Purpose:

Community-Based Chronic Disease Management (CCDM) is designed to increase access to primary and preventive health services by bringing services to vulnerable people in locations they are already frequenting, such as food pantries. Taking a “no-missed opportunity” approach to reaching people who are outside the reach of traditional systems of health care, CCDM demonstrates the benefits of eliminating poverty-related barriers to health services.

Addressing local needs of the targeted population in ways that are culturally sensitive and inclusive:

The most significant progress is the opening of the Holy Cathedral Wellness Site earlier than scheduled. The grand opening event received media coverage and resulted in a solid start to service. Both current clinic sites are providing chronic disease management for patients with hypertension, diabetes and high cholesterol. Participants are taught to improve health through diet improvement and smoking cessation. In addition, generic prescribed medications are dispensed at no cost to the participants.

Reaching a large number of individuals and families with messages that are useful to them:

The Community Health Worker (CHW) experience has also been notable. A CHW was hired to work with the target population to screen and provide education to an additional 1,000 central-city African-Americans yearly. The CHW has been successful in helping to develop the church health liaison volunteers within each of 42 participating Church of God in Christ (COGIC) churches, resulting in achieving the annual screening goals within this first six month period. The CHW is continuing to recruit new church health liaisons and solidify relationships with existing liaisons to build a strong social infrastructure. In the first six months, 2,100 people have been screened and health liaisons have been identified for 30 COGIC church sites. Project partners have gained new community collaborators with Progressive Health Center, Free and Community Clinic Collaborative, and CapCorp Volunteers.

Informed by research, evaluation and systematic data collection:

Project partners have established an inclusive and flexible model for problem-solving and decision-making to guide project planning and implementation. Partners have reported enrolled patients are responding positively to treatment. Data indicates an average 19 point systolic drop, 11 point diastolic drop, and an average drop of 1.2 points for HgbA1C among treated patients.

Goal:

CCDM will effect prevention of complications by screening for/managing hypertension, diabetes and obesity at churches and food pantries that serve Milwaukee’s poor and by promoting low-cost medicine, nutrition and education in a tiered community model.

Award:

$750,000 over five years

Project Dates:

2/1/2011 to 1/31/2016

Project partners:

- Columbia St. Mary’s
- Medical College of Wisconsin – Department of Family and Community Medicine