Chronic disease management audit tools

A fact sheet for Primary Care Partnerships

This fact sheet has been developed to provide Primary Care Partnerships (PCPs) with a briefing on audit and assessment tools for chronic disease care to assist in guiding choice and implementation. An overview of a selection of audit tools is provided.

Organisations that have committed to improving their systems for chronic illness care often find an organisational audit of current practice to be a valuable process. Establishing a baseline helps develop an action plan to improve chronic care and also allows the effectiveness of the strategies implemented to be measured.

The tools reviewed fall into four broad categories.

Tools that assess organisational systems

- *Assessment of chronic illness care (ACIC)*—MacColl Institute for Healthcare Innovation (USA)
- *The audit and best practice for chronic disease: systems assessment tool (ABCD-SAT)*—Menzies School of Health Research (NT, Australia)
- *Organisational skills analysis tool: Chronic disease care*—Gill and Willcox (Vic, Australia)

Tools that assess consumer experience of chronic disease care

- *Patient assessment of chronic illness care (PACIC)*—MacColl Institute for Healthcare Innovation (USA)

Tools that assess specific components of chronic disease care

- *Self-management assessment tool for community health organisations*—Gill and Willcox (Vic, Australia)
- *Self-management survey*—Department of Human Services (Vic, Australia)
- *Service coordination and ICDM survey*—Department of Health (Vic, Australia)

Tools that assess general practice provision of chronic disease care

- *PEN clinical audit tool*
- *Practice health atlas*

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Assessment of chronic illness care (ACIC)

Background

The ACIC was developed in 2000 through the MacColl Institute for Healthcare Innovation (USA) through a rigorous trial and evaluation process. It is strongly aligned with the Wagner improving chronic care model.

The ACIC was designed for the American system where multiple layers of health care may be provided through one large organisation. The introduction to the tool states that it should be used at one site for one chronic condition at a time, which recognises that services may be at different stages of development. However, many Victorian agencies have successfully used the ACIC more broadly to assess organisation-wide systems for chronic illness care.

Structure

The ACIC (version 3.5) has 34 questions divided into seven sections. There is one section for each of the six elements of the Wagner model and a seventh section to assess the integration of these elements, which recognises their interdependence.

Once completed and scored, the tool rates each of the seven sections as limited, basic, good or excellent support for chronic illness care.

Implementation

The ACIC can be distributed to clinicians, team leaders and managers for individual ratings that are then averaged out for final scoring. More commonly, it is implemented in small working parties guided by a manager or external facilitator. It may be done over a series of meetings or as a half-day workshop. With an experienced facilitator, and depending on the depth of discussion, the process can take as little as 90 minutes.

The scoring system lends itself to concise quantitative reports to governance groups.

The ACIC can support ongoing monitoring through periodic implementation, such as annually or before and after a period of change. It is preferable that the same process be used each time the tool is applied to optimise consistency of results.

Challenges

Without being facilitated by someone with a good understanding of the Wagner model, some of the questions may be interpreted in very different ways or may not be easy to answer. Some clarification of the Wagner model and its terminology prior to completion of the tool is advised—a range of useful resources for this purpose, including a video of Professor Wagner presenting the model, can be found at <www.improvingchroniccare.org>.

It is common for scores during the initial use of the tool to be high and to decrease when first repeated, especially where the tool is used before and after a period of focus on improving chronic care systems—this can be explained by increased understanding of the challenges of chronic care by those answering the questions.

> **For more information and to download the assessment tool, visit: <www.improvingchroniccare.org/index.php?p=ACIC_Survey&s=35>.**

The ABCD systems assessment tool (SAT)

Background

The SAT was developed by the Menzies School of Health Research in 2005 with support from the Northern Territory Government. It is an adaptation of the ACIC, designed specifically to meet the needs of organisations working with an indigenous population and with a focus on diabetes, but can be used by all Australian health agencies.

In addition to modifying some of the elements to capture an Australian context (such as linking to MBS enhanced primary care (EPC) items), the SAT has also incorporated the guiding principles of the World Health Organization's *Innovative care for chronic conditions (ICCC) framework*. This inclusion has broadened the scope to link chronic illness care with health-promotion initiatives.

The SAT encourages agencies to use a continuous improvement framework and apply annual plan, do, study, act (PDSA) cycles to appraise and improve performance in meeting the needs of people with or at risk of chronic conditions.

Structure

At a glance, the SAT looks longer and more complex than the ACIC but this is not the case. The SAT has maintained the seven sections of the ACIC and has 32 individual questions. The added length to the document is due to the added definitions and the comprehensive guidelines to assist implementation, which are provided within the tool.

Although initially developed for agencies providing services for type 2 diabetes, the focus of the SAT is on a whole-of-agency-systems approach to chronic illness prevention and management, not a diagnosis-specific approach. In each section, it requires consideration of activities and programs across three categories:

• clinical services for people known to have a chronic illness

• individual preventative services for prevention and early detection

• community or population-based activities.

The scoring system is the same as in the ACIC; however, the scoring form allows for comments on justification and would allow a clearer comparison if re-assessed annually.

Implementation

The SAT has an extensive facilitator's guide including detailed examples and appendices with a useful background to the chronic care model. It is suggested that an external facilitator assist with the process and that an entire health team is involved in a group process to complete the tool. It is likely to take a little longer than the ACIC given this standardisation of implementation.

> **For more information and to download the tool and facilitator guide, visit: <http://www.health.gov.au/internet/h4l/publishing.nsf/Content/toolkit-s5>.**

Organisational skills analysis tool—chronic disease care (OSAT-CDC)

Background

The OSAT-CDC (2002) is a Victorian tool adapted by Gill and Willcox from the department's *Health promotion skills assessment tool* for organisations. The chronic disease care adaptation was initially developed for type 2 diabetes and used the Australian Diabetes Educators Association *Best practice guidelines* as a key reference, but is not diagnosis specific. It combines best practice in chronic disease care with indicators from department service coordination and health promotion policy. Feedback from agencies that have utilised the tool has also contributed to its development.

It is more specific in terms of skills and practices that are audited, compared with the ACIC which is more broad in its statements.

This tool is designed to be implemented at an agency and direct client service level. It does not focus on individual chronic conditions, recognising that many organisations are aiming for consistent integrated systems and practices for chronic care more broadly and many staff work with a broad client group across multiple programs.

Structure

The tool has three subsections with 16 overall questions.

Specific examples of good practice are provided under each component and these are relevant to a Victorian context, and subsequently assist in developing awareness of best practice in chronic illness care as well as improving the reliability of self-rating.

Implementation

The process for implementation is quite clearly described within the tool. It is encouraged that the tool be given to practitioners to complete independently and to then discuss in teams or discipline groups. It is suggested that representatives from each of these groups then form a working party to discuss results with a facilitator who collates and summarises the completed forms.

It is recommended that the implementation of the process be facilitated by a person with a strong knowledge of chronic illness care and what constitutes good systems in health care. It is beneficial to use an external facilitator to encourage challenging of assumptions and reflection on ratings of elements.

It does not provide a score; ratings are on a scale of A–E.

The tool assists with identifying inconsistencies in practice across an organisation and also facilitates creation of an action plan for improving care delivery processes.

There is no cost associated with using this tool. However, to access a copy, it is requested that you contact the authors as their intention is to continue to collect feedback, review and develop the tool.

> **For more information, visit <www.gillandwillcox.com.au>.**

The patient assessment of chronic illness care (PACIC)

Background

In recognition that understanding patients' experiences of the health system is crucial to improving chronic illness care, the MacColl Institute developed the PACIC, a self-report instrument for assessing the extent to which patients with chronic illness receive care that aligns with the Wagner model. The PACIC is the only tool currently available that audits organisational systems for chronic care from the patient's perspective.

Structure

The PACIC asks patients to report on specific actions or qualities of care they have experienced. The survey has 20 questions, rated on a five-point scale.

Implementation

Guidelines for the tool do not specify how an agency should use it. The tool could be handed or posted to patients to complete and return to an agency, or completed as part of a consultation. It could be used in a snapshot survey, for example, given to all clients attending a specific service that is being evaluated within a defined time period such as week. It can become part of ongoing evaluation of a new service or program. All or some questions could be added to existing patient feedback mechanisms.

An organisation's procedures for patient consent to participate in research and evaluation must be followed when implementing the PACIC.

Although aligned strongly with the ACIC and a very useful addition to that tool, the PACIC has been validated as a stand-alone tool so does not have to be used alongside the ACIC—it can be used independently, or alongside another organisational audit tool.

> For more information and to download the tool, visit <http://www.improvingchroniccare.org/index.php?p=PACIC_Survey&s=36>.

Self-management assessment tool for community health

Background

This tool, developed by Gill and Wilcox, examines how effectively an organisation is integrating self-management into chronic disease management.

This tool drills down to the day-to-day detail of implementing self-management practices specifically. It facilitates development of an action plan to improve self-management support skills and practices within a community health organisation. It explores the client–clinician relationship as well as organisational practices for supporting self-management.

Although this tool stands alone, self-management support is just one component of chronic illness care and broader organisational assessment is advised. Depending on the local needs and priorities, a specific audit of self-management can in some instances be a good starting point.

Structure and implementation

This tool consists of eight questions. A similar process for implementing it should be followed as described for the OSAT-CDC. It is designed specifically for the needs of community health agencies.

> For more information, visit <www.gillandwillcox.com.au>.

Self-management mapping survey and Service coordination and ICDM survey

These two survey tools were developed by the department's Primary Health Branch and implemented through PCPs in the 2007–08 financial year. They provided a snapshot of self-management and service coordination at both PCP and statewide levels.

The service coordination survey was revised for 2009 to become the service coordination and ICDM survey, and is now conducted annually. The information that PCPs and agencies collect from these surveys can be used locally to inform planning for improvements of chronic illness care. The survey may also become a useful mechanism for measuring progress in ICDM over time.

> For more information on the tools and their purposes, visit <www.health.vic.gov.au/pcps/publications/self_management.htm> and <www.health.vic.gov.au/pcps/coordination/ppps.htm#survey>.

PEN clinical audit tool

Background

The clinical audit tool developed by PEN Computer Systems has been designed to work with the clinical software packages of general practices. It allows GPs to electronically analyse their patient populations using the information already stored in their clinical software packages, such as Medical Director. A wide range of information can be extracted and analysed by the tools, examples being: number of patients with a specific diagnosis, age, gender or cultural background (to some extent), as well as to examine whether clinical best practice is being achieved and clinical targets reached for people with various health conditions.

Structure

Many different queries and reports can be customised to the needs of the practice.

Once a group of clients with the requested characteristics has been identified the tool can provide how many people fit the criteria specified as well as the names and addresses of those people.

Implementation

A general practice can contact their local division of general practice for assistance with installation and implementation of this tool. Although it works with data already entered in a general practice software package, data cleansing is often required.

> For further information, PCPs should contact their local division of general practice.

Practice health atlas

Background

The Practice health atlas is a decision-support tool designed by the Adelaide Western General Practice Network for GPs and other general practice staff. It is being supported in Melbourne through the North East Valley Division of General Practice (NEVDGP).

The atlas is used for mapping client demographics, diagnoses and health services provided, all analysed against national population health data. This tool has a focus on analysing the financial viability of models of practice, particularly in relation to use of MBS items and practice nurses. However, it is also designed as a quality improvement tool and guides practices with PDSA cycles to assist in improvement of chronic illness care.

Structure

There are three main sections of the atlas (plus appendices)

Section 1: Epidemiology and mapping

Section 2: Business and clinical systems modelling

Section 3: Access to services and networks

Implementation

NEVDGP can provide support to general practices wishing to implement the *Practice health atlas* tool.

> For further information, contact <pha@healthprophets.com> (developers of the atlas) or <roy@nevdgp.org.au>, or ph 03 9496 4333 for local support.

Summary

The department does not specify or recommend a particular tool to be used by agencies wishing to evaluate their chronic illness care. Process chosen need to suit local needs.

Another perspective on auditing chronic disease management, and some concise comparative tables, can be found in the publication *Navigating self-management,* which can be downloaded from <http://som.flinders.edu.au/ FUSA/CCTU/self_management. htm#Navigating>.

It needs to be emphasised that an audit tool will not be effective in creating improvements in chronic illness care unless the organisation commits to supporting the changes needed and provides the necessary resources (staff and time) to implement the changes. Although use of an audit tool does assist in raising awareness of good chronic illness care and the gaps in the current systems, change will only happen if an auditing or organisational evaluation process is part of a planned, continuous improvement process. Preliminary discussion and training in chronic illness care is beneficial prior to commencing an auditing process.

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