Assessment of Chronic Illness Care (ACIC)

Thank you for taking the time to complete the Assessment of Chronic Illness Care (ACIC). By completing this survey your agency will gain valuable insight into areas of effective chronic illness care and highlight areas where improvements could be made.

The ACIC can be completed by department managers within the agency and their scores can be averaged out to provide a single score for each question or it can be completed in small working groups consisting of a mix of people who work in chronic illness care, whereby groups come to a consensus on the score for each of the questions.

When completing this survey please keep in mind that it is common for agencies to score below 5 on many of the areas assessed. Please be as honest as possible when answering each question and remember that your responses will remain confidential and will not be disclosed to other agencies.

Answering the questions involves circling the point value that best describes the level of care that currently exists. The points range in value from 0 to 11. The higher the point value the more fully implemented are the actions described for each question, and the greater the chronic illness care.

Before beginning the ACIC, please complete the following information about you and your agency. This will allow us to contact you with the results.

Your name: ____

Your phone number: ____________________________

Your email address: ________________________________

Agency name: __________________________________

Your answers to the questions within this survey should be from the perspective of one physical site (e.g. a clinic, practice, community health service) that supports chronic illness. Please provide the name and type of site:

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Name(s) of others who completed the survey with you: ____

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Part 1: Organisation of the Healthcare Delivery System

Components	Level D	Level C	Level B	Level A
Overall organisational leadership in chronic illness care	...does not exist of 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
Organisational 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 organised or supported consistently.	...utilises ad hoc approaches for targeted problems as they emerge.	...utilises proven improvement strategy for targeted problems.	...includes a proven improvement strategy and uses it proactively in meeting organisational 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 utilisation 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 enrolment 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

Part 2: Community Linkages

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 organisations	...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 coordinates 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

Part 3: Self-Management Support

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 standardised manner.	...are regularly assessed and recorded in standardised form linked to 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 behaviour 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 specialised 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**

Part 4: Decision Support

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 behaviour 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

Part 5: Delivery System Design

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 recognised locally or by the system.	...is assumed by the organisation to reside in specific organisational 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 preventative visits.	...assures scheduled follow-up with chronically ill patients.	...are flexible and can accommodate innovations such as customisable visit length or group visits.	...includes organisation of care that facilitates the patients 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 utilisation.	...is customisable 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, preventative 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

Part 6: Clinical Information Systems

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 standardised approach.	...are established collaboratively and include self-management as well as clinical goals.	...are established collaboratively and 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**

Part 7: Integration of Chronic Care Model Components

Components	Level D	Level C	Level B	Level A
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 program.	...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
Organisational 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 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 or behaviour 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 behaviour 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