Collaborative Care: Cycle of Self-Management Support **Gather Patient Experiences Gather Clinical Data** symptom monitoring • medication taking • stressors • labs • screenings • specialist reports **Improved Outcomes** Before the Visit Increased Healthy Behaviors Improved Clinical Outcomes Increased Collaboration between Patient and Provider Improved Physician Satisfaction and Retention **CARE PLAN During the Visit** Follow Up **Front Office** After the Visit **Specialist Referrals** Provider Exam review clinical and patient experience information **Community Linkages** Nurse/MA Coaching & Support **Peer Programs**

The challenge to delivering optimal care for chronic conditions lies partly in the need to sustain vigilant monitoring of health indicators to optimize treatment, and also the need to develop collaborative relationships with patients and families that support them in the day-to-day management of their conditions. These activities can be viewed as a cycle of care and support that has as its center the maintenance of a shared care plan.

"The purpose of self management support is to aid and inspire patients to become informed about their conditions and take an active role in their treatment." —Bodenheimer 2005

A continuous healing relationship outlined in the Institute of Medicine Crossing the Quality Chasm report extends care beyond the office visit to the home and community, and beyond the primary care physician to the multidisciplinary care team—a team that now includes patients and their families and caregivers. This cycle of self-management support details the preparatory, relational, and follow-up activities that sustain this relationship and provide patients with the information, skills, and confidence needed to lead fuller lives. The cycle also helps care teams feel the joy in practice.