

## Measure #10. Patient Assessment of Chronic Illness Care (PACIC)

**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

# Patient Assessment of Chronic Illness Care (PACIC)

**Purpose:** To develop a patient self-report instrument that measures the extent to which patients receive clinical services and actions consistent with the Chronic Care Model.

**Format/Data Source:** A 20-item survey administered to patients with chronic conditions for evaluation of their care within the past 6 months. Scales address 5 topics: (1) Patient Activation; (2) Delivery System Design/Decision Support; (3) Goal Setting; (4) Problem-Solving/Contextual Counseling, and (5) Follow-up/Coordination.

**Date:** Measure published in 2005.<sup>1</sup>

**Perspective:** Patient/Family

## Measure Item Mapping:

- **Communicate:**
  - *Between health care professional(s) and patient/family:* B11, B15, B19, B20
  - Interpersonal communication:
    - *Between health care professional(s) and patient/family:* B1
  - Information transfer:
    - *Between health care professional(s) and patient/family:* B3
    - *Participants not specified:* B9
- **Assess needs and goals:** B1, B2, B7-9, B12, B13
- **Create a proactive plan of care:** B1, B4, B13, B14
- **Monitor, follow up, and respond to change:** B16
- **Support self-management goals:** B4, B6, B7, B8, B10, B13, B14, B17
- **Link to community resources:** B10, B17, B18
- **Medication management:** B3

**Development and Testing:** Face, construct, and concurrent validity, as well as measurement performance were demonstrated, characterizing the PACIC as a reliable instrument. Test-retest reliability was moderately stable over a three-month interval. Most items strongly related to their respective subscale(s), and the overall model had moderate goodness of fit. The instrument is appropriate across a variety of chronic conditions.<sup>1</sup>

**Link to Outcomes or Health System Characteristics:** None described in the sources identified.

**Logic Model/Conceptual Framework:** The Chronic Care Model establishes a framework from which the Patient Assessment of Chronic Illness Care (PACIC) arises.<sup>1</sup>

**Country:** United States

## Past or Validated Applications\*:

- **Patient Age:** Adults

- **Patient Condition:** Combined Chronic Conditions, General Chronic Conditions, Multiple Chronic Conditions
- **Setting:** Primary Care Facility

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

#### Notes:

- Instrument items located in the Appendix of the source article.<sup>1</sup>
- Instrument items are also located online.<sup>3</sup>
- This instrument contains 20 items; 19 were mapped.
- A 25-item version is also available, which can be scored according to the “5 As” model of health behavior change.<sup>3</sup>
- Additional information regarding the measure and how to contact its developers is available online.<sup>5</sup>
- An adapted two-factor structure version of the five-factor structure PACIC (tested in the United States and Europe) was developed and tested in Australia.<sup>6</sup>
- Studies using the PACIC have also been applied to diabetic patient populations, assessing the level of literacy in relation to self-management support.<sup>7</sup>

#### Sources:

1. Glasgow RE, Wagner EH, Schaefer J, et al. Development and validation of the Patient Assessment of Chronic Illness Care (PACIC). *Med Care* 2005;43(5):436-44.
2. Gensichen J, Serras A, Paulitsch MA, et al. The Patient Assessment of Chronic Illness Care questionnaire: Evaluation in patients with mental disorders in primary care. *Community Ment Health J* 2010 Aug 24. [ePub ahead of print]. No doi number listed.
3. Robert Wood Johnson Foundation Improving Chronic Illness Care Web site. Available at: <http://improvingchroniccare.org/tools/pacic.htm>. Accessed: 17 September 2010.
4. Glasgow RE, Nelson CC, Whitesides H, et al. Use of the Patient Assessment of Chronic Illness Care (PACIC) with diabetic patients: Relationship to patient characteristics, receipt of care, and self-management. *Diabetes Care* 2005;28:2655-61.
5. National Cancer Institute Grid-Enabled Measures Database (GEM), beta. Available at: <https://www.gem-beta.org/public/MeasureDetail.aspx?mid=100&cat=2&mode=m>. Accessed: 24 September 2010.
6. Taggart J, Chan B, Jayasinghe UW, et al. Patients Assessment of Chronic Illness Care (PACIC) in two Australian studies: Structure and utility. *J Eval Clin Pract* 2010 Sep 16 [ePub ahead of print] doi:10.1111/j.1365-2753.2010.01423.x.
7. Wallace AS, Carlson JR, Malone RM, et al. The influence of literacy on patient-reported experiences of diabetes self-management support. *Nurs Res* 2010;59(5):356-63.
8. Schmittdiel J, Mosen DM, Glasgow RE, et al. Patient Assessment of Chronic Illness Care (PACIC) and improved patient-centered outcomes for chronic conditions. *J Gen Int Med* 2008;23(1):77-80.