Patient Self-Management Collaborative

A key step on the journey toward the patient-centered medical home

Overview and Goal

The Patient Self-Management Collaborative (PSMC) is a unique opportunity for community health centers to improve outcomes for patients with chronic health conditions **and** move toward key elements of the patient-centered medical home (PCMH) model.

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.

The goal of the PSMC is to increase referrals of appropriate patients with chronic diseases to community-based self-management resources. These community programs include Living Well with Chronic Conditions, Tomando Control de su Salud, the Oregon Tobacco Quit Line and the Arthritis Foundation exercise programs.

"Medical care must assure that persons with chronic illnesses have the confidence and skill to manage their conditions, a mutually understood care plan, and careful, continuous follow-up. Well-designed interactions between practice team and patient will be needed to complete the important clinical and behavioral work of modern chronic illness care."

—Ed Wagner, MD
Director, MacColl Institute

The Medical Home Connection

The aims, goals and objectives of the collaborative fit perfectly into the PCMH model of care. This model focuses on care that is comprehensive, integrated and coordinated. The PSMC supports many of the model's fundamental characteristics—patient-centeredness, team-based practices, coordinated care, chronic disease management, functional linkages, measurement of health outcomes and ongoing quality improvement.

Participation in the collaborative can start a health center on its journey toward the primary care home. For health centers already working toward primary care transformation through the medical home model, the PSMC can add depth and capacity to the work they are doing.

Elements of the PSMC

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

Timeline

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

Topics of Focus

- Quality improvement
- Developing sustainable systems for connecting patients to community resources
- The "5As" approach to tobacco cessation
- Motivational interviewing
- Management of asthma, diabetes and other chronic diseases
- The connection between self-management and the PCMH model

For more information:

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