

Assessment of Chronic Illness Care in the IHS

(Adapted from ACIC Version 3.5; MacColl Center)

This tool is an adaptation of a tool designed by the Improving Chronic Illness Care (ICIC) to help health care organizations assess their capacity to provide care for persons with chronic conditions. It is based on the evidence that health care organizations that use the elements of the Chronic Care Model (MacColl Center) are able to show improved health outcomes

Your name:	Date: <div style="text-align: center; margin-top: 5px;"> _____ / _____ / _____ Month Day Year </div>
Organization & Address:	Names of other persons completing the survey with you:
	1.
	2.
	3.

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) that supports care for chronic illness.

 Please provide name and of the site assessed: _____

2. **Answer each question** regarding how your organization is doing with respect to one or more diseases or conditions.

 Please specify condition(s) _____

3. For each row, **circle the point value** that best describes the level of care that currently exists in the site and condition(s) 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 7.

5. **Process for filling out the form:** reach consensus with key staff in a face-to-face meeting; have one designated staff member fill out form in consultation with other staff as needed; have multiple staff members fill out a separate form and average the responses.

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 Score	...does not exist or there is a little interest. 0 1 2	...is reflected in vision statements and business plans, but no resources are specifically earmarked to execute the work. 3 4 5	...is reflected by senior leadership and specific dedicated resources (dollars and personnel). 6 7 8	...is part of the system's long term planning strategy, receive necessary resources, and specific people are held accountable. 9 10 11
Organizational Goals for Chronic Care Score	...do not exist or are limited to one condition. 0 1 2	...exist but are not actively reviewed. 3 4 5	...are measurable and reviewed. 6 7 8	...are measurable, reviewed routinely, and are incorporated into plans for improvement. 9 10 11
Improvement Strategy for Chronic Illness Care Score	...is ad hoc and not organized or supported consistently. 0 1 2	...utilizes ad hoc approaches for targeted problems as they emerge. 3 4 5	...utilizes a proven improvement strategy for targeted problems. 6 7 8	...includes a proven improvement strategy and uses it proactively in meeting organizational goals. 9 10 11

Total Health Care Organization Score _____ Average Score (Health Care Org. Score / 3) _____

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
Listening to Community	...is not done systematically	...is accomplished through patient satisfaction surveys	...is accomplished through events or modalities dedicated to this purpose with staff held accountable to address concerns and to follow up on recommendations for care delivery enhancements	...is accomplished on a regular basis using a variety of modalities (e.g. special events or meetings, internet or email access for community members) with staff held accountable to address concerns and to follow up on recommendations for care delivery enhancements
Linking Patients to Outside Resources	...is not done systematically.	...is limited to a list of identified community resources in an	...is accomplished through a designated staff person or resource	... is accomplished through active coordination between the health

Components	Level D	Level C	Level B	Level A
		accessible format.	responsible for ensuring providers and patients make maximum use of community resources.	system, community service agencies and patients.
Score	0 1 2	3 4 5	6 7 8	9 10 11
Partnerships with Community Organizations and Tribal Programs	...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

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
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 / 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
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Components	Level D	Level C	Level B	Level A
Care 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
Care Team Leadership	...is not recognized at the facility level 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
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

Total Delivery System Design Score _____

Average Score (Delivery System Design Score / 6) _____

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

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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 and Tribal 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
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

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Components	Little support	Basic support	Good support	Full support
	0 1 2	3 4 5	6 7 8	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

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

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.