Chronic Disease Management Collaborative

Request for Pilot Site Proposals

Application Deadline: May 15, 2006

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Part I: Application Instructions

A. Funding opportunity description

The Indian Health Service (IHS) announces a new funding opportunity under the IHS Chronic Disease Initiative. The purposes of the funding opportunity are to:

1. Support a group of selected applicants (from a pool of federal IHS sites) who will work together through a collaborative process to develop an innovative approach to chronic disease management in the Indian health system.
2. Demonstrate that changing or enhancing our systems for delivering care can improve patient outcomes across a variety of chronic diseases in a cost-effective manner.
3. Support innovative efforts and models throughout the Indian health system that address chronic disease, especially those that have already been shown to be effective in IHS, tribal, and urban Indian health settings.
4. Spread successes in the management of chronic diseases throughout the Indian health system.

Pilot sites will receive one year of funding to pay for travel to one in-person training meeting, as well as the supplies and equipment required to participate in Chronic Disease Collaborative web-based activities (see Part C). Pilot sites will also receive a small amount of additional funding to ensure dedicated time for a local pilot site coordinator who will provide day-to-day leadership. Subsequent to the first year, pilot sites will receive ongoing technical support through the Chronic Disease Collaborative as long as the IHS Chronic Disease Initiative continues and funding allows. Interested sites may apply through this application kit to participate in this new program.

B. Background

The IHS has established a long and successful history of addressing acute, infectious diseases. Today, a new epidemiologic challenge faces the Indian health system: chronic disease. The IHS recognizes that the future of American Indian and Alaska Native communities depends on how effectively we address chronic diseases like diabetes, cardiovascular disease, asthma, obesity, depression, and some cancers.

The IHS recently launched the Chronic Disease Initiative to develop a process to effectively and efficiently address chronic diseases. The initiative has developed a strategic plan using a model for chronic disease care created from the experience of the IHS Division of Diabetes Treatment and Prevention and the Institute of Healthcare Improvement, and from models like the Chronic Care Model (see below). The model outlined in the strategic plan suggests that **our approach to chronic diseases can be improved by creating a health care system that is practical, supportive, population-based, and evidence-based**.

What is the Chronic Care Model?

As described above, the Chronic Care Model provided the foundation for the IHS Chronic Disease Initiative's strategic plan. The MacColl Institute for Healthcare Innovation developed the Chronic Care Model by drawing upon the available literature on promising strategies for chronic disease management. The model identifies the essential elements of a health care system that effectively *manages patients and encourages high quality chronic disease care*.

These elements are:

- Community resources and policies
- Self-management support
- Decision support
- Organization of the health care system
- Delivery system design
- Clinical information systems

The Chronic Care Model can be applied to a variety of chronic diseases, health care settings, and target populations. It provides the Indian health system with a framework through which a proactive practice team can prepare and facilitate productive interactions with patients who are better informed and activated. These improved outcomes can only be achieved through a comprehensive approach to improving health in our communities and within our system.

C. Program Description

Pilot sites

The IHS will select pilot sites among a pool of federal (IHS) programs that submit applications (see eligibility criteria in Part E). The pilot sites will work collaboratively with one another and IHS staff to design, implement, and evaluate innovative chronic disease interventions.

Pilot site activities

During the first year of this project, the pilot sites will receive training in proven improvement techniques to begin making improvements at their local sites. These improvements will facilitate local implementation of the Chronic Care Model so that patients will receive high quality, customized, and reliable care. The pilot sites will also develop process and outcomes measures to demonstrate that interventions are worth pursuing in a broader fashion. The size of the ongoing Collaborative will be determined from this evaluation activity, and will be reflected in the subsequent years of the project as more pilot sites are brought into the Collaborative. Ultimately, the pilot sites will help disseminate the lessons learned from this program and provide technical assistance to other non-pilot site facilities throughout the Indian health system.

Chronic Disease Management Collaborative

The pilot sites and IHS will form a group called the *Chronic Disease Management Collaborative*. The Collaborative will meet in person one time a year and through virtual WebEx™-style meetings and teleconferencing. They will also communicate frequently through e-mail and a Chronic Disease Management Collaborative listserv to share their successes and failures. Through the Collaborative, pilot sites will obtain information technology support, ongoing training and development programs, and technical assistance from IHS partners, such as the Institute for Healthcare Improvement and the MacColl Institute for Healthcare Innovation.

Pilot sites will be required to attend an in-person Chronic Disease Management Collaborative Kick-off Meeting (date and location to be determined). Two individuals from each selected pilot site will attend this meeting, which will help pilot sites understand how collaboratives work and prepare them to become active members of the Chronic Disease Management Collaborative.

D. Anticipated benefits to be gained by pilot sites (or "What's in it for us?")

Many international and national health care organizations have accomplished significant improvements in patient care after making minimal investments by using proven techniques from the Institute for Healthcare Improvement, one of IHS's partners in the Chronic Disease Initiative. As such, it is anticipated that pilot sites should expect to gain several benefits as a result of their participation in the Chronic Disease Management Collaborative (in addition to first year funding for local costs). These include:

- Local access to web-based training by national experts.
- Support from Collaborative leaders and national consultants to enhance the quality of chronic care.
- Increased patient satisfaction with care.
- Improvement in Clinical Reporting System (CRS) outcomes data.
- Local WebEx™ capability for activities outside of pilot site activities.

E. Applicant eligibility requirements and expectations

At a minimum, applicants must:

1. Be a federal IHS program.
2. Guarantee the support of their organizational leadership to make the changes necessary throughout the organization to improve chronic disease care.
3. Demonstrate participation of the community through support of community partners.

4. Demonstrate commitment from their organizational leadership that staff time will be protected to participate in the Collaborative's activities, including program planning, travel to Collaborative meetings and trainings, and program implementation and evaluation.
5. Identify a local champion who will lead the chronic disease intervention and evaluation efforts. This person must be able to devote a significant portion of their time to the intervention and evaluation.
6. Have solid data infrastructure with the ability to collect, manage, and report the required data elements that will assess and describe the intervention's effectiveness in improving chronic disease care. Applicants must also use the Electronic Health Record (EHR) or be in the process of implementing the EHR.
7. Participate in a multi-site evaluation of the intervention led by the IHS.
8. Attend the in-person Collaborative meeting, participate in all of the web-based meetings during the year, participate in regular conference calls, and maintain frequent communication with the Collaborative.

Changing the way health care organizations deliver chronic disease care requires change throughout entire organizations. Many aspects of the way organizations deliver care—staff roles and responsibilities, patient access to care, and clinic flow, to name a few—may change.

Successful applications will **show that the organization's leadership strongly supports changing the way the organization delivers care**. Reviewers will look for evidence that the organization's leadership will champion the pilot project, providing it with the necessary additional resources, staff, and infrastructure to ensure its success. Providing evidence that organization leadership was involved in preparing the application will lend strength and credibility to applications.

Applicants that are not selected as pilot sites can still benefit from the IHS Chronic Disease Initiative. These applicants may attend Collaborative meetings and benefit from the discussions on program planning, evaluation, and technical assistance. The IHS Chronic Disease Initiative also plans to continuously update the Indian health system on the progress of the interventions by: (1) sharing materials that will be developed; (2) providing information through newsletters and listservs; (3) possibly starting a virtual collaborative to help all Indian health organizations communicate with one another and benefit from what the pilot sites learn; and (4) other methods.

F. Application instructions and review information

Letter of intent: Due May 1, 2006

If you intend to apply to be a pilot site, you must submit a letter of intent by **May 1, 2006**. Your letter of intent should simply and briefly state:

- Your name and title.
- The name and location of your organization.
- That your organization is a federal (IHS) site.
- That you plan to submit an application to be a pilot site.

Please mail your typed and signed letter of intent to:

Bonnie Bowekaty
Chronic Disease Initiative Program Assistant
Indian Health Service Division of Diabetes Treatment and Prevention
5300 Homestead Avenue NE
Albuquerque, New Mexico 87110

Application: Due May 15, 2006

The application includes four required elements, which you must submit to the IHS by **May 15, 2006**:

- **Letter of commitment**. The proposed pilot site coordinator and the organization's Chief Executive Officer must sign the letter of commitment. (You can find a sample letter of commitment on page 12.)
- **Applicant assessment and narrative**. Please submit the following:
  1. Completed applicant assessment checklist found on pages 8–11.
  2. A separate document (no more than six pages) with your responses to the narrative questions on pages 8–11.

  The assessment and narrative will help reviewers determine the applicant's level of infrastructure and capacity necessary to participate as a pilot site. In the narrative, applicants should also describe what makes them uniquely qualified to participate in this new program.
- **Letter of support from community partners**. We encourage applicants to discuss this project with the community at multiple levels and gather letters of support from as many different levels as possible. The letters may be from the local health board or other community partner organizations and should document existing community resources that will support the pilot site's efforts.
- **Letter from the information technology site manager** to ensure that the pilot site is either using EHR or in the process of implementing the EHR. (You can find a sample letter of support on page 13.)

G. Submission and contact information

You will need to submit a typed and signed letter of support, original application, and supporting documents in one package to:

Bonnie Bowekaty
Chronic Disease Initiative Program Assistant
Indian Health Service Division of Diabetes Treatment and Prevention
5300 Homestead Avenue NE
Albuquerque, New Mexico 87110
Phone: (505) 248-4182
e-mail: bonnie.bowekaty@ihs.hhs.gov

Questions can be directed to:

Pat Lundgren
Phone: (928) 338-4911 x3707
e-mail: pat.lundgren@ihs.gov

Charles Ty Reidhead, MD
Phone: (928) 338-4911
e-mail: charles.reidhead@ihs.gov

H. Important dates

- May 1, 2006: Deadline to submit a **mandatory** letter of intent to apply
- May 15, 2006: Deadline for application submission
- June 5, 2006: Notice of award
- Date to be announced: **Mandatory** Chronic Disease Management Collaborative Kick-off meeting
- July 25–28, 2006: Special Diabetes Program for Indians Regional Meeting in San Francisco, California. "Implementing Chronic Disease Care in Indian Health Settings" workshop. This workshop is *not* affiliated with the Collaborative, but may be helpful to people who want introductory information on the Chronic Care Model or collaboratives. Pilot sites are ***not*** required to attend this workshop.

I. Further information

For further information, please visit the following websites:

- http://www.ihs.gov/NonMedicalPrograms/DirInitiatives/index.cfm?module=fact_chronic
  Information on the IHS Director's Chronic Disease Initiative

- www.ihi.org
  Information on collaboratives

Part II: Chronic Disease Management Collaborative Pilot Site Application

A. Applicant assessment and narrative

Applicant assessment and narrative	
Describe your facility	
Service Unit: IHS Area: Service Population:	
Organization of health care delivery system	
1. Narrative: Describe your organization leadership's commitment to improving chronic disease care.	
2. Does your organization's strategic plan address chronic disease care? Narrative: Describe how your organization's strategic plan addresses chronic disease care.	❒ Yes ❒ No
3. Does your organization have a process in place to address improvement of clinical care? Narrative: Describe your clinical care improvement processes and your organization's approach to quality improvement. How have you improved clinic flow and organization?	❒ Yes ❒ No
4. Has your organization appointed a local champion who can dedicate at least 0.25 FTE to serve as the coordinator for the pilot program? Provide the name and contact information for this coordinator:	❒ Yes ❒ No
Clinical information systems	
5. Does your organization currently use the Resource and Patient Management System (RPMS)?	❒ Yes ❒ No
6. Does your organization meet "Electronic Health Record (EHR)-ready" criteria as defined by the IHS Office of Information Technology? (Please submit a letter from your site manager.)	❒ Yes ❒ No
7. Has your organization begun using EHR? Narrative: Describe your level of EHR implementation.	❒ Yes ❒ No

(Applicant assessment and narrative continued on the next page)

Applicant assessment and narrative (continued)	
Clinical information systems (continued)	
8. Does your organization routinely use at least one active RPMS-based registry? Narrative: Describe your use of RPMS-based registries.	❒ Yes ❒ No
9. Has your organization successfully submitted Clinical Reporting System (CRS) data every quarter?	❒ Yes ❒ No
10. Has your organization successfully submitted an electronic diabetes audit to the IHS Division of Diabetes Treatment and Prevention?	❒ Yes ❒ No
11. Does your organization routinely use the Diabetes Management System (DMS) or a similar disease management application (e.g., asthma, behavioral health, HIV, women's health) for care management for at least one disease? Narrative: Describe the disease management applications that you use and how you use them.	❒ Yes ❒ No
12. Does your organization use team- or provider-specific CRS patient lists or DMS features in visit planning for individual patients? Narrative: Describe your use of CRS patient lists or DMS features in visit planning.	❒ Yes ❒ No
Community resources and linkages	
13. Narrative: Describe the existing community resources that you use for patient education and treatment around chronic diseases and their risk factors.	
14. Narrative: Discuss potential partners in the community that could be developed to support your efforts to improve patient education and treatment around chronic diseases and their risk factors.	
Patient self-management support	
15. Does your program use a standardized individual patient needs assessment tool? Narrative: Describe how this tool is used in your program.	❒ Yes ❒ No
16. Does your program use customizable patient self-management plans? Narrative: Describe how patient self-management plans are used in your program.	❒ Yes ❒ No

(Applicant assessment and narrative continued on the next page)

Applicant assessment and narrative (continued)	
Patient self-management support (continued)	
17. Narrative: Describe how you use health educators, dietitians, public health nurses, pharmacists, and others to teach patients. Discuss potential resources (both in the system and the community) that could be engaged in this process.	
Delivery system design	
18. Has your organization identified a multidisciplinary care team? Narrative: Describe the providers who are included on the multidisciplinary care team and describe how the team functions (e.g., communication, meetings).	❒ Yes ❒ No
19. Does your organization offer case-management approaches to care? Narrative: Describe the existing case-management approaches that you use, including staff training, number of staff involved, and number of clinics involved.	❒ Yes ❒ No
20. Does your organization have a functional appointment and recall system in place? Narrative: Describe how your organization uses the appointment and recall system.	❒ Yes ❒ No
Decision support	
21. Are evidence-based clinical guidelines available throughout the organization? Narrative: Describe how the guidelines are used by providers in daily practice, for what diseases, and the process by which they were agreed upon and implemented.	❒ Yes ❒ No
22. Do providers recognize the importance of sharing care guidelines with patients? Narrative: Describe how the guidelines are shared with patients.	❒ Yes ❒ No
23. Does your organization use a standardized chronic disease treatment plan? Narrative: Describe how the treatment plans are used by providers in daily practice, for what diseases, and the process by which they were agreed upon and implemented.	❒ Yes ❒ No

(Applicant assessment and narrative continued on the next page)

Applicant assessment and narrative (continued)	
Decision support (continued)	
24. Does your organization's administration support continuing education for providers on chronic disease? Narrative: Describe the continuing education opportunities that are currently available to providers in your organization.	❒ Yes ❒ No
Pilot site staff	
Narrative: For each staff member who will participate in the pilot project, provide or describe: a. Name and title. b. FTE allocated to working on the pilot project. c. Anticipated roles and responsibilities in the pilot project. d. Experience that makes them qualified to participate in the pilot project.	
Other	
Narrative: Provide other compelling information that you feel would help reviewers understand why your organization is uniquely qualified to participate as a pilot site.	

Approved by:

_____
Pilot Site Coordinator

_____
Chief Executive Officer

_____
Clinical Director

_____
Area Chief Medical Officer

B. Sample letter of commitment

Date: _____

Bonnie Bowekaty
Chronic Disease Initiative Program Assistant
Indian Health Service Division of Diabetes Treatment and Prevention
5300 Homestead Avenue NE
Albuquerque, New Mexico 87110

To the Pilot Site Selection Workgroup:

We, the Pilot Site Coordinator of the Chronic Disease Management Pilot Site, _____,
(name)
and the Chief Executive Officer of the Sponsoring Organization, _____, for the
(name)
_____Service Unit, attest to the following:
(name)

The _____ Service Unit has evaluated and meets all criteria to participate as a Chronic Care Collaborative Pilot Site.

The _____ Service Unit has the administrative support and commitment necessary to successfully develop, implement, and evaluate the pilot project. This includes allocating a significant amount of staff time for a Chronic Disease Pilot Program Coordinator.

The **Administration of the sponsoring organization** grants the IHS application reviewer with permission to contact the Coordinator of the Chronic Disease Management Pilot Program and the Chief Executive Officer of the sponsoring organization to verify the content of our application.

The **Administration of the sponsoring organization** acknowledges and supports the concept that the pilot project may implement fundamental changes in the manner by which patients access the health care system and the way chronic disease care is delivered within the organization.

The **Administration of the sponsoring organization** will allow pilot project staff to participate in the in-person Chronic Disease Management Collaborative meeting and the virtual training sessions that will occur throughout the year.

_____	_____
Coordinator	Chief Executive Officer
Chronic Disease Management Pilot Program	Sponsoring Institution

Please submit on the sponsoring institution's letterhead

C. Sample letter from information technology site manager to ensure "EHR-ready" status

Date: _____

Bonnie Bowekaty
Chronic Disease Initiative Program Assistant
Indian Health Service Division of Diabetes Treatment and Prevention
5300 Homestead Avenue NE
Albuquerque, New Mexico 87110

To the Pilot Site Selection Workgroup:

As the IT Site Manager for the_____ Service Unit, I attest to the following:
(name)

The _____ Service Unit is currently using the IHS Electronic Health Record.

- or -

The _____ Service Unit has installed all of the appropriate patches to prepare the site for implementation of the IHS Electronic Health Record (EHR). As a result, we will fully implement the EHR in the outpatient setting within the next year.

_____
Site Manager

Please submit on the sponsoring institution's letterhead

Part III: Appendix A

Assessment of Chronic Disease Care

The MacColl Institute for Healthcare Improvement developed the following survey to help health care organizations and providers move toward "state-of-the-art" chronic disease management. You can use this survey to help you better understand some of the questions and criteria discussed in the pilot site application. You can also take this survey to help your team identify areas for improvement.

If you choose to take this survey, you ***do not need*** to submit it to the IHS with your pilot site application. We have included it to help and assist you. Here are the instructions for the survey:

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

   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 survey identify key aspects of chronic disease care. Each aspect is divided into levels showing various stages in improving chronic disease 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.

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.

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 3: Practice Level. Several components that manifest themselves at the level of the individual provider practice (e.g. individual clinic) have been shown to improve chronic illness care. These characteristics fall into general areas of self-management support, delivery system design issues that directly affect the practice, decision support, and clinical information systems.

Part 3a: Self-Management Support. Effective self-management support can help patients and families cope with the challenges of living with and treating chronic illness and reduce complications and symptoms.

Components	Level D	Level C	Level B	Level A
Assessment and Documentation of Self-Management Needs and Activities	…are not done.	…are expected.	…are completed in a standardized manner.	…are regularly assessed and recorded in standardized form linked to a treatment plan available to practice and patients.
Score	0 1 2	3 4 5	6 7 8	9 10 11
Self-Management Support	…is limited to the distribution of information (pamphlets, booklets).	…is available by referral to self-management classes or educators.	…is provided by trained clinical educators who are designated to do self-management support, affiliated with each practice, and see patients on referral.	…is provided by clinical educators affiliated with each practice, trained in patient empowerment and problem-solving methodologies, and see most patients with chronic illness.
Score	0 1 2	3 4 5	6 7 8	9 10 11
Addressing Concerns of Patients and Families	…is not consistently done.	…is provided for specific patients and families through referral.	…is encouraged, and peer support, groups, and mentoring programs are available.	…is an integral part of care and includes systematic assessment and routine involvement in peer support, groups or mentoring programs.
Score	0 1 2	3 4 5	6 7 8	9 10 11
Effective Behavior Change Interventions and Peer Support	…are not available.	…are limited to the distribution of pamphlets, booklets or other written information.	…are available only by referral to specialized centers staffed by trained personnel.	…are readily available and an integral part of routine care.
Score	0 1 2	3 4 5	6 7 8	9 10 11

Total Self-Management Score_____ Average Score (Self Management Score / 4) _____

Part 3b: Decision Support. Effective chronic illness management programs assure that providers have access to evidence-based information necessary to care for patients--decision support. This includes evidence-based practice guidelines or protocols, specialty consultation, provider education, and activating patients to make provider teams aware of effective therapies.

Components	Level D	Level C	Level B	Level A
Evidence-Based Guidelines	…are not available.	…are available but are not integrated into care delivery.	…are available and supported by provider education.	…are available, supported by provider education and integrated into care through reminders and other proven provider behavior change methods.
Score	0 1 2	3 4 5	6 7 8	9 10 11
Involvement of Specialists in Improving Primary Care	…is primarily through traditional referral.	…is achieved through specialist leadership to enhance the capacity of the overall system to routinely implement guidelines.	…includes specialist leadership and designated specialists who provide primary care team training.	…includes specialist leadership and specialist involvement in improving the care of primary care patients.
Score	0 1 2	3 4 5	6 7 8	9 10 11
Provider Education for Chronic Illness Care	…is provided sporadically.	…is provided systematically through traditional methods.	…is provided using optimal methods (e.g. academic detailing).	…includes training all practice teams in chronic illness care methods such as population-based management, and self-management support.
Score	0 1 2	3 4 5	6 7 8	9 10 11
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

Total Decision Support Score_____ Average Score (Decision Support Score / 4) _____

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 assessment, preventive interventions and attention to self-management support.
Score	0 1 2	3 4 5	6 7 8	9 10 11

(Part 3c continued on next page)

Components	Level D	Level C	Level B	Level A
Continuity of Care	…is not a priority.	…depends on written communication between primary care providers and specialists, case managers or disease management companies.	…between primary care providers and specialists and other relevant providers is a priority but not implemented systematically.	…is a high priority and all chronic 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.

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 an include self management as well as clinical management. Follow-up occurs and guides care at every point of service.
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.
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

(Integration of Chronic Care Model Components continued on next page)

Components	Little support	Basic support	Good support	Full support
Routine follow-up for appointments, patient assessments and goal planning	…is not ensured. 0 1 2	is sporadically done, usually for appointments only. 3 4 5	is ensured by assigning responsibilities to specific staff (e.g., nurse case manager). 6 7 8	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. 9 10 11
Guidelines for chronic illness care	…are not shared with patients. 0 1 2	…are given to patients who express a specific interest in self-management of their condition. 3 4 5	…are provided for all patients to help them develop effective self-management or behavior modification programs, and identify when they should see a provider. 6 7 8	…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. 9 10 11

(From previous page)

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):

Scoring Summary:
(Bring forward the scores at the end of each section to this page)

Total Organization 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 Assessment of Chronic Illness Care (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 of 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.