# Patient Self-Management Collaborative

**A unique opportunity to connect patients with chronic illnesses to self-management resources.**

## Overview

The Patient Self-Management Collaborative (PSMC) is a unique opportunity to improve care and outcomes for patients with chronic health conditions.

The PSMC is co-sponsored by the Oregon Primary Care Association and the Health Promotion and Chronic Disease Prevention section of the Oregon Public Health Division. We invite your health center, and one or more of your community partners, to join our collaborative. You'll learn to build systems connecting patients to community-based chronic disease self-management and cessation resources so they can better manage their health between clinic visits.

## Goal and Expected Outcomes

- Overall goal of the PSMC:
  - Increase referrals of appropriate patients with chronic disease to community-based self-management resources, including Living Well with Chronic Conditions, Tomando Control de su Salud, the Oregon Tobacco Quit Line and the Arthritis Foundation exercise programs.
- Expected outcomes:
  - Primary care teams collaborate with community partners to help patients build their skills and confidence in better managing their health or chronic conditions.
  - Patients demonstrate better health outcomes and become: More confident in their ability to handle their own medical condition(s); more skilled in goal-setting, problem-solving and communications; more engaged in their own health care; and better informed about their role in managing their health.

More than one million Oregon adults live with asthma, diabetes or other chronic health conditions. Tobacco use and obesity are the leading causes of disease, disability, and premature death and the leading drivers of health care costs. In 2009, smoking in Oregon cost the health care system nearly $1.3 billion.

### Elements

- Collaborative learning community
- Monthly distance learning sessions
- Coaching with expert consultants
- Data reporting, making use of commonly collected measures

### Timeline

- Cohort 2 kick-off planned for October 2011
- Planned multi-year initiative
- Monthly training webinars

### Topics of Focus

- Develop sustainable systems for connecting patients to community resources
- The "5As" approach to cessation counseling
- Motivational interviewing
- Management of asthma, diabetes and other chronic diseases

For more information:

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