

For Better Practice: Assessment of Chronic Illness Care (Diabetes)

Start improving your team care by completing this survey.

Assessment of Chronic Illness Care (Diabetes)	
Your name:	Date: _____/_____/_____ Month Day Year
Name of Your Practice:	Names of other persons completing the survey with you:
	1.
	2.
	3.
Directions for Using This Tool	
This is a survey designed to help you move toward the “state-of-the-art” in managing chronic illnesses such as diabetes. The results can be used to help your team identify areas for improvement. Instructions are as follows:	
<ol style="list-style-type: none"> 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. 2. Answer each question regarding how your organization is doing with respect to managing patients with diabetes. 3. For each row, circle the point value that best describes the level of care that currently exists in your practice. The rows 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. Total the points in each section, calculate the average score (total score/number of questions) for each section, and enter these average scores in the space provided at the end of each section. Then add up all of the average section scores and complete the average score for the program as a whole by dividing this number by 6. 	

Assessment of Chronic Illness Care (Diabetes)

Part 1: Organization of the Health-Care 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, receives necessary resources, and holds specific people accountable.
Score	0 1 2	3 4 5	6 7 8	9 10 11
Organizational Goals for Chronic Illness 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 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 illness care.	...visibly participate in improvement efforts in chronic illness 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 (Total Health Care Organization Score divided by 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 (Total Community Linkages Score divided by 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 and 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 distribution of information (pamphlets, booklets).			...is available by referral to self-management classes or educators.			...is provided by designated trained clinical educators who do self-management support, are affiliated with each practice, and see patients on referral.			...is provided by clinical educators who are affiliated with each practice, are 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; 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 (Total Self-Management Score divided by 4) _____

Part 3b: Decision Support. Effective chronic illness management programs ensure that providers have access to evidence-based information necessary to care for patients and provide decision support. This includes evidence-based practice guidelines or protocols, specialty consultation, and provider education, as well as asking 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 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 that 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 (Total Decision Support Score divided by 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 affect provision of care.

Components	Level D			Level C			Level B			Level A		
Practice Team Functioning	...is not addressed.			...is addressed by ensuring the availability of individuals with appropriate training in key elements of chronic illness care.			...is ensured by regular team meetings to address guidelines, roles, accountability, and problems in chronic illness care.			...is ensured by teams who meet regularly and have clearly defined roles, including patient self-management education, proactive follow-up, 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 ensured by the appointment of a team leader, but his/her role in chronic illness is not defined.			...is guaranteed by the appointment of a team leader who ensures 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 schedule acute care, follow-up, and preventive visits.			...ensures scheduled follow-up with chronically ill patients.			... can accommodate innovations, such as customized visit length or group visits.			...includes organization of care that facilitates a patient's 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 ensured by the practice team by monitoring patient utilization.			...is customized to patient needs, varies in intensity and methods (phone, in person, e-mail), and ensures 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 patients with complications.			...are an option for interested patients.			...are used for all patients. Include regular assessment, preventive interventions, and 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 among 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 (Total Delivery System Design Score divided by 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 subpopulations 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.	...include indications of needed service for populations of patients through periodic reporting.	...include 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 not 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 and clinical goals.	...are established collaboratively and include self-management and 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 Systems Score _____ Average Score (Total Clinical Information Systems Score divided by 5) _____

Integration of Chronic Illness Care Model Components. Effective systems of care integrate and combine all elements of the Chronic Illness Care Model (e.g., by 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 that 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 and self-management goals that are developed using input from the practice team/provider and patient.	...include results of patient assessments and self-management goals that are developed using input from the practice team and patient; 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
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 use 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 or behavior modification 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 the patient's goals and readiness to change.
Score	0 1 2	3 4 5	6 7 8	9 10 11

Total Integration Score (Total of all scores): _____ Average Score (Total Integration Score divided by 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 Health-Care Organization 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 (Total of all scores) _____

Average Program Score (Total Program divided by 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 the collaborative program 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 this process, 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.