

Update Form

How Are You Using the Assessment of Chronic Illness Care?

We maintain a database that includes information about the types of projects in which the Assessment of Chronic Illness Care is being used. This helps us keep in touch with collaborators who have a specific interest in evaluating quality improvement or change processes in chronic illness care.

If you are currently using, or plan to use, the Assessment of Chronic Illness Care, we would appreciate you taking a few minutes to provide the following information. **Please fax to 206.287.2138.**

Name:	Organization:		
Title:	Address:		
Telephone:			
Facsimile:			
E-mail:			
Please describe the type of organization with which you are primarily affiliated:			
<table style="width: 100%; border: none;"> <tr> <td style="width: 50%; vertical-align: top;"> <input type="checkbox"/> Academic Medical Facility <input type="checkbox"/> University Hospital <input type="checkbox"/> Private Practice <input type="checkbox"/> Provider Network <input type="checkbox"/> Foundation/Non-Profit <input type="checkbox"/> University/College <input type="checkbox"/> Rehabilitation Facility </td> <td style="width: 50%; vertical-align: top;"> <input type="checkbox"/> Managed Care Facility <input type="checkbox"/> Health Care System <input type="checkbox"/> Staff-model HMO <input type="checkbox"/> Professional/Trade Organization <input type="checkbox"/> Government Agency <input type="checkbox"/> Group Practice <input type="checkbox"/> Long Term/Home Care </td> </tr> </table>		<input type="checkbox"/> Academic Medical Facility <input type="checkbox"/> University Hospital <input type="checkbox"/> Private Practice <input type="checkbox"/> Provider Network <input type="checkbox"/> Foundation/Non-Profit <input type="checkbox"/> University/College <input type="checkbox"/> Rehabilitation Facility	<input type="checkbox"/> Managed Care Facility <input type="checkbox"/> Health Care System <input type="checkbox"/> Staff-model HMO <input type="checkbox"/> Professional/Trade Organization <input type="checkbox"/> Government Agency <input type="checkbox"/> Group Practice <input type="checkbox"/> Long Term/Home Care
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Please check the box that most closely describes the objectives of your project:	Please describe the design of your study if you are conducting research (check all that apply):		
<input type="checkbox"/> Identify areas to improve care for chronically ill patients <input type="checkbox"/> Evaluate how organizations are performing with respect to care delivery <input type="checkbox"/> Evaluate the effectiveness of a quality improvement intervention <input type="checkbox"/> To identify cost-effective methods to improve functional & clinical outcomes in a given population	<input type="checkbox"/> Cross-sectional <input type="checkbox"/> Longitudinal <input type="checkbox"/> Cohort <input type="checkbox"/> Case control <input type="checkbox"/> Population-based <input type="checkbox"/> Randomized, control group <input type="checkbox"/> Randomized, no control group <input type="checkbox"/> Non-randomized, control group <input type="checkbox"/> Intervention <input type="checkbox"/> Retrospective <input type="checkbox"/> Observational		

<p>Is there a specific condition(s) that is of interest in your project (check all that apply):</p> <ul style="list-style-type: none"> <input type="checkbox"/> Arthritis <input type="checkbox"/> Asthma <input type="checkbox"/> Back pain <input type="checkbox"/> Cancer <input type="checkbox"/> Chronic fatigue syndrome <input type="checkbox"/> Congestive heart failure <input type="checkbox"/> Depression <input type="checkbox"/> Diabetes <input type="checkbox"/> End of life care <input type="checkbox"/> Frailty in the elderly <input type="checkbox"/> Gastrointestinal reflux disease <input type="checkbox"/> Heart disease <input type="checkbox"/> Hypertension <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Renal failure <input type="checkbox"/> Schizophrenia <input type="checkbox"/> Sickle cell disease <input type="checkbox"/> Other: _____ 	<p>Please describe the respondents in your study (check all that apply):</p> <ul style="list-style-type: none"> <input type="checkbox"/> Physicians <input type="checkbox"/> Nurses <input type="checkbox"/> Medical support staff <input type="checkbox"/> Social support staff <input type="checkbox"/> Quality management directors <input type="checkbox"/> Utilization review team members <input type="checkbox"/> Medical director <input type="checkbox"/> Chief Executive Officer <input type="checkbox"/> Vice President, Medical Affairs <input type="checkbox"/> Chief Financial Officer <input type="checkbox"/> Chief Operating Officer <input type="checkbox"/> Clinic directors <input type="checkbox"/> Other: _____
<p>Please describe the specific intervention to be used in your study (if applicable).....</p>	
<p>Please indicate the primary data collection method to be used:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Self-administered self-report <input type="checkbox"/> Interview-administered (in person) <input type="checkbox"/> Telephone interview administration <input type="checkbox"/> Computer-assisted self-report <input type="checkbox"/> Other 	<p>Did you modify the survey for your study:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Yes <input type="checkbox"/> No <p>If yes, please describe the modifications:</p>
<p>What is your project timeline?</p> <p>From _____/_____/_____</p> <p style="margin-left: 40px;">Month Day Year</p>	<p>Please indicate the source of funding (if any) for your study (check all that apply):</p> <ul style="list-style-type: none"> <input type="checkbox"/> Government <input type="checkbox"/> Foundation <input type="checkbox"/> In kind contribution

To _____/_____/_____
Month Day Year

- Pharmaceutical
- Biotech
- Other: _____

Assessment of Chronic Illness Care

Version 3.5

Please complete the following information about you and your organization. This information will not be disclosed to anyone besides the ICIC/IHI team. We would like to get your phone number and e-mail address in the event that we need to contact you/your team in the future. Please also indicate the names of persons (e.g., team members) who complete the survey with you. Later on in the survey, you will be asked to describe the process by which you complete the survey.

Your name:

Date:

_____/_____/_____
Month Day Year

Organization & Address:

Names of other persons completing the survey with you:

1.

2.

3.

Your phone number: (_____) _____ - _____

Your e-mail address:

Directions for Completing the Survey

This survey is designed to help systems and provider practices move toward the “state-of-the-art” in managing chronic illness. The results can be used to help your team identify areas for improvement. Instructions are as follows:

1. **Answer each question** from the perspective of one physical site (e.g., a practice, clinic, hospital, health plan) that supports care for chronic illness.

Please provide name and type of site (e.g., Group Health Cooperative/Plan) _____

2. **Answer each question** regarding how your organization is doing with respect to one disease or condition.

Please specify condition _____

3. For each row, **circle the point value** that best describes the level of care that currently exists in the site and condition you chose. The rows in this form present key aspects of chronic illness care. Each aspect is divided into levels showing various stages in improving chronic illness care. The stages are represented by points that range from 0 to 11. The higher point values indicate that the actions described in that box are more fully implemented.

4. **Sum the points in each section** (e.g., total part 1 score), calculate the average score (e.g., total part 1 score / # of questions), and enter these scores in the space provided at the end of each section. Then sum all of the section scores and complete the average score for the program as a whole by dividing this by 6.

For more information about how to complete the survey, please contact:

Judith Schaefer, MPH

Improving Chronic Illness Care

A National Program of the Robert Wood Johnson Foundation

Group Health Cooperative of Puget Sound

1730 Minor Avenue, Suite 1290

Seattle, WA 98101-1448

tel. 206.287.2207; Schaefer.jk@ghc.org

Assessment of Chronic Illness Care, Version 3.5

Part 1: Organization of the Healthcare Delivery System. Chronic illness management programs can be more effective if the overall system (organization) in which care is provided is oriented and led in a manner that allows for a focus on chronic illness care.

Components	Level D	Level C	Level B	Level A
Overall Organizational Leadership in Chronic Illness Care	...does not exist or there is a little interest.	...is reflected in vision statements and business plans, but no resources are specifically earmarked to execute the work.	...is reflected by senior leadership and specific dedicated resources (dollars and personnel).	...is part of the system's long term planning strategy, receive necessary resources, and specific people are held accountable.
Score	0 1 2	3 4 5	6 7 8	9 10 11
Organizational Goals for Chronic Care	...do not exist or are limited to one condition.	...exist but are not actively reviewed.	...are measurable and reviewed.	...are measurable, reviewed routinely, and are incorporated into plans for improvement.
Score	0 1 2	3 4 5	6 7 8	9 10 11
Improvement Strategy for Chronic Illness Care	...is ad hoc and not organized or supported consistently.	...utilizes ad hoc approaches for targeted problems as they emerge.	...utilizes a proven improvement strategy for targeted problems.	...includes a proven improvement strategy and uses it proactively in meeting organizational goals.
Score	0 1 2	3 4 5	6 7 8	9 10 11
Incentives and Regulations for Chronic Illness Care	...are not used to influence clinical performance goals.	...are used to influence utilization and costs of chronic illness care.	...are used to support patient care goals.	...are used to motivate and empower providers to support patient care goals.
Score	0 1 2	3 4 5	6 7 8	9 10 11
Senior Leaders	...discourage enrollment of the chronically ill.	...do not make improvements to chronic illness care a priority.	...encourage improvement efforts in chronic care.	...visibly participate in improvement efforts in chronic care.
Score	0 1 2	3 4 5	6 7 8	9 10 11
Benefits	...discourage patient self-management or system changes.	...neither encourage nor discourage patient self-management or system changes.	...encourage patient self-management or system changes.	...are specifically designed to promote better chronic illness care.
Score	0 1 2	3 4 5	6 7 8	9 10 11

Total Health Care Organization Score _____ Average Score (Health Care Org. Score / 6) _____

Part 2: Community Linkages. Linkages between the health delivery system (or provider practice) and community resources play important roles in the management of chronic illness.

Components	Level D	Level C	Level B	Level A
Linking Patients to Outside Resources	...is not done systematically.	...is limited to a list of identified community resources in an accessible format.	...is accomplished through a designated staff person or resource responsible for ensuring providers and patients make maximum use of community resources.	... is accomplished through active coordination between the health system, community service agencies and patients.
Score	0 1 2	3 4 5	6 7 8	9 10 11
Partnerships with Community Organizations	...do not exist.	...are being considered but have not yet been implemented.	...are formed to develop supportive programs and policies.	...are actively sought to develop formal supportive programs and policies across the entire system.
Score	0 1 2	3 4 5	6 7 8	9 10 11
Regional Health Plans	...do not coordinate chronic illness guidelines, measures or care resources at the practice level.	...would consider some degree of coordination of guidelines, measures or care resources at the practice level but have not yet implemented changes.	...currently coordinate guidelines, measures or care resources in one or two chronic illness areas.	...currently coordinate chronic illness guidelines, measures and resources at the practice level for most chronic illnesses.
Score	0 1 2	3 4 5	6 7 8	9 10 11

Total Community Linkages Score _____ Average Score (Community Linkages Score / 3) _____

Part 3c: Delivery System Design. Evidence suggests that effective chronic illness management involves more than simply adding additional interventions to a current system focused on acute care. It may necessitate changes to the organization of practice that impact provision of care.

Components	Level D	Level C	Level B	Level A
Practice Team Functioning	...is not addressed.	...is addressed by assuring the availability of individuals with appropriate training in key elements of chronic illness care.	...is assured by regular team meetings to address guidelines, roles and accountability, and problems in chronic illness care.	...is assured by teams who meet regularly and have clearly defined roles including patient self-management education, proactive follow-up, and resource coordination and other skills in chronic illness care.
Score	0 1 2	3 4 5	6 7 8	9 10 11
Practice Team Leadership	...is not recognized locally or by the system.	...is assumed by the organization to reside in specific organizational roles.	...is assured by the appointment of a team leader but the role in chronic illness is not defined.	...is guaranteed by the appointment of a team leader who assures that roles and responsibilities for chronic illness care are clearly defined.
Score	0 1 2	3 4 5	6 7 8	9 10 11
Appointment System	...can be used to schedule acute care visits, follow-up and preventive visits.	...assures scheduled follow-up with chronically ill patients.	...are flexible and can accommodate innovations such as customized visit length or group visits.	...includes organization of care that facilitates the patient seeing multiple providers in a single visit.
Score	0 1 2	3 4 5	6 7 8	9 10 11
Follow-up	...is scheduled by patients or providers in an ad hoc fashion.	...is scheduled by the practice in accordance with guidelines.	...is assured by the practice team by monitoring patient utilization.	...is customized to patient needs, varies in intensity and methodology (phone, in person, email) and assures guideline follow-up.
Score	0 1 2	3 4 5	6 7 8	9 10 11
Planned Visits for Chronic Illness Care	...are not used.	...are occasionally used for complicated patients.	...are an option for interested patients.	...are used for all patients and include regular assessments, preventive interventions and attention to self-management support.
Score	0 1 2	3 4 5	6 7 8	9 10 11
Continuity of Care	...is not a priority.	...depends on written	...between primary care providers	...is a high priority and all chronic

Components	Level D	Level C	Level B	Level A
		communication between primary care providers and specialists, case managers or disease management companies.	and specialists and other relevant providers is a priority but not implemented systematically.	disease interventions include active coordination between primary care, specialists and other relevant groups.
Score	0 1 2	3 4 5	6 7 8	9 10 11

(From Previous Page)

Total Delivery System Design Score _____ Average Score (Delivery System Design Score / 6) _____

Part 3d: Clinical Information Systems. Timely, useful information about individual patients and populations of patients with chronic conditions is a critical feature of effective programs, especially those that employ population-based approaches.^{7, 8}

Components	Level D	Level C	Level B	Level A
Registry (list of patients with specific conditions)	...is not available.	...includes name, diagnosis, contact information and date of last contact either on paper or in a computer database.	...allows queries to sort sub-populations by clinical priorities.	...is tied to guidelines which provide prompts and reminders about needed services.
Score	0 1 2	3 4 5	6 7 8	9 10 11
Reminders to Providers	...are not available.	... include general notification of the existence of a chronic illness, but does not describe needed services at time of encounter.	...includes indications of needed service for populations of patients through periodic reporting.	...includes specific information for the team about guideline adherence at the time of individual patient encounters.
Score	0 1 2	3 4 5	6 7 8	9 10 11
Feedback	...is not available or is non-specific to the team.	...is provided at infrequent intervals and is delivered impersonally.	...occurs at frequent enough intervals to monitor performance and is specific to the team's population.	...is timely, specific to the team, routine and personally delivered by a respected opinion leader to improve team performance.
Score	0 1 2	3 4 5	6 7 8	9 10 11
Information about Relevant Subgroups of Patients Needing Services	...is not available.	...can only be obtained with special efforts or additional programming.	...can be obtained upon request but is not routinely available.	...is provided routinely to providers to help them deliver planned care.
Score	0 1 2	3 4 5	6 7 8	9 10 11
Patient Treatment Plans	...are not expected.	...are achieved through a standardized approach.	...are established collaboratively and include self management as well as clinical goals.	...are established collaborative and include self management as well as clinical management. Follow-up occurs and guides care at every

Components	Level D	Level C	Level B	Level A
Score	0 1 2 3 4 5 6 7 8 9 10 11			

Total Clinical Information System Score _____ Average Score (Clinical Information System Score / 5) _____

Integration of Chronic Care Model Components. Effective systems of care integrate and combine all elements of the Chronic Care Model; e.g., linking patients' self-management goals to information systems/registries.

Components	Little support	Basic support	Good support	Full support
Informing Patients about Guidelines	...is not done.	...happens on request or through system publications.	...is done through specific patient education materials for each guideline.	...includes specific materials developed for patients which describe their role in achieving guideline adherence.
Score	0 1 2	3 4 5	6 7 8	9 10 11
Information Systems/Registries	...do not include patient self-management goals.	...include results of patient assessments (e.g., functional status rating; readiness to engage in self-management activities), but no goals.	...include results of patient assessments, as well as self-management goals that are developed using input from the practice team/provider and patient.	...include results of patient assessments, as well as self-management goals that are developed using input from the practice team and patient; and prompt reminders to the patient and/or provider about follow-up and periodic re-evaluation of goals.
Score	0 1 2	3 4 5	6 7 8	9 10 11
Community Programs	...do not provide feedback to the health care system/clinic about patients' progress in their programs.	...provide sporadic feedback at joint meetings between the community and health care system about patients' progress in their programs.	...provide regular feedback to the health care system/clinic using formal mechanisms (e.g., Internet progress report) about patients' progress.	...provide regular feedback to the health care system about patients' progress that requires input from patients that is then used to modify programs to better meet the needs of patients.

Components	Little support	Basic support	Good support	Full support
Score	0 1 2	3 4 5	6 7 8	9 10 11
Organizational Planning for Chronic Illness Care	...does not involve a population-based approach.	...uses data from information systems to plan care.	...uses data from information systems to proactively plan population-based care, including the development of self-management programs and partnerships with community resources.	...uses systematic data and input from practice teams to proactively plan population-based care, including the development of self-management programs and community partnerships, that include a built-in evaluation plan to determine success over time.
Score	0 1 2	3 4 5	6 7 8	9 10 11
Routine follow-up for appointments, patient assessments and goal planning	...is not ensured.	is sporadically done, usually for appointments only.	is ensured by assigning responsibilities to specific staff (e.g., nurse case manager).	is ensured by assigning responsibilities to specific staff (e.g., nurse case manager) who uses the registry and other prompts to coordinate with patients and the entire practice team.
Score	0 1 2	3 4 5	6 7 8	9 10 11
Guidelines for chronic illness care	...are not shared with patients.	...are given to patients who express a specific interest in self-management of their condition.	...are provided for all patients to help them develop effective self-management programs, and identify when they should see a provider.	...are reviewed by the practice team with the patient to devise a self-management or behavior modification program consistent with the guidelines that takes into account patient's goals and readiness to change.
Score	0 1 2	3 4 5	6 7 8	9 10 11

Total Integration Score (SUM items): _____ ➤ **Average Score (Integration Score/6) = _____**

Briefly describe the process you used to fill out the form (e.g., reached consensus in a face-to-face meeting; filled out by the team leader in consultation with other team members as needed; each team member filled out a separate form and the responses were averaged).

Description: _____

Scoring Summary
(bring forward scoring at end of each section to this page)

Total Org. of Health Care System Score	_____
Total Community Linkages Score	_____
Total Self-Management Score	_____
Total Decision Support Score	_____
Total Delivery System Design Score	_____
Total Clinical Information System Score	_____
Total Integration Score	_____

Overall Total Program Score (Sum of all scores) _____

Average Program Score (Total Program /7) _____

What does it mean?

The ACIC is organized such that the highest “score” (an “11”) on any individual item, subscale, or the overall score (an average of the six ACIC subscale scores) indicates optimal support for chronic illness. The lowest possible score on any given item or subscale is a “0”, which corresponds to limited support for chronic illness care. The interpretation guidelines are as follows:

Between “0” and “2” = limited support for chronic illness care

Between “3” and “5” = basic support for chronic illness care

Between “6” and “8” = reasonably good support for chronic illness care

Between “9” and “11” = fully developed chronic illness care

It is fairly typical for teams to begin a collaborative with average scores below “5” on some (or all) areas the ACIC. After all, if everyone was providing optimal care for chronic illness, there would be no need for a chronic illness collaborative or other quality improvement programs. It is also common for teams to initially believe they are providing better care for chronic illness than they actually are. As you progress in the Collaborative, you will become more familiar with what an effective system of care involves. You may even notice your ACIC scores “declining” even though you have made improvements; this is most likely the result of your better understanding of what a good system of care looks like. Over time, as your understanding of good care increases and you continue to implement effective practice changes, you should see overall improvement on your ACIC scores.