

# Measure #1. Assessment of Chronic Illness Care (ACIC)

**CARE COORDINATION MEASURE MAPPING TABLE**

	MEASUREMENT PERSPECTIVE		
	<i>Patient/Family</i>	<i>Health Care Professional(s)</i>	<i>System Representative(s)</i>
<b>CARE COORDINATION ACTIVITIES</b>			
Establish accountability or negotiate responsibility			□
Communicate			□
<i>Interpersonal communication</i>			
<i>Information transfer</i>			■
Facilitate transitions			
<i>Across settings</i>			
<i>As coordination needs change</i>			
Assess needs and goals			■
Create a proactive plan of care			□
Monitor, follow up, and respond to change			■
Support self-management goals			■
Link to community resources			■
Align resources with patient and population needs			■
<b>BROAD APPROACHES POTENTIALLY RELATED TO CARE COORDINATION</b>			
Teamwork focused on coordination			■*
Health care home			
Care management			
Medication management			
Health IT-enabled coordination			■

**Legend:**

■ = ≥ 3 corresponding measure items

□ = 1-2 corresponding measure items

\*The use of a filled square for this measure indicates that it is a composite score.

# Assessment of Chronic Illness Care (ACIC)

**Purpose:** To evaluate the quality-improvement-related strengths and weaknesses of care delivery for chronic illness.

**Format/Data Source:** Version 3.5 is a 34-item survey that covers 6 areas: (1) community linkages, (2) self-management support, (3) decision support, (4) delivery system design, (5) information systems, and (6) organization of care. Questions are divided by area of focus (6 areas of chronic illness care) and responses are in the form of a rating scale (Levels A–D).

**Date:** Measure released in 2000.<sup>1</sup>

**Perspective:** System Representative(s)

## Measure Item Mapping:

- **Establish accountability or negotiate responsibility:** 18, 19
- **Communicate:**
  - *Across health care teams or settings:* 15, 23
  - Information transfer:
    - *Between health care professional(s) and patient/family:* 17, 29
    - *Participants not specified:* 27
- **Assess needs and goals:** 10, 30, 33
- **Create a proactive plan of care:** 28
- **Monitor, follow up, and respond to change:** 20-22, 25, 33
- **Support self-management goals:** 10-13, 30, 34
- **Link to community resources:** 7, 8, 31
- **Align resources with patient and population needs:** 9, 16, 32
- **Teamwork focused on coordination:** 18, composite score
- **Health IT-enabled coordination:** 24-26, 30

**Development and Testing:** Instrument development was based on areas of system change suggested by the Chronic Care Model (CCM) that have been shown to influence quality of care. The instrument was tested in 108 organizational teams implementing 13-month long quality-improvement collaboratives in health care systems across the U.S. Paired t-tests were used to evaluate the sensitivity of the ACIC to detect system improvements. Testing revealed that all six subscale scores were responsive to system improvements made by care teams. In addition, a significant positive relationship between differences in self-reported ACIC scores and a RAND measure of the presence of chronic care model components in care program implementation was found.<sup>2</sup>

**Link to Outcomes or Health System Characteristics:** Moderately strong and positive Pearson correlations were found between ACIC scores and observational ratings of chronic care outcomes made by faculty from each collaborative program, with the exception of the community linkages subscale. Faculty ratings were based on team-prepared cumulative monthly reports, which included process and outcomes data (e.g., chart review data).<sup>2</sup> Another study

found that, controlling for patient and clinic characteristics, a 1-point increase in the ACIC score was associated with a 16 percent relative decrease in risk for coronary heart disease attributable to modifiable risk factors.<sup>3</sup> Another study found that characteristics of the primary care clinic where a patient receives care, as measured by the ACIC, are an important predictor of glucose control.<sup>4</sup>

**Logic Model/Conceptual Framework:** Chronic Care Model.

**Country:** United States

**Past or Validated Applications\*:**

- **Patient Age:** Adults, Older Adults
- **Patient Condition:** Combined Chronic Conditions, General Chronic Conditions, Mental Illness & Substance Use Disorders
- **Setting:** Primary Care Facility, Not Setting Specific

\*Based on the sources listed below and input from the measure developers.

**Notes:**

- All instrument items are located online.<sup>1</sup>
- This instrument contains 34 items; 25 were mapped.
- Spanish, Thai, German, and Hebrew translations are available online.<sup>1</sup>

**Sources:**

1. Improving Chronic Illness Care Web site. Available at: <http://www.improvingchroniccare.org/index.php?p=Versions&s=297>. Accessed: 23 September 2010.
2. Bonomi AE, Wagner EH, Glasgow RE, et al. Assessment of Chronic Illness Care (ACIC): A practical tool to measure quality improvement. *Health Serv Res* 2002;37(3):791-820.
3. Parchman ML, Zeber JE, Romero RR, et al. Risk of coronary artery disease in type 2 diabetes and the delivery of care consistent with the chronic care model in primary care settings: A STARNet study. *Med Care* 2007;45(12):1129-34.
4. Parchman ML, Pugh JA, Wang CP, et al. Glucose control, self-care behaviors, and the presence of the chronic care model in primary care clinics. *Diabetes Care* 2007;30(11):2849-54.
5. Solberg LI, Crain AL, Sperl-Hillen JM, et al. Care quality and implementation of the chronic care model: A quantitative study. *Ann Fam Med* 2006;4(4):310-16.
6. Sunaert P, Bastiaens H, Feyen L, et al. Implementation of a program for type 2 diabetes based on the Chronic Care Model in a hospital-centered health care system: The Belgian experience. *Health Serv Res* 2009;9(152).