existed during each of the 6-week sessions (Lorig, 2010).

Data Analysis Plan

Coding followed the tradition of content analysis to identify themes and commonalities. I read the transcripts of the interview and noted recurrent or significant points in the margin of the script. These significant points designated units of meaning to each of the participant responses. The next step was to group these points into themes and to recheck this against the original transcript. Researchers refer to these two steps of content analysis as open and axial coding, respectively (Strauss & Corbin, 1994). The following sections detail the procedures for open and axial coding.

Open coding. Open coding refers to the breakdown of a response into a set of underlying substituent meanings. During this phase of coding, units of meaning are assigned to each response. If a participant's response contained more than one unit of meaning, I identified the response as containing each of the resulting open codes. Completion of the open coding phase resulted in a list of annotated responses to each open-ended survey question (Clandinin & Connelly, 2000).

Axial coding. During axial coding, I matched the units of meaning that resulted from open coding between participants. Any resulting groups of open codes were referred to as a theme. A single response may contain several themes. The coding also included indicating discrepant responses at this time to capture all perspectives. The resulting thematic responses, or axial codes, were then organized chronologically so that an ordered, detailed narrative of the participant experiences may be examined (Clandinin & Connelly, 2000).

Content analysis does not specifically determine outlying cases or discover the true meaning of experience, but rather provides a detailed narrative that outlines the overarching, straightforward responses from a sample (Merriam, 2009). Using this method, the final presentation of results provides a chronologically ordered presentation of the views, opinions, and thoughts regarding leadership of the CDSMP.

Following final coding, resulting themes were subjected to inter-rater agreement and member checking. I noted any new that themes emerged from these fidelity checks. A final inspection included the analysis of the transcripts from an independent researcher during inter-rater comparison to evaluate the noted themes and points. This occurred with de-identified information, and a quality assurance check ensured that all information remained confidential (Barlow et al., 2005).

Issues of Trustworthiness

Credibility

The goal of credibility in qualitative research is to ensure that the research findings are accurate and valid. Anderson (2010) stated that when performed correctly, qualitative analysis is "valid, reliable, credible and rigorous" (p. 22). Qualitative findings may afford rich and detailed accounts germane to the central focus of the study. As Rolfe (2006) explained, validity in qualitative research is referred to by a variety of nomenclature, including the term *credibility*. Credibility refers to the extent to which the results reflect the participants' true and accurate experiences. Researchers may use a number of methods to improve the credibility.

Participants were informed prior to beginning the study of any known risks associated with their participation in the study. Participants signed a consent form prior to their participation in the study. All participants were informed that their participation in the study was voluntary and that they may withdraw from the study at any point. I aimed to support participants in providing honest and candid information throughout the interviews. I encouraged participants to elaborate on responses that warrant additional explanation.

I audio-recorded all interviews, which a third-party designee later transcribed. I reported anomalies or contradictory findings within the data. A discussion of the resulting themes in Chapter 4 includes the contradictory findings to ensure that the data represented the entire breadth of participants' perspectives.

Transferability

Researchers have traditionally viewed transferability as a barrier in qualitative research. Because of the relatively small sample size, transferability may be difficult to achieve, even when stringent sampling procedures are used (Stake, 1995). This presents a generally accepted limitation in qualitative research, and without exhaustive sampling procedures, researchers can do little to remedy this limitation (Moustakas, 1994). However, several researchers have argued that transferability is not a relevant concern in qualitative research because qualitative studies aim to describe a unique experience, rather than produce broad generalizations (Kreftin, 1990; Seidman, 2006).

Dependability

Dependability in qualitative research refers to the reliability, or repeatability, of the findings within the study. Willig (2013) suggested maintaining an audit trail to detail the evolution of thoughts and record the rationale behind each of the choices and decisions in the study. In this study, observational note taking during interviews ensured dependability, as well as the retention of a chronological list of insights and decisions made during the study. These notes were used during data analysis to confirm that extracted themes and interpretations were not swayed by bias or misunderstanding.

Confirmability

Confirmability in a qualitative study is equivalent to the concept of objectivity found in quantitative studies. Confirmability "occurs when credibility, transferability, and dependability have been established" (Thomas & Magilvy, 2011, p. 154). To obtain confirmable results, the study must accurately and comprehensively reflect the participants' actual voices. The participants' narratives should directly inform each theme that emerges from the analysis. Reflexivity is essential to achieving confirmability in a qualitative study (Thomas & Magilvy, 2011). Using the concept of reflexivity, I excluded my preconceptions and biases from the data analysis process and focused on the participants' direct responses. During the interview, I followed rather than lead the conversation so that participants spoke naturally of their experiences and perceptions. My role was to get as much detail as possible from the participants and ask for clarification when necessary (Thomas & Magilvy, 2011).

Ethical Procedures

Issues of beneficence and respect during the interview process are a potential concern in qualitative research. Ethical considerations regarding interaction with human subjects while conducting the research were based on the "Belmont Report" and adhere to the principles of justice, beneficence, and respect. All sampled participants within the targeted population were ensured respectful treatment and an accurate representation.

I made efforts to ensure comfort and safety of the participants as they detailed their perceptions on the role transition. Participants were made aware that they could choose to stop for a break or completely drop out of the inquiry at any time and with no penalty before, during, or after data collection.

Following transcription, participants received the opportunity to review the transcripts or opt out of member checking. If a participant elected to review the transcripts, he or she received a textural copy of their interview and was asked to confirm that the data collected were accurate. If a participant determined that any of the textural data were unrepresentative of his or her experiences, I instructed the participant to amend the incorrect data through email. All corrections were evaluated in comparison to the original text to ensure that the participant did not significantly alter the response. Any such alterations may have presented an issue of credibility. Chapter 4 reports the member-checking results.

Summary

Chapter 3 provided a detailed delineation of the methodological procedures applied in the study. In addition, the chapter presented details of data collection and analysis procedures, as well as ethical procedures and issues of trustworthiness. Further, I discussed potential methods to remediate these issues. The objective of this qualitative study was to investigate the perceived effect the CDSMP has had on Georgia CDSMP lay leaders regarding their perceived quality of health. Analysis centered on providing a thematic description of participant response content. Chapter 4 presents the results of the research and the comprehensive findings.

Chapter 4: Results

The purpose of this qualitative study was to investigate the perceptions of CDSMP lay leaders regarding the effect the CDSMP has had on their individual quality of health. The skills, concepts, and ideas introduced to the participant are the ones actually lived by the facilitator. The open dialogue that occurred in weekly sessions provided insight into the lay leader's own chronic condition. The self-management tasks taught by the lay leader were initially modeled and expected to be followed and reported on as "action plans" the following week (Lorig, 2005). I explored the effects of these self-management tasks on the facilitator. The intent of this study was to find the patterns or consistencies among Georgia CDSMP lay leaders regarding their perceptions, views, opinions, and thoughts of the program, as well as how the program has affected their own quality of life.

Research Questions

1. What are the perceptions of CDSMP facilitators toward the health benefits of the program?
    a. What are the perceptions of CDSMP facilitators toward their own health habits?
    b. What are the perceptions of CDSMP facilitators toward the health habits of those involved with the program?
2. How has facilitating the CDSMP changed the health habits of the facilitator?
    a. What are the perspectives of CDSMP facilitators toward their own quality of life living with a chronic condition?

Setting

The data collection involved a telephone interview protocol. I invited 12 leaders to participate in the interview, and all 12 completed the interview process. One of the interviews failed to record properly and could not be transcribed. As such, the final data set consisted of the transcribed responses of 11 of these CDSMP leaders. The interviews focused on the thoughts, opinions, and views of the CDSMP leaders, and the data gathered informed the research questions.

Demographic Information

The participants consisted of mostly all women (10, 91%), and included a majority of Caucasian facilitators. Roles within the sample ranged from leader to leader trainer (1, 9%) to program directors and coordinators (3, 27%), to trainers (6, 55), and included a single manager (1, 9%). Most participants had taken a refresher course (6, 55%), though those who did not report taking a refresher course tended to indicate that they had not been a part of the program long enough to need one. Most participants had never been an unpaid volunteer (8, 73%), and almost all were a paid leader at some point in time (10, 91%). Table 1 presents frequencies and percentages of the demographic information.

Table 1

Frequencies and Percentages of Demographics

Demographic	*n*	%
Gender		
Female	10	91
Male	1	9
Ethnicity		
African American	4	36
Asian	1	9
White	6	55
Role		
Leader to leader trainer	1	9
Manager	1	9
Master Trainer	4	36
Trainer	2	18
Program coordinator or director	3	27
Ever taken a refresher course		
Yes	6	55
No	5	46
Even been or currently are an unpaid volunteer		
Yes	3	27
No	8	73
Ever been or currently are a paid leader		
Yes	10	91
No	1	9

Note. Due to rounding error, not all percentages may sum to 100.

Participant ages ranged from 38 to 66 years old, with an average age of 51.30 (*SD* = 10.46). Participants tended to have taken their initial training an average of 4.45 years prior to the interview. Participants reported an average of 2.05 months between training and facilitating in the program. Reasons for this gap ranged from scheduling around the

holiday season to taking the time to set up and organize classes or collaborate with the venue. Table 2 presents descriptive statistics of continuous demographics.

Table 2

Descriptive Statistics of Continuous Demographics

Continuous Demographics	*Min.*	*Max.*	*M*	*SD*
Age (in years)	38	66	51.30	10.46
Length of time since training (in years)	1	9	4.45	2.42
Length of time between training and facilitating (in months)	0	4.5	2.05	1.29

Data Collection

All participants were asked to sign an informed consent form prior to participation in the study. In-depth interviews were administered one-on-one with 12 participants identified as satisfying the inclusion criteria. Data collection began with close-ended questions produced to gather demographic information for the sample. Interviews occurred during each CDMSP facilitator's chosen time and tended to last between 10 and 15 minutes.

Individual interviews served to gather data for this study. Rubin and Rubin (2005) asserted that qualitative interviews are conversations wherein the researcher controls a conversational pattern in a lengthy discussion. Each conversation was distinct, as I matched the questions to what each interviewee spoke about and was willing to express. The individual interviews occurred at a time and place chosen by the interviewees. I recorded all interviews using an iPad and a Livescribe pen. Interviews followed a

standard set of open-ended questions derived from the research questions (see Appendix A).

Data Analysis

Coding followed the tradition of content analysis to identify themes and commonalities. I read the transcripts of the interview and noted recurrent or significant points in the margin of the script. These significant points designated units of meaning to each of the participant responses. In the next step, I grouped these data points into themes and rechecked the themes against the original transcript. Strauss and Corbin (1994) referred to these two steps of content analysis as open and axial coding, respectively.

Content analysis is not designed specifically to determine outlying cases or discover the true meaning of experience, but rather to provide a detailed narrative that outlines the overarching straightforward responses from a sample (Merriam, 2009). Using this method, the final presentation of results provides a chronologically ordered presentation of the views, opinions, and thoughts regarding leadership of the CDSMP in reference to each research question.

Evidence of Trustworthiness

The credibility of the researcher controls the trustworthiness of a qualitative study (Merriam, 2009). Lincoln and Guba (1989) characterized three evaluative criteria for implementing trustworthiness. These criteria include credibility, transferability, and dependability. To ensure credibility, interviews were audio-recorded and later transcribed to text. I also reported anomalies or contradictory findings within the data. This chapter

details the contradictory findings among the other resulting themes to ensure that the data represents the entire breadth of participant perspectives. Transferability was not a relevant concern in the current study because qualitative researchers aim to describe a unique experience, rather than produce broad generalizations (Kreftin, 1990; Seidman, 2006). Providing rich detail regarding the procedures in the study ensured dependability. I also used reflexivity to ensure the confirmability of the research during both the data collection and data analysis. In doing so, I set aside my biases and followed the interviewee rather than leading the conversation. I also maintained the participants' voices when reporting their perceptions and experiences.

Results

After coding the participants' responses, I compiled relevant open codes based on their usefulness to inform the research questions. These open codes involved categorization into axial codes, or themes, and resulted in 10 unique overarching responses (i.e., five themes and five subthemes). These themes and subthemes were categorized as pertinent to either Research Question 1, or to Research Question 2. I sorted irrelevant data for reference, but did not reported the data unless it could be used to further inform an existing and relevant theme.

Research Question 1

What are the perceptions of CDSMP facilitators toward the health benefits of the program?

a. What are the perceptions of CDSMP facilitators toward their own health habits?
b. What are the perceptions of CDSMP facilitators toward the health habits of those involved with the program?

Three themes were relevant to Research Question 1 and Subquestion a, while one theme informed Subquestion b. Participants felt that *the CDSMP program benefits health in general*, beyond just helping in the management of chronic disease, though many others stated that *the CDSMP program helps manage chronic disease* as well. The participants did not directly indicate *facilitator health behaviors*, though participants did indicate the relative levels of the healthy behavior in reference to those after the program. The following sections detail the three themes.

The CDSMP program benefits health in general. Each of the 11 participants (100%) indicated that the CDSMP program was highly beneficial to healthy behaviors. The participants felt that learners only had to participate in the class to gain some form of health benefit. Participant 2 noted that a large benefit to the program was the way that it helped learners feel in control, "That's what I liked about the class, it was really empowering people to look at a way to solve an issue or to address a problem." Participant 7 also contributed to this idea, stating, "people come away [from the program] with the tools they need for their health." Participants often cited the large amount of skills and tools afforded to learners in this program, as learners could effectively target and remedy issues with their lives, their family's lives, and their general health.

Participant 10 had taken a CDSMP course once before becoming a facilitator and commented, "that's when I fell in love with it because it really taught me to be a better self-manager of my health."

While some participants cited empowerment, others noted that the program allowed learners to be more aware of their behaviors, and that simply participating in the program caused heightened awareness of one's healthy and unhealthy behaviors. Several participants attested to seeing this change in their own lives, though many others commented that they were able to see the change in their learners as well. Participant 10 suggested:

> The materials really hit home to a variety of people, no matter what their ethnicity may be or gender [sic]. A lot of people there have issues with their health so it helps, and the tools that the program gives really helps out.

Later in the interview, Participant 10 recounted experiences where, "You see a person who's being shy or not aware of what the health is all about week one and then week six they're the guru of health." Participants also noted that learners were more likely to read ingredient lists on food and pay attention to their food intake. Participants' responses that informed this research question generally pertained to overall health improvement and increased awareness from themes pertinent to Research Question 2. As such, much of the data informed the second area of research.

Some participants cited the usefulness of the program's stress reduction tools. Many reported that these meditative and breathing techniques could help to manage stress

in one's daily lives. Participant 11 explained that, "In terms of managing stress, some of the techniques that are taught like the breathing and the diaphragm breathing I'm able to utilize in my everyday life and that's taught me a lot." Participant 3 added, "it is clear that it helps them understand their role much better and have the tools." She continued to assert, "I see change that nothing in my nursing life in the hospital setting could accomplish . . . You've got to have 1,000 cups of tea to make a difference and it's allowing for that." She felt that the program allowed learners to make long-term behavioral changes in their lives, which may be more difficult to accomplish in a different setting.

Participants also noted that action plans provided effective tools to help learners succeed and stay on track. Participants felt that action plans were largely responsible for keeping learners from losing track or feeling overwhelmed. Participant 3 mentioned her affinity for the action planning and stated: "It's a hard list. I find it compelling." She detailed that the action plan gave participants a concrete way to manage a healthy lifestyle with little planning. Participant 3 also noted her love for the buddy system and the shifting of empowerment. She believed that learners felt much more empowered when they learned about all the ways to improve their health and were able to use these approaches easily in their daily lives.

The CDSMP program helps manage chronic disease. Participant 7 stated that the program allowed her to gain control of her chronic condition, and that the action plan had even improved other areas of her life. Participant 5 cited using the program's

exercises to manage her chronic shoulder pain. Participant 11 also reported having her chronic illness under control, commenting: "I think even for me, it taught me how to be a better self-manager of my disease as well. I've been making progress when it comes to managing my chronic illness and it's been good." Further, Participant 11 reported seeing improvement in others who participated in the program, stating, "I can't say all, but a lot of the participants that have gone through the program have really improved themselves and their chronic disease. I'll see them on the street and they'll say I've been doing my action plan."

Participant 2 still had the chronic disease that she was diagnosed with in 2006, but reported no decline in health. She felt grateful that she was able to continue with normal life and had not declined in health because of her chronic disease. Participant 2 stated:

> It hasn't gotten worse but I've had to add medication to the regimen that I have. So I think just incorporating some of the skills I learned, even though I haven't came [sic] off of the blood pressure medication, I have maintained. I have not had to add additional medication on top of that.

Although she did take medication for her illness, Participant 2 did not need to add to the regimen, and used the skills from the program to manage her medication. Two facilitators (i.e., Participant 1 and Participant 4) did not have any chronic diseases, but they were caretakers to individuals with a chronic disease. These participants could not speak directly to the fact that the program alleviates chronic conditions firsthand, but did indicate that they had seen many successes from the program.

Facilitator health behaviors. Participants did not report much information regarding their health habits before becoming a CDSMP facilitator, and most information was gleaned from their responses about how the program changed their habits. None of the six (55%) participants who stated that they currently exercised (i.e., Participants 3, 4, 5, 6, 9, and 11) reported exercising before facilitating in the program. The other participants indicated that they did not pay attention to the foods they consumed prior to the program as much as they did after the program, and a large portion of the participants felt that they were not eating well before the program. Overall, participants did not seem to have any specific health-related behaviors before the program, and did not spend time considering their health or how their behaviors affected their individual lives.

c. What are the perceptions of CDSMP facilitators toward the health habits of those involved with the program?

One theme described the perceptions of CDSMP facilitators toward the habits of those involved with the program. Although facilitators did not explicitly describe their learners' health habits, they described their learners' change in quality of life and the resulting improvements to their health.

I love watching learners' lives improve. Facilitators reported the joy they felt seeing learners improve their lives with the new skills that the program provided. Participant 6 felt satisfied because she was promoting self-management for participants and putting the ability to change in their hands. This experience was fulfilling to Participant 6, but was also fulfilling to the learner. She enjoyed her role in the program,

and explained that, “I think you are making a difference and helping them help themselves.” Participant 2 reported the joy that she felt when she empowered learners and gave them the ability to improve their lives. She indicated;

> Change is so difficult for a lot of people and they don't think that they can change something that they’ve been dealing with for a long time. But with the right skills they may take changes but they have a better skillset on how to deal with it. That's what I liked about the class, it was really empowering people to look at a way to solve an issue or to address a problem.

Participant 3 stated, “My quality of life is driven by how successful I think I am in influencing people’s health behaviors.” She continued to detail that the program changed participants in a way that she had never seen in previous settings. Participant 3 was pleased that she was able to see this magnitude of difference, and rejoiced that the program allowed her to continue her work as a nurse without interruption. Participant 3 detailed her experiences with facilitating the course while maintaining her nursing role:

> It's probably the most fun teaching my baccalaureate students and being able to do nursing on the side. That's kind of a perfect little... but it's so gratifying because even though it is an environmental improvement, it is clear that it helps them understand their role much better and have the tools. So, it becomes a part of my language and part of my convictions and I'm more and more appreciative.

This theme was prevalent and many participants cited this as the most rewarding aspect of their role as facilitator. Participant 1 stated,

> I get something out of it every time I lead a group through it because of what they bring to the table and just the material itself the information and seeing the aha moment as they go through it and get the material and hear what others have to say makes it really seem worthwhile.

She continued to describe that leading the CDSMP enhanced her quality of life through the people she encounters, "I get to do it over and over again and meet interesting people that I can see benefit from the program so that makes me feel good." Participant 10 summed up this idea by stating, "It has enhanced my quality of life because I've always liked helping people."

Research Question 2

How has facilitating the CDSMP changed the health habits of the facilitator?

a. What are the perspectives of CDSMP facilitators toward their own quality of life living with a chronic condition?

Examination of the data in reference to Research Question 2 and Subquestion a indicated that *facilitators gained healthy habits* and that *the program increased facilitators' quality of life.* Within the theme of facilitators gained healthy habits, participants tended to respond with one or more of the following subthemes: *I'm more aware, my diet has improved,* and *the program might help facilitators the most.* Within the theme of the program increased facilitators' quality of life, participants tended to respond with the main concept of *I'm less stressed.* The following sections detail these two overall themes, as well as the four extracted subthemes.

Facilitators gained healthy habits. Participants talked at length about the benefits they received because of the habits they acquired by facilitating the CDSMP program. Overall, participants did not feel that these habits interrupted their daily lives, but rather the habits integrated into their routines somewhat seamlessly. For example, Participant 2 mentioned that these habits became second nature following her role in the CDSMP. Participant 2 elaborated:

> I think that empowered me. Now it's pretty much automatic, it's not something I have to think about. I know I can do that. Okay, I need to go out and walk. When I'm walking my mind is clear I'm not so much thinking about what's going on so it helps me with stress.

Other participants also felt that they became more aware of their behaviors, their diets had improved, and even suggested that the program may be even more helpful to facilitators than to the learners themselves.

Overall, responses that fell into this theme were classified into three subthemes. The subthemes included the following: (a) *I'm more aware*, which detailed their newfound awareness of their healthy and unhealthy habits; (b) *my diet had improved*, which explained the ways that their day-to-day food intake has been affected; and (c) *the program might help facilitators the most*, which explained the degree to which the program influenced the facilitator specifically.

I'm more aware. Nearly half the participants (5, 45%) directly indicated that the program had affected their awareness of their habits. Some participants noted that they

were more aware of ingredient lists and food content. Participant 6 felt that the program allowed her to better analyze her health habits. She commented: "I think that maybe it has helped me take a step back and see the things that I was doing that affected my health aversely. So I had to get more exercise and take better care of myself." Participant 10 was surprised by the knowledge he gained while facilitating the program and cited:

> Seeing how much sugar is in a product when they say it's sugar free or seeing how much sodium is in a product. It was amazing to me how much sugar is in food, particularly processed foods. Just being aware of those food labels and portion sizes has made a difference in my life.

Participant 5 acknowledged this, concluding that, "I'm very much more aware of labels on things." Awareness was not limited to food, but extended into the facilitators' perceptions of their activity levels and their awareness of stressors and how to cope. Participant 9 felt the difference in her awareness after facilitating in the program, stating, "It's made me more aware that I need to exercise more and also do stress management to calm my mind in understanding the importance of sleep." She continued: "If I don't get sleep, I don't exercise because I'm too tired. It's a reason to look at portion size and what kind of foods I should be eating." This increased awareness of healthy habits allowed her to take active control and better manage her life using informed choices. Participant 8 had a similar experience after facilitating in the program. She mentioned:

> [Healthy habits have] been on my brain since I finished up session five last Thursday. I need to be eating 5-7 servings of vegetables a day. And I need to be doing some of those exercises that are important for posture. Little things like that and drinking a lot more water.

She went on to say that the program allowed her to change her habits gradually and naturally stating that, "it's a gentle program, and it's not nagging." The participant thought this gentle introduction was the reason that these habits were so easily set in place. Participant 3 confirmed the claim that the program integrated this positive change gently, stating that the program made change accessible. Participant 3 stated:

> It gives me a power to be myself but also to communicate to my children and neighbors, this can be baby steps. We're not trying to rapidly change you, we need you to choose what you'd like to do. It's just the encouragement that you would give a toddler to launch them on their way in confidence.

My diet has improved. Most participants cited a change in the way that they thought about their food and drink intake. Participants felt that they were not drinking enough water before their service in the program. Many had set action plans in place to remind themselves to drink more water. Others focused on their lack of adequate fruit and vegetable consumption. In both cases, participants cited making better choices and felt that this reflected on their quality of life. Participant 1 specifically concluded that the facilitators were able to better diagnose their eating and drinking habits after facilitating in the program. Participant 1 stated:

> I will periodically realize I'm not drinking enough water and I'm not eating enough fruits and vegetables or I'm eating too much of the bad things. And so I'll say to myself, I'll make an action plan with myself alright I'm going to have fruit for dessert this many times this week or I'm going to drink this many glasses for water these days. I use the actual plans to work on my behaviors.

Participant 7 indicated that she had been eating healthy for years before teaching the course, but felt that the course still helped her to push harder. She amended even the smaller areas of her daily routine so that everything in the course reflected in her healthy habits at home. Participant 7 stated:

> What I find is that I will do... I will make an extra effort. As a leader you have to follow the action plan. By making every plan work for you, in little areas like drinking more water or little things like that.

Dietary improvements did not stop at drinking more water or eating more vegetables. Other participants also amended their daily activities to be healthier. In one example, Participant 4 changed her day to incorporate breakfast into her daily routine, and related this to an improved quality of life. Participant 4 stated:

> I eat breakfast now, I never ate breakfast. Several years ago I was reading that chart to people, what is healthy eating and I thought I always eat lunch or if I don't eat lunch I eat a really big dinner and feel miserable. So now every day I eat breakfast. It's changed my metabolism, it's helped me lose a little bit of weight. I feel better throughout the day, at dinner I don't feel like I'm super hungry.

Participant 3 enjoyed using different diets for different parts of the week to accommodate realistic goals, stating, “For weekday diets versus weekend diets, that's extremely helpful. I’m slender and I'm not a diabetic but it has helped me appreciate ... it becomes so accessible, change.” She felt that this aspect of the diet plans allowed her to prompt a change in her habits with minimal distress.

The program might help facilitators the most. Participants tended to feel that, in some ways, being a facilitator in the program gave them an advantage over the learners. Participant 5 backed this idea, and felt that she was motivated to follow the action plans provided in the program. She stated that when leading a workshop, “[following action plans] is reinforced because how are you going to model it if you're not doing it yourself? So the more workshops you read, the more likely you are to follow through on the concepts that you're teaching.” Other participants simply felt that the program improved their lives because in guiding the program, they had committed so much useful information to memory. Participant 4 confirmed:

> It's enhanced my quality of life because it's a lot of information that's truthful. When you get truthful information you get educated and you start to react from what you know is true. Drinking more water is important and eating right. When you say it over and over again you evaluate it. I think it's changed my life because I'm educated now through the books and teaching it.

These facilitators tended to agree that the program might have been even more effective for the facilitator than the learners, as the facilitator was more highly and consistently

exposed to the course content. The participants also felt that facilitating in the program gave them a higher motivation to acquire the available skills and work towards the program's goals. This motivation stemmed from a feeling of being a leader and spearheading the program's goals and action plans. Participant 2 provided insight regarding this idea and stated:

> As leaders you really want to set an example. So therefore you set a goal and had to come back and report on how well you achieved that goal. So that makes you self-aware of the things in your own self that you need to address. Because it's kind of hard to teach other people about things when you're not applying them yourself. At least I find it hard and difficult to tell people to drink more water and you yourself aren't making an effort to do that.

She hinted that becoming familiar with the course content is a part of the job and that course habits and ideas become a part of the facilitator's life. In most cases, the facilitator specifically mentioned how the program's values become second nature. Participant 2 detailed this idea:

> I think [being a part of the program] has made me feel better about my own health because as I'm out teaching these classes and telling people about how to deal with chronic pain, depression, I have learned the skillset for myself. Initially that was true for me but now it's almost automatic.

The program increased facilitators' quality of life. Each of the participants responded that their inclusion in the program improved their quality of life. Participant 5

stated, “being so familiar with the concepts that they become part of your life is [sic] really valuable, and also it has allowed me to share those concepts even outside of the workshop concept.” She continued by noting that, “you can do problem solving with [others] because you're familiar with the concept.” Participant 9 also simply enjoyed the course, and when asked how the program improved her quality of life, responded:

> Oh just the pure enjoyment of the class, but also I have high cholesterol so every time I go to get checked up my numbers are high so it helps me take my health more seriously and to try using it more as a tool. Now I have the tools to try to fix my health.

Participants tended to focus on one main area of life improvement outside of the aforementioned health habits, which included their overall reduction in stress. The following section presents this subtheme.

I’m less stressed. Many of the facilitators mentioned that their participation in the program provided them with stress reduction techniques. These facilitators recounted instances where they felt the first signs of stress arise and were able to effectively calm themselves before the stress could take hold. Participant 1 suggested that she was able to use these techniques easily on a daily basis. Participant 3 specifically mentioned the way that the program had helped her deal with stress:

> What has been helpful is the breathing. I really, really appreciate the breathing exercises, certainly the distraction techniques have been helpful from the point of view if I run too hard or am needing to wind down those mechanisms have helped.

Participant 5 also mentioned the benefit from relaxation techniques, such as breathing, and felt, “Much more conscious of relaxation, deep breathing and those kinds of methods for coping with pain, or you know needing to do something in spite of pain.” Other participants focused on the way that the acquired skillset allowed them to identify stress before it became an issue. Participant 2 noted instances where she was able to identify the stress and automatically change how she looked at it. She indicated that she was able to tell herself to go on a walk or take some other action to eliminate the stress. The technique that she reported as an automatic response to stress was walking. Participant 2 went on to say that, “When I'm walking my mind is clear I'm not so much thinking about what's going on so it helps me with stress.” Participant 7 particularly enjoyed the meditation techniques to cope with stressors. Each of these participants seemed to cope with the stress almost naturally. The participants experienced an immediate and ingrained response to stress, and immediately took to correcting the situation with their favored tool learned from the program.

Summary

Chapter 4 presented the findings of the research. The chapter opened with a restatement of the purpose and research questions to frame the findings. The chapter then detailed the setting for data collection, as well as the participant demographics from the final pool of participants. I then outlined the data collection process to describe the actual occurrences that happened during interviewing. Providing the details of the analyses contributed to the dependability of the study and allows other researchers to replicate the

findings. The chapter also presented issues, such as dependability and overall trustworthiness, to inform the study's validity. Following the study details, I explained the findings in regards to each research question and subquestion. Chapter 5 presents a discussion on these findings in synthesis with the extant literature. This synthesis allowed me to contribute further knowledge regarding the conceptual framework. The chapter also includes suggestions for further research and an in-depth interpretation of the meaning behind the findings of the narrative analysis.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

The purpose of this qualitative study was to investigate the perceptions of CDSMP lay leaders regarding the health benefits of the program and whether leading the CDSMP changed program leaders' health habits and their own quality of health. The CDSMP is an innovative self-management program that has received international recognition as the gold standard in chronic disease management intervention. Researchers have extensively studied the effects of programs on participants; however, few researchers have investigated the effects of the program on the lay or peer leaders who teach the program. This research was necessary because health education programs that emphasize the need to promote and facilitate self-management techniques are increasing in popularity (Schulman-Green et al., 2012). Consequently, a rise exists in the recruitment and retention of community lay leaders to supplement professional leadership, and the recruitment of lay leaders has become an important consideration in self-management delivery programs (Carter-Pokras et al., 2011; Ory et al., 2013). Lay leaders occupy a position between program participants and professional leaders and may be able to provide unique information regarding the benefits of CDSMPs to themselves and participants.

This study was necessary to provide more data on the benefits of CDSMPs from sources other than program participants to paint a more complete picture of the sustainability of CDSMPs as they become increasingly popular. This chapter continues

with a brief summary of the findings, interpretation of the findings in relation to previous research, and limitations of the study. The chapter also contains implications for theory and practice, recommendations for future research, implications for social change, and a conclusion.

Summary and Interpretation of Findings

Research Question 1. What are the perceptions of CDSMP facilitators towards the health benefits of the program?

Research Question 1, Subquestion a. What are the perceptions of CDMP facilitators toward their own health habits?

Research Question 1, Subquestion b. What are the perceptions of CDSMP facilitators toward the health habits of those involved with the program?

For Research Question 1, Subquestion a, the data centered on three thematic categories: (a) the CDSMP program benefits health in general, (b) the CDSMP program helps manage chronic disease, and (c) facilitator health behaviors. The findings of the present study confirmed the findings of previous researchers who found CDSMPs are beneficial to individual health (Nolte & Osborne, 2013; Ritter et al., 2011) and provide tools to help individuals manage chronic disease (Ory et al., 2013; Schulman-Green et al., 2012). However, study participants reported little information regarding their health habits before becoming a CDSMP facilitator. The following sections detail the findings of the study in relation to previous literature by theme.

Research Question 1, Subquestion b. What are the perceptions of CDSMP facilitators toward the health habits of those involved with the program?

For Research Question 1, Subquestion b, one theme emerged from the perceptions of CDSMP facilitators toward the habits of those involved with the program: I love watching learners' lives improve. Facilitators did not explicitly describe their learners' health habits, but they described their learners' change in quality of life, the resulting improvements to learners' health, and the resulting joy and fulfillment felt from watching learners' lives improve. The finding that program leaders take joy and fulfillment in watching learners' lives improve is novel and suggests that emotional dimensions may be important to facilitators' overall quality of life.

Interpretation of Findings for Research Question 1, Subquestion a

The CDSMP program benefits health in general. All of the participants perceived that the CDSMP as a whole was beneficial to their overall health. This finding aligns with the findings of previous research that showed the CDSMPs not only improve individual health, but in doing so decrease strain on the health care system as a whole in ways that affect the consumer (Nolte & Osborne, 2013; Ritter et al., 2011). Participants spoke of the program empowering them to address and solve their health issues, as well as leaving the program with tools needed to improve their health. Schulman-Green et al. (2012) found that CDSMPs allow patients to make informed decisions necessary to improve their overall state of health, and that the daily practice of using the tools and skills

learned through education practices can encourage individuals with chronic diseases to take an active role in their health management.

Researchers (Lu et al., 2014; Nielsen & Gron, 2012) have also shown that participation in CDSMPs increases individuals' involvement in self-managing a chronic condition, thereby improving outcomes by increasing individuals' confidence in self-managing the chronic condition correctly and consistently. In the present study, participants indicated willingness and eagerness to report back and follow through with action plans and goals. In addition, participants saw the self-management tools used in the program as catalysts for changing daily habits that would benefit their health. For example, many reported that stress-reducing techniques, such as deep breathing and meditation, were easy to do and remember. The World Health Organization (2012) noted that psychosocial stress affects chronic disease occurrence. In addition, managing complex routines, fear of the unknown, and not being able to communicate effectively with health care professionals are among the challenges faced with dealing with a chronic condition (Schulman-Green et al., 2012). One of the components of the CDSMP was an action plan to assist program participants with tasks, such as coping with psychosocial stress and the unknown, communicating with health care professionals, and managing complex routines. Lay leaders of a CDSMP noted that the action plans were of significant assistance in maintaining a healthy lifestyle, communicating with health care professionals, and following through with health related goals as they taught participants to make and manage weekly plans.

The CDSMP program helps manage chronic disease. Taking an active, daily role in one's own health management is imperative to effectively managing a chronic disease. Daily practice and close attention to the symptoms of a chronic condition are critical to effective self-management and, consequently, are encouraged through educational tools in CDSMPs (Ory, 2013; Schulman-Green et al., 2012). The findings related to this theme of self-management confirmed the effectiveness of CDSMPs in helping individuals to manage their chronic diseases, and many study participants reported seeing improvements in how program participants managed their conditions. One study participant explicitly connected program participants' improvement to their adherence to action plans. Researchers (Handley et al., 2006; Lorig, 2005) have proven that action plans can be effective in helping patients manage their health conditions and adopt healthy behaviors.

In cases where the CDSMP did not outright improve program participants' chronic condition through teaching effective self-management skills, the program helped to prevent decline in health conditions, for which one respondent was grateful. This study participant reported feeling grateful that her health condition had not declined because of her chronic disease and for being able to continue with a "normal" life. Although not a direct improvement to her health condition, this participant's response suggests that maintaining a level of health and preventing further decline may bolster individuals suffering from chronic conditions emotionally. Researchers Cramm and Nieboer (2012) and Ory (2013) found that an important component of effective self-management of

chronic conditions involves emotional coping and adaptation, as well as paying attention to physical and psychological symptoms.

Interpretation of Findings for Research Question 1, Subquestion b

I love watching learners' lives improve. One subtheme of the program, increasing facilitators' quality of life, included the love of watching learners' lives improve, and study participants spoke favorably about their feelings of seeing program participants' lives improve. One participant described helping people to solve an issue or to address a problem as empowering. The finding that program leaders take joy and fulfillment in watching learners' lives improve is novel and suggests that improving emotional states for facilitators may be an important aspect of facilitators' overall quality of life.

Research Question 2, Subquestion a. How has facilitating the CDSMP changed the health habits of the facilitator? What are the perspectives of CDSMP facilitators toward their own quality of life living with a chronic condition?

For Research Question 2 and Subquestion a, the data centered on two categories: facilitators gained healthy habits and the program increased facilitators' quality of life. For the first category, three subthemes emerged: (a) I'm more aware, (b) my diet has improved, and (c) the program might help facilitators the most. For the second category, one subtheme emerged: I'm less stressed. These findings are novel because few studies exist regarding the effects of CDSMPs on the leaders of these programs. The following sections detail the findings of the study in relation to previous literature by theme.

Interpretation and Discussion of Findings for Research Question 2, Subquestion a

Facilitators gained healthy habits. An important part of the leadership duties of CDSMP facilitators is to act as a role model for program participants by enacting and advocating the strategies that facilitators are teaching in program sessions (British Health Foundation, 2010; Lorig & Sobel, 2001). In their study of the chronic care model, Cramm and Nieboer (2012) found that leaders must connect strongly to patients via effective communication and task integration, which may include modelling health management behavior to help provide effective health management education. Participants in the present study felt that they not only acquired positive communication techniques from leading sessions, but also acquired the benefits of positive health management habits as well. Several study participants discussed how seamlessly they were able to integrate the skills they taught into their own health routines. One participant mentioned that after she began leading a CDSMP, managing her health regimens became second nature. Schulman-Green et al. (2012) found that strategies to increase health knowledge and the viable use of accessible and easy to understand educational tools allow individuals to take an active and informed role in their personal health care decisions. The finding that facilitators gained healthy habits supports Schulman-Green et al.'s finding relating to leaders of CDSMP as well as participants.

I'm more aware and my diet has improved. Two subthemes of facilitators gaining healthy habits resulting from facilitating CDSMPs included facilitators becoming

more aware of their health habits and facilitators improving their diets. Helping individuals to become aware of their health habits and diet in relation to their lifestyles is a major component of effective health self-management (Jang & Yoo, 2012; Lorig, 2001; Redman, 2011). Health habits and diet are important to good health and are modifiable; consequently, health habits and diet represent important areas for facilitators to target when helping individuals to manage their health conditions (Jang & Yoo, 2012; Lorig, 2001; Redman, 2011).

Participants of the present study reported that leading CDSMPs made them more aware of the positive effects of exercise, including its role in reducing stress, and the need to be more aware of the food they consumed, such as a heightened awareness of ingredients on food labels. One participant indicated that this increased awareness of health habits and diet allowed her to "take a step back" and to see what kinds of factors affected her health adversely. Furthermore, this awareness led to behavior modification. One participant mentioned reducing her sugar intake because of her becoming aware of the large amounts of sugar in processed foods. Other participants mentioned that becoming aware of healthy habits led them to gradually make positive changes in their routines that affected their health positively. Observing program participants' positive changes in current health status brought change in the daily activities of program leaders. In addition, improvements in diet, accommodation of dietary needs, and responsibility to sustain nutritional choices were reinforced for leaders when they reported back to the group. Jang and Yoo (2012) found that when program leaders practiced good health

habits and reported their practices to program groups, the process served as a motivation for program participants who then model these good habits. The results of this study suggested that the actions of program participants and program leaders are reciprocal, and that the actions of program participants influence the health behaviors of program leaders as well as the other way around.

The program might help facilitators the most. Another subtheme of facilitators gaining healthy habits resulting from facilitating CDSMPs was that the program might help facilitators more than program participants. Several study participants felt as though teaching the program gave them an advantage over learners. The repetitive and scripted nature of the program allowed program leaders to feel a sense of obligation and responsibility to carry out the specific tasks they taught when making weekly action plans with participants. In addition, teaching, memorizing, and modelling program content reinforced for leaders the importance of positive health self-management. Nielsen and Gron (2012) stated that lay or peer leaders especially had a responsibility in building trust with program participants by teaching participants to take better care of themselves through example. In the present study, it was the weekly teachings that most of the program leaders felt encouraged them to change their quality of life via the role they played in leadership and modelling behavior. Such a finding is novel because it suggests that not only do program participants benefit from leaders enacting positive health management behaviors, but also that programs leaders themselves may benefit as much, if not more so, than participants.

Program increased facilitators' quality of life. All study participants reported enjoyment in teaching the concepts of the CDSMP as well as how their inclusion in the program improved their own quality of life. As one participant put it, being so familiar with the concepts allowed the concepts to become a part of her life. The above findings are novel because researchers have typically not looked at the effects of CDSMPs on program leaders. The findings suggest that because of their role in teaching and modelling health education tools and strategies, program leaders may experience more health self-efficacy and confidence in self-management than program participants, as a result of leading CDSMPs. The findings of the present study also support the idea that individuals with self-efficacious beliefs avoid being stressed when they believe they can successfully address a given issue or complete a specific task (Bandura, 2004).

Another subtheme was that program leaders felt less stressed by teaching and participating in the stress-reduction techniques of the CDSMP. Individuals who suffer from chronic diseases often experience high degrees of psychosocial and emotional stress, and many symptoms manifest through stress-related occurrences (WHO, 2012). Consequently, stress-reduction is an important component of the effective self-management of chronic diseases (Cramm & Nieboer, 2012; Ory, 2013). The finding of watching learners' lives improve and stress reduction suggest that the emotional benefits, important to the self-management of chronic conditions, of CDSMPs extend indirectly to programs leaders through their feelings of making a difference in the lives of others.

Consequently, leading CDSMPs may improve the emotional dimensions of leaders' lives, as well as those facets involving health and dietary habits.

Social Cognitive Theory, Self-Efficacy, and Self-Management Behaviors

Social cognitive theory and the construct of self-efficacy were the theoretical underpinnings for the present study. Health behavior is influenced by the outcomes people expect their actions to produce, and the stronger their perceived efficacy, the higher the goals people set for themselves, the more they expect their efforts to produce desired outcomes, and the more they believe they can achieve those goals (Bandura, 2004). Researchers linked increased patient self-efficacy to CDSMPs in a number of studies (Jang & Yoo, 2012; Lorig et al., 2014; Lu et al., 2014; Nielsen & Gron, 2012; Nolte & Osborne, 2013; Ritter et al., 2011). In the present study, I found that CDSMP leaders believed that CDSMPs benefitted themselves and program participants, confirming recent research and suggesting that CDSMPs provide a higher sense of health self-efficacy to program participants. However, I also found that CDSMPs provided a higher sense of health self-efficacy to program leaders as well, which is novel.

One way CDSMPs helped improve individuals' health self-efficacy was by providing participants with tools and strategies in the form of action plans to help manage their chronic conditions. Leaders of CDSMPs noted that the programs provide individuals with strategies and the tools necessary to manage their chronic diseases effectively, and reported seeing improvements in how program participants managed their conditions. This finding suggests that by providing tools and skills, CDSMPs positively influenced

participants' health-related self-efficacy and influenced participants' confidence in self-managing chronic conditions correctly and consistently. Health self-efficacy refers to the perceived confidence that individuals can improve their health by exercising control of their health habits (Bandura, 2004). Action plans helped program participants with tasks, such as coping with psychosocial stress and the unknown dimensions of their conditions, communicating with health care professionals, and managing complex routines. By providing plans and tools to help individuals manage their chronic conditions, CDSMPs helped individuals make decisions about and take control of their health behaviors to improve their health and instill confidence in their abilities to manage their conditions.

Furthermore, the findings suggested that CDSMPs gained more control of their own health habits, thereby improving the health self-efficacy of CDSMP leaders as well. Participants spoke about the program empowering them to address and solve their health issues, as well as coming away from the program with the tools and confidence needed to improve their health by positively modifying their own health behaviors. The act of leading CDSMPs helped leaders to improve their own overall states of health by incorporating the tools and skills of CDSMPs into their own lives, thereby positively influencing leaders' health self-efficacy (Bandura, 2004). The leaders were able to integrate program skills into their own health habits, to the extent that healthy practices became routine and second nature. Findings of the present study suggest that because of their role in teaching and modelling health education tools and strategies, program leaders

experience health self-efficacy and confidence in health self-management because of leading CDSMPs. In addition, program leaders reported feeling less stressed because of implementing stress reduction techniques they taught in CDSMPs; individuals with self-efficacious beliefs avoid being stressed when they believe they can successfully address a given issue or complete a specific task (Bandura, 2004).

Limitations of the Study

Qualitative research has limitations involving the generalization of the findings to other populations, sample size, and the interpretation of themes. Because qualitative studies often involve small populations, Krueger (1998) observed that qualitative research has the purpose of obtaining expressive results rather than making broad generalizations. Therefore, the true quality of a qualitative study is not in the sample size and generalizability, but in trustworthiness and the depth of insight in the data obtained.

Because of limitations of the present study, readers should interpret findings with some caution. First, while the sample was small, it consisted mainly of White women. Future studies with more diverse populations may yield different data related to these populations. Second, the geographical location of the study was the southeastern United States; consequently, findings of the present study may be specific to this region. Last, another limitation of this study may be age. The majority of program leaders were under 65 years of age. Part of the appeal of CDSMPs are the benefits that the programs can provide to participants 65 and older (CDC, 2013). Chronic Disease Self-Management

Programs may be of particular importance to individuals at this age because around this age, many older adults experience the effects of chronic conditions (CDC, 2013).

To address issues of credibility and dependability in obtaining findings, I informed each participant of any known risks related with their participation in the study, as well as their voluntary status and option to withdraw from the study at any time. Each participant signed an informed consent agreement for their involvement in the study. During the interviewing process, I encouraged the participants to expound on responses needing further explanation. In this study, I used observational note taking to ensure dependability. I chronicled a list of insights and pronouncements that decreased the opportunity for researcher bias and maintained neutrality.

Implications

The findings from this study may have both theoretical and practical implications. Since little information exists on this underrepresented population, the information from the study will supplement the body of knowledge that exists on CDSMPs. The findings of this study suggest that peer or program lay leaders reap health benefits from leading self-management programs. Because leaders must learn, teach, and model program tools and strategies, leaders believed they benefited more than participants did. In addition, the influence of lay or peer program leaders' and program participants' health behaviors on one another was reciprocal and mutually beneficial. Leaders provided participants with tools and strategies for effective self-management, and observing participants' lives

improve benefitted leaders emotionally and filled them with a sense of accomplishment. The implication of these findings is that lay leadership includes bidirectional benefits that are both altruistic and self-interested. Findings from this study may change how administrators conceptualize and approach leadership of CDSMPs, including leadership for programs, such as The Flinders Chronic Condition Management Program, that have not used lay leaders. In addition, how lay leaders are able to connect with program participants may hold clues for how health care professionals and trained leaders may to do the same.

The practical implications for this study are valuable as well. The information yielded from this study can enable the creators of the CDSMP to further evaluate and analyze strategies for recruitment and retention of additional leaders. This implication may help fuel recruitment approaches for lay leaders by emphasizing the positive health benefits to lay leaders of CDSMPs. Recruitment of lay leaders may also occur by contacting past participants of self-management programs. The use of lay leaders can also support cost-saving measures to decrease the national health care debt. For example, the use of lay leaders who would like to contribute back to society by teaching their peers and also reap the health benefits of program leadership would decrease medical costs of individual treatment for leaders themselves. Lay leaders also cost less to employ than professional leaders. In addition, using volunteer leaders, a type of lay leader, can enable programs to run without the additional costs of paid leadership. The results of the study also showed that lay leaders can forge important bonds with participants, and such

connections can strengthen programs and promote interest in programs among older adults. In turn, administrators can use the benefits to leaders as motivation to help recruit other qualified lay leaders to sustain self-management programs.

Recommendations for Future Research

The unique perspectives of lay leaders provided novel information regarding the benefits to lay leaders of CDSMPs and their abilities to connect with program participants, which points to directions for further research. Research on the perceptions of CDSMPs by program leaders is limited, and future avenues for research include exploration of the mutually reciprocal nature and the bidirectional flow of health benefits between program participants and lay leaders. Research in this area might involve how these mutually reciprocal benefits influence recruitment of lay leaders for CDSMPs, including studies on leader demographics, such as age and gender, which may affect CDSMP involvement. Other avenues for future research include whether a leader's style of teaching or leading is connected to the health benefits received from teaching CDSMPs. Finally, future researchers might examine how altruistic and self-interested motivations for leading health programs may not be mutually exclusive and may actually reinforce one another.

Positive Social Change

Research on the leaders of CDSMPs and their views, opinions, and thoughts can lead to positive social change by adding effective strategies for self-management programs and information pertaining to the role of these leaders in creating effective self-management programs to the public health literature. Findings of this study can help

researchers in public health understand how these leaders perceive self-management programs and provide unique insight regarding how to sustain and improve CDSMPs. Information collected from this study may lead to positive social change because sustaining and improving CDSMPs can help to improve the health not only of program participants suffering from chronic conditions but also the health of program leaders. In addition, improving the health of program participants and leaders may help to reduce overall medical costs. Information from this study might also add to a better understanding of peer-led educational components of CDSMPs, thereby facilitating more effective leadership strategies. In addition, in providing information on the health benefits to lay leaders the study may aid in the recruitment of CDSMP lay leaders.

Conclusion

Ample research exists pertaining to the effects of CDSMPs on participants. However, few studies investigate the effects of CDSMPs on leaders. As the popularity of CDSMPs increases, programs are coming to rely more and more on community lay leaders to supplement professional leadership. Consequently, recruitment and retention of lay leaders is becoming increasingly important. The CDSMP leader is often the driving force of a program and can largely influence a program's effectiveness. The findings of this study that CDSMPs can be mutually beneficial to both participants and lay leaders are novel and suggest ways to facilitate and retain qualified lay leaders. Finally, in improving the health of program participants and program leaders, CDSMPs may help to reduce

individual and overall medical expenses, thereby benefitting not only individuals, but also the social system as a whole.

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Appendix: CDSMP Facilitator Impressions Interview

Demographic Questions

1. Are you male or female?
2. How old are you?
3. What is your ethnicity?
4. What is your occupation?
5. What chronic condition have you been diagnosed with?
6. What is your role in the CDSMP?
7. Have you taken a refresher course in the CDSMP?
8. Were, or are, you a volunteer with no pay in the CDSMP?
9. Were, or are, you a paid leader in the CDSMP?
10. Have you taken a refresher course in the CDSMP?
11. How long has it been since you were initially trained to fulfill this role in the CDSMP?
12. After your initial training in the CDSMP, how long was it before you taught your first session? (If there is a gap for more than a month, ask why there was an extended gap?)

Open-ended Questions

1. What is your perception of your readiness, right after you were trained, to go out and lead a CDSMP 6-week session?
2. After your initial training in the CDSMP, did you go on to teach your first session? If not, why not?
3. After you taught your first session, did you go on to complete all six sessions?
4. If you didn't teach all six sessions, on what session did you stop?
5. How did you get involved in the CDSMP?
6. Have you led a CDSMP course in the last 6 months? Last year? Last 2 years?
7. Please describe your thoughts on leading the CDSMP.
8. From your experiences, do you think the CDSMP has improved your health?
9. In your opinion, how has leading the CDSMP enhanced your quality of life?
10. From your point of view, can you describe how the CDSMP has changed your health habits?
11. From your viewpoint, what are the barriers to disease self-management that are not addressed by the CDSMP program?