

# OREGON CHRONIC DISEASE SELF-MANAGEMENT EDUCATION



## Goals, Strategies, and Activities

The overall purpose of this cooperative agreement is to increase access to evidence-based chronic disease self-management programs for older adults and adults with disabilities. The Oregon Health Authority, Public Health Division, Health Promotion and Chronic Disease Prevention Section proposes to serve 4,098 individuals with the Chronic Disease Self-Management Program and Tomando Control de su Salud. HPCDP and the State Unit on Aging, the co-lead agency, will work together to coordinate all state-level activities to:

- Maintain a partnership between the SUA and HPCDP to support project goals;
- Engage key health system/health plan partners to embed programs into program referral systems and covered benefits;
- Implement the Oregon Living Well Business Plan to create centralized, statewide program support and financing infrastructure; and
- Monitor progress toward project goals, program quality benchmarks, and outcomes.

## Partnerships

Effective partnerships to embed CDSME programs into statewide health and long-term services and supports systems to reach older adults and adults with disabilities who have chronic conditions include: Area Agencies on Aging/ADRCs, local health departments, Oregon Division of Medical Assistance Programs (Medicaid), Oregon Office on Disability and Health, Public Employees Benefit Board, Oregon Educators Benefit Board, Medicare Advantage plans, Coordinated Care Organizations (CCO), Patient-Centered Primary Care Homes (PCPCH), and

## Acronyms

ADRC – Aging and Disability Resource Center  
CCO – Coordinated Care Organization  
CDSME – Chronic Disease Self-Management Education  
CDSMP – Chronic Disease Self-Management Program  
HPCDP – Health Authority/Health Promotion and Chronic Disease Prevention Section  
PCPCH – Patient-Centered Primary Care Home

## Contact

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health systems.

Oregon will ensure 26 counties will regularly offer workshops, utilizing nearly 200 host organizations and implementation sites throughout the state.

### **Key Components**

*Programs to be offered are:* CDSMP and Tomando Control de su Salud. Other Stanford self-management programs offered by partner organizations in Oregon include Diabetes Self-Management Program, Chronic Pain Self-Management Program, Positive Self-Management Program for HIV, and Better Choices, Better Health (online CDSMP).

*Targeted audiences are:* older adults, adults age 18+ with disabilities, tribal populations, and residents of rural areas.

*Integration with ADRCs includes:* a statewide ADRC website, a statewide ADRC toll-free number, and newly created ADRC standards will provide systematic referrals to evidence-based health promotion programs.

*State level coordinators will:* ensure quality, track outcomes, monitor progress, and identify lessons learned utilizing the state's performance monitoring blueprint.

*Plans for sustainability include:* implementing the Oregon Living Well Business Plan to establish a public/private partnership to coordinate and systematize self-management program delivery and financing statewide, working with strategic partners that are potential large-scale purchasers of program delivery services for populations of older adults and adults with disabilities who have chronic conditions, and establishing large-scale referral and payment agreements such as embedding referral systems into CCOs and PCPCHs and securing incentive payments for self-management support. HPCDP will work with medical homes to establish referral protocols through community health centers.

### **Anticipated Results**

- Reaching 4,098 completers over the course of three years
- Expanding the reach of the program to 10 additional counties

Competitive funds to match Older Americans Act III D funding will support CDSME programs, improve referral systems from Information and Assistance, Options Counseling, and Care Transitions efforts, and develop closer working relationships with Centers for Independent Living in support of CDSMEs to support training and implementation of at least two workshops per year in these underserved areas. HPCDP and SUA will collaborate with



agencies being supported through the Affordable Care Act to conduct care transitions, health homes, and other innovative programs.

**For more information about ACL**

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