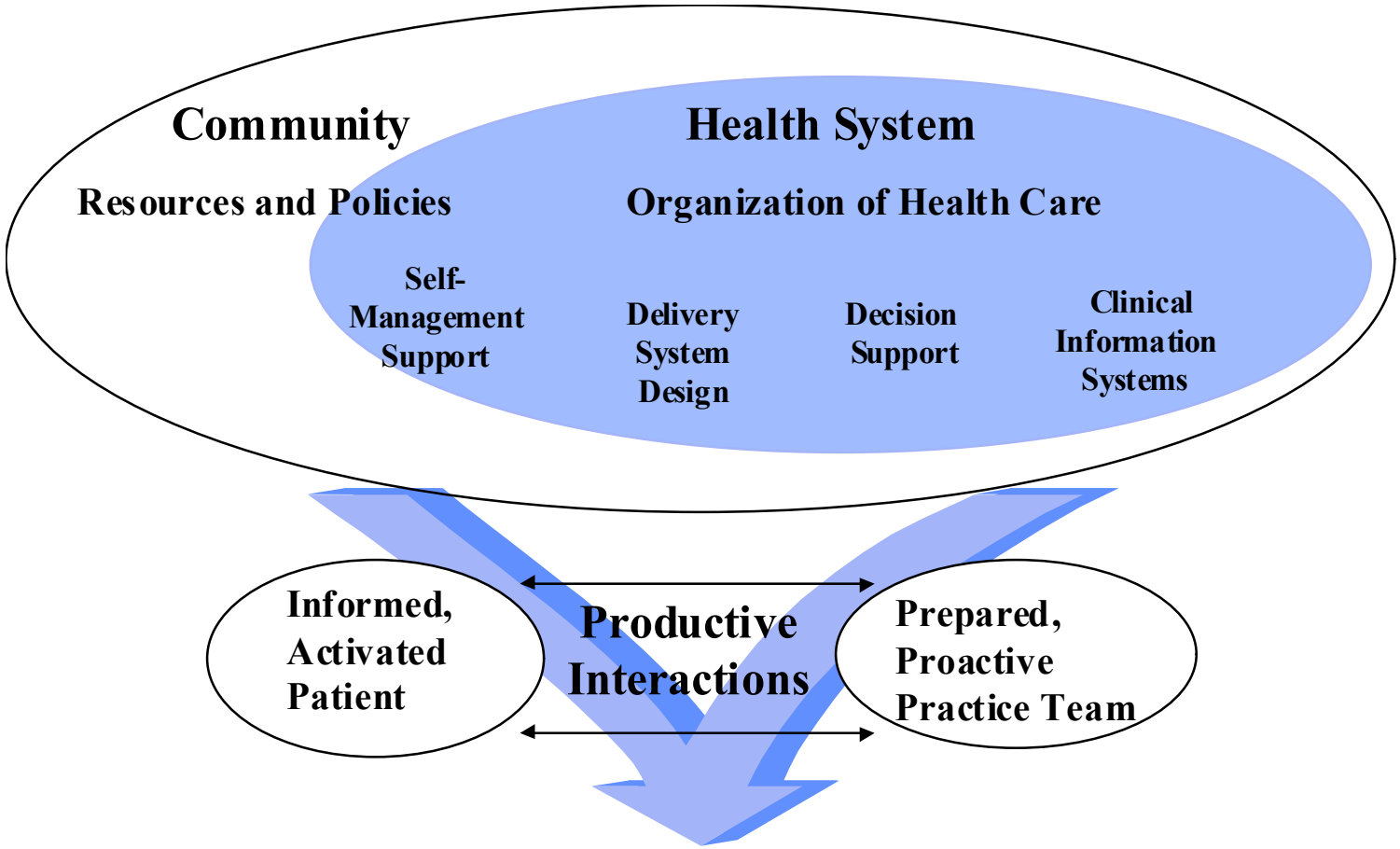
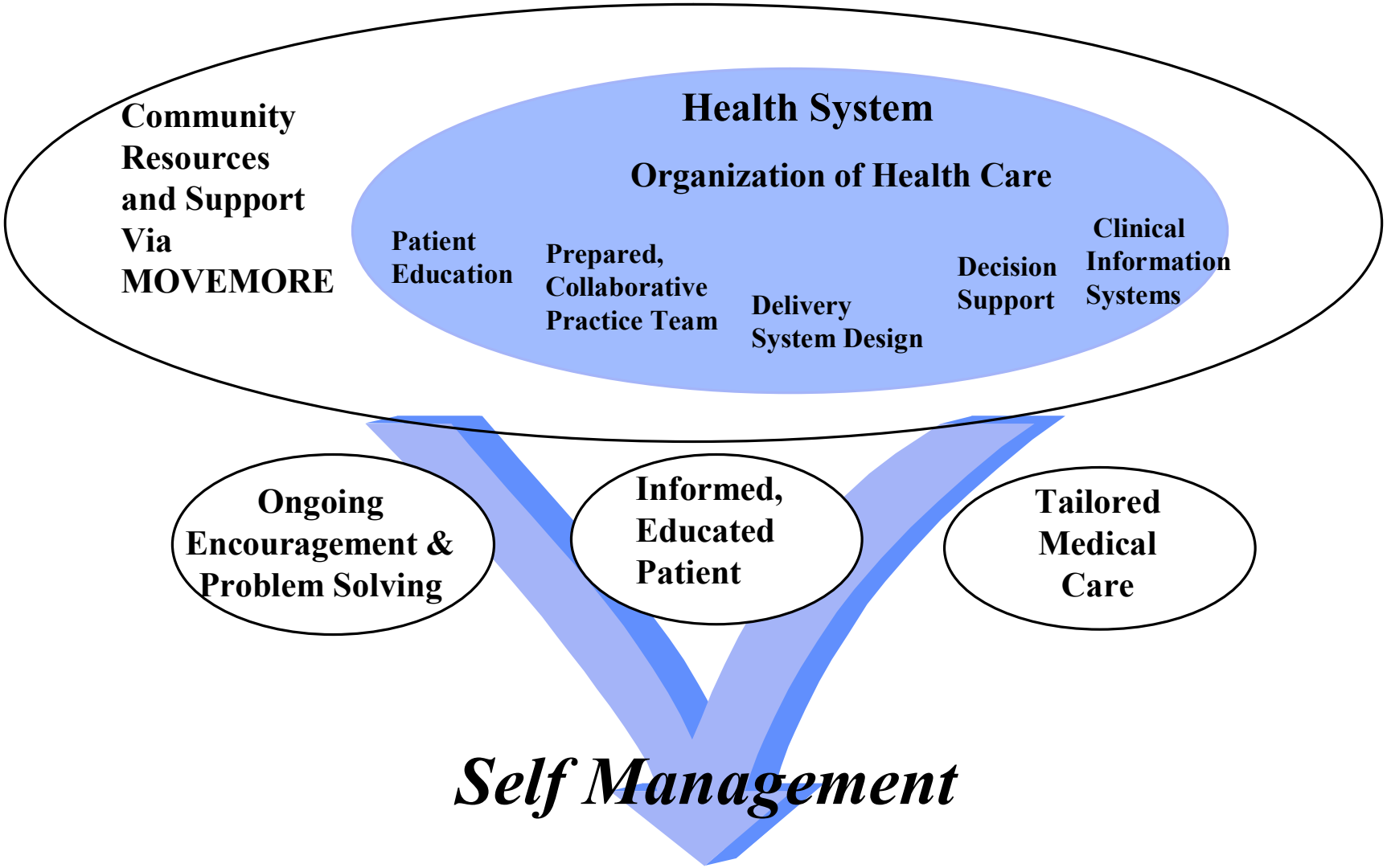
This product was developed by the Move More program at MaineGeneral Health in Waterville, ME. Support for this product was provided by a grant from the Robert Wood Johnson Foundation® in Princeton, New Jersey.

Wagner's *Chronic Care Model*



www.improvingchroniccare.org

Chronic Disease Self Management Model



Ongoing Dialogue

- What does our health system need to support ongoing improvement in chronic disease care
- Who can help us???????
- What can the community do that can be sustained over time to prevent chronic disease and chronic disease complications
- How can we work together????

Community Based Move More

- Trails/ Paths/ Indoor space (Capacity)
- Nutrition Resources
- PreDiabetes and CVD Resources
- Gym Memberships (low cost/ not cost)
- Policy/ Advocacy
- Non Directive Peer Support linking patients to community resources to prevent DM / reduce risk and improve DSM
- Website resources (nutrition, physical activity and chronic disease)
- Print Resources/ standardized distribution system
- CDSM Program

Health System/ DCI

- Changes in Primary Care Practice
  Disease Registry/ EMR
  LHE/ Mover embedded within or linked to
  community setting

  Your Health/ Your Choice/ Incentives
  (health risk assessments with health ed/ nurse goal setting)

  Community Case Managers

The Hospital

- Monitoring of chronic disease admissions
- Implementation of standards and protocols
- Automatic screen for CD and referral to chronic disease resources
- Training of Nursing staff re community resources
- Distribution of standardized education materials/ “with emphasis on Self Management after discharge