Link of Community Health Practice Indicators (CHPIs) and Community Health Impact Indicators (CHII) to the Wagner Model

The Chronic Care Model

**Community**
- Resources and Policies
- Self-Management Support

**Health Systems**
- Organization of Health Care
- Delivery System Design
- Decision Support
- Clinical Information Systems

**Improved Outcomes**
- Informed, Activated Patient
- Productive Interactions
- Prepared, Proactive Practice Team

CHII: 
- That may be used by agencies when reporting on the assessment of chronic illness care (ACIC) and service coordination surveys
- Care plans (Nos. 12 & 14), Communication with GP re Care Plan (No. 13) and end of episode of care (No. 20), Care Plan Review (No. 15), Diabetes Care Data (No. 11), Diabetes Best Practice Care Review (No. 17) and indicators relevant to Intake (Nos. 1-4) and Access (Nos. 6-8).

**CHPIs: Improved client outcomes measured by the CHII**
- Health Behaviours: Smoking rates, nutrition, body weight, exercise and physical activity, and alcohol consumption.
- Health Conditions: Cardiac health (i.e., systolic & diastolic blood pressure, blood levels of LDL and total cholesterol) and diabetes HbA1c.
- Wellbeing measures: Quality of life (EQ-5D-5L), Wellbeing/Life Satisfaction (HILDA) survey and chronic disease self-management (Stanford self-efficacy).

**Effectiveness of Care at Program & Systems Level Measured by CHII & CHPIs**
- CHII: Avoidable admissions to emergency department and/or hospital
- CHPI: Client goal achievement (Indicator 16)