Assessment of Chronic Illness Care-PRISON

Please complete the following information about the correctional health system in which you practice. The purpose of this survey is to gain an understanding of how chronic illness care is provided within your correctional health system and how best to improve the quality of care. Read "Directions for Completing the Survey" and then answer the questions from the perspective of the correctional health site in which you work. The information you provide will not be disclosed to anyone besides the study team. Thank you.

Date:

_____/_____/_____
Month Day Year

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 regarding how your clinic is doing with respect to the care provided to persons with a chronic disease
2. For each row, circle the point value that best describes the level of care that currently exists in the site. 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.
3. 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 the survey. Then sum all of the average section scores and divide by 7. The total score should be between 0 and 11.

For more information about how to complete the survey, please contact:

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Assessment of Chronic Illness Care-Prison, Version 1.0

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
1-1: Executive leaders	...are focused on short-term business priorities.	...visibly support and create an infrastructure for chronic illness care, but do not commit resources.	...allocate resources and actively reward chronic illness care initiatives.	...support continuous learning throughout the organization, review and act upon quality data, have a strategy and funding commitment to explore, implement chronic illness care.
Score	0 1 2	3 4 5	6 7 8	9 10 11
1-2: Organizational 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
1-3: 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
1-4: Regulations for Chronic Illness Care	...are not used to influence clinical performance goals.	...are used to influence utilization and performance 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
1-5: Clinical leaders	...intermittently focus on chronic illness care.	...have developed a vision for chronic illness care, but no consistent process for getting there.	...are committed to chronic illness care, and sometimes engage teams in problem solving and implementation.	... consistently champion and engage clinical teams in improving patient experience of care and clinical outcomes.
Score	0 1 2	3 4 5	6 7 8	9 10 11
1-6: Custody	...intermittently focuses on chronic illness care.	...has developed a vision for chronic illness care, but no consistent process for getting there.	...is committed to chronic illness care, and sometimes engages teams in implementation and problem solving.	...consistently champions and engages clinical teams in improving patient experience of care and clinical outcomes.
Score	0 1 2	3 4 5	6 7 8	9 10 11
1-7: The organization's hiring and training processes (of health care providers)	...focus only on the narrowly defined functions and requirements of each position.	...reflect how potential hires will affect the culture and participate in chronic illness care activities	...place a priority on the ability of new and existing staff to improve chronic illness care and create a patient-centered culture.	...support and sustain improvements in chronic illness care through training and incentives focused on rewarding patient-centered care.

Components	Level D	Level C	Level B	Level A
Score	0 1 2	3 4 5	6 7 8	9 10 11

Part 2: Other Clinical Linkages. Linkages between the health delivery system (or provider practice) and other resources (behavioral, mental and medical specialty services) play important roles in the management of chronic illness.

Components	Level D	Level C	Level B	Level A
2-1: Medical and surgical specialty services	…are difficult to obtain reliably.	…are available from community specialists but are neither timely nor convenient.	…. are available from community specialists and are generally timely and convenient.	…are readily available from specialists who are members of the care team or who work in an organization with which the practice has a referral protocol or agreement.
Score	0 1 2	3 4 5	6 7 8	9 10 11
2-2: Behavioral health services	…are difficult to obtain reliably.	…are available from mental health specialists but are neither timely nor convenient.	…are available from specialists and are generally timely and convenient.	…are readily available from behavior health specialists who are onsite members of the care team or who work in a organization with which the practice has a referral protocol or agreement.
Score	0 1 2	3 4 5	6 7 8	9 10 11
2-3: Linking patients to community resources in prison (health education)	…is not done systematically.	…is limited to providing patients a list of identified resources in an accessible format.	…is accomplished through a designated staff person or resource responsible for connecting patients with resources.	…is accomplished through active coordination between the health system, agencies and patients and accomplished by a designated staff person.
Score	0 1 2	3 4 5	6 7 8	9 10 11
2-4: Linking patients to medical resources after discharge from prison	…is not done systematically.	…is limited to providing patients a list of identified resources in an accessible format.	…is accomplished through a designated staff person or resource responsible for connecting patients with resources.	…is accomplished through active coordination between the health system, agencies and patients and accomplished by a designated staff person.

Components	Level D	Level C	Level B	Level A
Score	0 1 2	3 4 5	6 7 8	9 10 11

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 patient self-management support, delivery system design issues that directly affect the practice, decision support, and clinical information systems.

Part 3a: Patient self-management support. Effective patient 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
3-1-1: Assessment and Documentation of Patient Self-management Needs and Activities **Score**	...are not done. 0 1 2	...are expected. 3 4 5	...are completed in a standardized manner. 6 7 8	...are regularly assessed and recorded in standardized form linked to a treatment plan available to practice and patients. 9 10 11
3-1-2: Patient Self-management Support **Score**	...are limited to the distribution of information (pamphlets, booklets) or not available 0 1 2	...are available by referral to patient self-management classes or educators. 3 4 5	...are provided by trained clinical educators who are designated to do patient self-management support, affiliated with each practice, and see patients on referral. 6 7 8	...are provided by clinical educators affiliated with each practice, trained in patient empowerment and problem-solving methodologies, and see most patients with chronic illness. 9 10 11
3-1-3: Addressing Concerns of Patients Regarding Self-Management **Score**	...is not consistently done. 0 1 2	...is provided for specific patients through referral. 3 4 5	...is encouraged, and peer support, groups, and mentoring programs are available. 6 7 8	...is an integral part of care and includes systematic assessment and routine involvement in peer support, groups or mentoring programs. 9 10 11
3-1-4: 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

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
3-2-1: Evidence-Based Guidelines	...are not available or not updated.	...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
3-2-2: 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
3-2-3: Provider Education for Chronic Illness Care	...is provided sporadically.	...is provided systematically through traditional methods.	...is provided using optimal methods (e.g. face to face education of providers by trained professionals on evidence based practice).	...includes training all multidisciplinary clinical teams in chronic illness care methods, such as population-based management and patient self-management support.
Score	0 1 2	3 4 5	6 7 8	9 10 11
3-2-4: Informing Patients about Guidelines	...is not done.	...happens on request or verbally.	...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 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
3-3-1: Multi-disciplinary Clinical 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
3-3-2: Multi-disciplinary Clinical Team Leadership	...is not recognized locally 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
3-3-3: Appointment System	...can be used to schedule acute care visits, follow-up and preventive visits.	...assures scheduled follow-up with chronically ill patients.	...is 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
3-3-4: 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 multidisciplinary clinical team by monitoring patient utilization.	...is customized to patient needs, varies in and assures guideline follow-up.
Score	0 1 2	3 4 5	6 7 8	9 10 11
3-3-5: Planned Visits for Chronic Illness Care	...are not used.	...are occasionally used for complicated patients.	...are often used for complicated patients.	...are used for all patients and include regular assessment, preventive interventions and attention to patient self-management support.
Score	0 1 2	3 4 5	6 7 8	9 10 11
3-3-6: Continuity of Care	...is not a priority.	...depends on written communication between primary care providers, specialists, and case managers.	...between primary care providers and specialists and other relevant providers is a priority but not implemented	...is a high priority and all chronic disease interventions include active coordination between primary care,

Components	Level D	Level C	Level B	Level A
			systematically.	specialists and other groups.
Score	0 1 2	3 4 5	6 7 8	9 10 11

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
3-4-1: 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
3-4-2: 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
3-4-3: 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
3-4-4: 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
3-4-5: Patient Treatment Plans	...are not expected.	...are achieved through a standardized approach.	...are established collaboratively and include self management as well as clinical goals.	...are established collaborative 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 4: Integration of Chronic Care Model Components. Effective systems of care integrate and combine all elements of the Chronic Care Model; e.g., linking patients' patient self-management goals to information systems/registries.

Components	Little support	Basic support	Good support	Full support
4-1: Informing Patients about Guidelines **Score**	…is not done. 0 1 2	…happens on request or through system publications. 3 4 5	…is done through specific patient education materials for each guideline. 6 7 8	…includes specific materials developed for patients which describe their role in achieving guideline adherence. 9 10 11
4-2: Information Systems/ Registries **Score**	…do not include patient self-management goals. 0 1 2	…include results of patient assessments (e.g., functional status rating; readiness to engage in patient self-management activities), but no goals. 3 4 5	…include results of patient assessments, as well as patient self-management goals that are developed using input from the multidisciplinary clinical team/provider and patient. 6 7 8	…include results of patient assessments, as well as patient self-management goals that are developed using input from the multidisciplinary clinical team and patient; and prompt reminders to the patient and/or provider about follow-up and periodic re-evaluation of goals. 9 10 11
4-3: Other Clinical Programs (behavioral, mental and medical specialty services) **Score**	…do not provide feedback to the health care system/clinic about patients' progress in their programs. 0 1 2	…provide sporadic feedback at joint meetings between the other clinical care agencies and health care system about patients' progress in their programs. 3 4 5	…provide regular feedback to the health care system/clinic using formal mechanisms (e.g., Internet progress report) about patients' progress. 6 7 8	…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. 9 10 11
4-4: 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 patient self-management programs and partnerships with community resources.	…uses systematic data and input from multidisciplinary clinical teams to proactively plan population-based care, including the development of patient self-management programs and community

Components	Little support	Basic support	Good support	Full support
				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
4-5: 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 to coordinate with patients and the entire multidisciplinary clinical team.
Score	0 1 2	3 4 5	6 7 8	9 10 11
4-6: Guidelines for chronic illness care	…are not shared with patients.	…are given to patients who express a specific interest in patient self-management of their condition.	…are provided for all patients to help them develop effective patient self-management or behavior modification programs, and identify when they should see a provider.	…are reviewed by the multidisciplinary clinical team with the patient to devise a patient self-management or behavior 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

Scoring Summary

Category for ACIC-Prison	**Total Score**	**Number of questions**	**Average score** **(Total Score/number of questions)**
Organization of Health Care System		7	
Other Clinical Linkages		4	
Patient self-management support		4	
Decision Support		4	
Delivery System Design		6	
Clinical Information System		5	
Integration of Chronic Care Model Components		6	
		36	