ACI Chronic Care Network
Launch Event

4 December 2013

Welcome and Introduction

Chris Shipway
Director, Primary Care and Chronic Services
Overview

- Welcome to Country
- Purpose of the day – “Orientation”
  - The ACI and the Clinical Network model
  - The Chronic Care Network
- Introduce the Co-Chairs and the Chronic Care team
- Planning, prioritisation and next steps

The ACI is the lead agency for promoting innovation, engaging clinicians and designing and implementing new models of patient care.
Our Vision

We will be valued as the leader in the health system for designing, evaluating and supporting implementation of innovative models of patient care.

Our Purpose

We work with clinicians, consumers and partners to design and drive evidence based innovation to ensure appropriate, effective and sustainable patient centered health care.
The ACI works closely with the NSW Ministry of Health, LHDs, other Pillars, Medicare Locals, Aboriginal Medical Services and other partners.
We promote an integrated health system

**History**

- 2000: NSW Chronic Care Collaborative
  - Improving care for people with chronic disease: A practical toolkit for clinicians and managers
- NSW Chronic Care Program: Phase 2 and 3
  - NSW Clinical Services Framework: Heart Failure and Chronic Respiratory diseases
  - Rehabilitation for Chronic Disease
- 2008: Chronic Care for Aboriginal People
- 2010: NSW Chronic Disease Management Program – Connecting Care in the Community (CDMP).
Rationale

- Formalise existing governance and strategic advisory bodies for CDMP.
- Align with the ACI’s effective clinical network model.
- Provide a structure for clinicians, consumers and managers to provide advice about opportunities to improve chronic care in NSW.
Chronic Care Network

Purpose

Provide advice and recommendations to improve care across the continuum for people with chronic disease in NSW including by enhancing and integrating care for people with chronic disease across providers, settings and time.

Objectives/ Responsibilities

- Engage and collaborate with key stakeholders.
- Bring together clinicians, consumers and managers across services and sectors who are interested in, working across and managing a range of chronic diseases.
- Promote opportunities to learn from each other and develop synergies to inform policy and practice.
- Improve outcomes for Aboriginal people with chronic disease.
Introducing…

- Interim Co-Chairs:
  - Ms Linda Soars
  - Dr Lissa Spencer

- Manager:
  - Ms Susan Brownlowe

Introducing the Respiratory Network

Cecily Barrack
Manager, Respiratory Network
ACI Network Overview

▲ WHAT is an ACI Network?
▲ WHO is involved in a Network?
▲ WHY were Networks formed?
▲ HOW do they work?
▲ DO Networks drive meaningful change?

What is a Network?

- Clinical Networks provide a forum for doctors, nurses, allied health professionals, managers, researchers and consumers to collaborate across the NSW health system.

- Aim: create an environment and capability for innovation and redesign and promote an integrated health system.
Why were Networks formed?

- Garling Report 2008
- Patient needs are paramount
- Engage the dedication of clinicians in designing new evidence based ‘teamwork’ models of care (MOC)
- Support clinical leaders in the field to implement the changes required
- Monitor to track the degree of success

How do they WORK

- Executive
- Working Groups
- Network Manager

- Evidence into practice - Adult Tracheostomy Care
- Model of Care - Cystic Fibrosis
- Clinical Guidelines - Pleural Drains in Adults
- Workforce development - Pulmonary Rehab
- Clinical Variation - COPD
Do Networks = Silos?

- Lung Cancer: NSW Cancer Institute
- Sepsis: CEC
- COPD: BHI/ LHD pilot sites
- CF: ACI Transition/Pall Care
- Aboriginal Respiratory Health
- Chronic Care for Aboriginal People

Meaningful Change

- **Pulmonary Rehab PR** – clinician concerns/low commence rates/ retention
- **Survey** NSW PR program - workforce needs
- **Data** MoH PR 2008 – 2011/12
- **Education** PR Webex Series in 2012
- **Activity based funding** - IHPA submission
- Intermediate/ advanced PR course 2014
ACI Acute Care Portfolio

- Stroke
- Gastro
- Resp
- Chronic Care
- Cardiac
- Endo
- Renal
Any Questions?

Cecily Barrack
Respiratory Network Manager
94644625
cecil.barrack@aci.health/nsw.gov.au
Engaging General Practice – the hub of primary health care

Dr Liz Marles
ACI GP Advisory Group

What is general practice

Specialists in the whole person - RACGP definition:

• Person centeredness
• Continuity of care
• Comprehensiveness
• Whole person care
• Coordination and clinical teamwork
General Practice – what do we know

- Beach data – 126.8 million consultations 2012-13 from 85% of population
  - Chronic disease – 36% of all consultations
  - Aged 65 and over – 30%
  - New to the practice – 7.2% (decline from 9.3% 2003-04)
  - Number of conditions managed 155 per 100 encounters

General practitioners

- 41.3% aged over 55
- 43% female
- 66.2% gained primary medical degree in Australia
- 55.7 % FRACGP
- Average hours direct patient care 38
What does general practice look like

- Solo GP 10% of practices – common in some areas eg western sydney
- Group practice of 10 or more -21%
- Corporate practice
- ACCHO
- Specialty practice
- Rural practice

General practice models

![Bar chart showing estimated number of corporate practices participating in the Practice Incentive Program – 2010](chart.png)
How do they operate

- 96% computerised
- 31% provide own after hours care
- 14% shared after hours care
- 53% used deputising service

The team

- In the practice:
  - GP
  - Nurse
  - PM and reception
The expanded team

- Psychologist
- Allied health
- Visiting specialist
- Pharmacy
- Community health

Common gripes

- Too much red tape
- Poor communication across sectors
- Poor remuneration for complex work
- Difficulty knowing what support services are out there
- Criteria for accessing programs
- Limited infrastructure
- Time - a scarce resource
Supports for general practices
- Acronym city…..
- ML’s
- RACGP
- APNA, APM
- MDO’s
- RTPs
- RHWA
- In the future ?LHD’s

Why engage
Solve a problem
Simplify a system
Support staff
Make our lives easier
Networks to tap into

- ML’s
- RACGP – faculties
- ACCHO’s
- GP unity

Questions?
Question Time

Chronic Care Overview

Susan Brownlowe
Manager, Chronic Care
Chronic Care at the ACI

Aged Health Network
- Integrated Care for Older People with Complex Health Needs Framework

Cardiac Network
- Clinical Variation Project for CHF and COPD, Rehabilitation for CD Guidelines

Chronic Care Network
- Chronic Disease Management Program + others TBD

Chronic Care for Aboriginal People
- One Deadly Step, Knockout Health Challenge and 48 Hour Follow Up

Endocrinology Network
- Model of Care for Diabetes Mellitus, Rehabilitation for CD Guidelines

Musculoskeletal Network
- Integrated Delivery of MSK Programs (OPR and OACCP) by LHDs and Medicare Locals

Palliative Care Network
- Development of Palliative and End of Life Model of Care

Pain Management Network
- Implementation of Pain Plan and primary health care initiatives

Rehabilitation Network
- Implementation of Rehabilitation Model of Care

Respiratory Network
- Clinical Variation Project for CHF and COPD, Rehabilitation for CD Guidelines

... Plus others!

Chronic Care team

- Supports the implementation of the Chronic Disease Management Program (CDMP)
- + broader work plan related to chronic care
- + will support the Chronic Care Network

Susan Brownlowe
Debbie Banovic
Sarah Barter
Mary Fien
Joe Harrison
Chronic Care activities/achievements

- CDMP Service Model and Self-Assessment
- CDMP Evaluation: Public Health Register
- Governance support
- ADMA Conference
- Review of Rehabilitation for Chronic Disease Guidelines
- Chronic Care for Aboriginal People
- Information systems and technology

...Plus many more!

Structure

Chronic Care Team
- CDMP Evaluation Steering Committee
- CDM Program Steering Committee
- CDMP Implementation Working Group

Chronic Care Network
- CCN Executive Committee
- CCN Manager
- CCN Co-Chairs
- Working Group
- Working Group

Other ACI Networks, Taskforces and Institutes
Network Structure

- Network Member: subscribed to Network mailing list and invited to whole of Network events (1-2 per year).
- Executive Committee member: 15-16 network members who meet bi-monthly to develop and oversee the Network work plan.
- Co-Chairs: 2 Executive Committee members who provide leadership to the Network.
- Working Groups: approx. 2 network members with interest and expertise in specific, time-limited projects.

Chronic Care Network Membership

- Currently over 280 members
- Spread across disciplines, sectors and NSW
- Over 40 nominations for the Network Executive Committee
- 80 expressions of interest for membership to a Working Group
Membership occupation

Membership sector
Membership spread

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<th>Members</th>
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Membership still open!

- We welcome anyone with interest or expertise in improving care for people with chronic disease in NSW.
- To apply for membership or express interest in the Network Executive or Working Group, please contact: chroniccare@aci.health.nsw.gov.au
Supporting Aboriginal People with Chronic Disease

Raylene Gordon
Manager, Chronic Care for Aboriginal People
Function

To provide strategic advice on the development and implementation of CD prevention and management policies and programs to NSW Stakeholders involved in improving the health of Aboriginal people in NSW
**NSW Aboriginal Health Partnership Committee**

- Sub committee
- Operates on the same guiding principles
- AH&MRC and NSW Government equal members
- Brings ACCHS expertise and experience to health care processes of the NSW Government

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**Key Priority**

Development of a high level strategic framework for CD Prevention and Management for Aboriginal people in NSW

1. Vision
2. Key principles
3. Agreed definition
4. Key priority areas
5. Roles of stakeholders
6. Time frame - June 2014 complete
Follow up

Development of a framework for the follow up care of Aboriginal people with Chronic Disease

1. Established working group
2. Building on the 48 hour follow up program
3. Involving integration across sectors and levels of care
4. Support local collaborative service planning
Membership

- ACI & AHMRC – Co chairs
- Ministry of Health (CAH and population Health)
- ACCHS
- LHD representation
- OATSIH
- GP NSW
- RACGP
- Medicare local representation

Chronic care Network

“tailored Solutions to increase equity and access”

1. What will be the relationship with the partnership committee
2. Will there be appropriate Aboriginal representation on the network
3. How will the network support Aboriginal specific work
4. How will implementation be supported
Aboriginal specific Network

- Re-working the function
- Broader focus than Chronic Disease
- Implementation support for Networks
- Examples include, use of the Aboriginal Health Impact statement, consultation processes, integration & partnerships, governance, cultural training

Thank You!
Workshop: Network Priorities
Linda Soars and Lissa Spencer
Co-Chairs

Purpose

- Membership application form asked members to identify their top 3 priorities for the Network.
- This information was reviewed to identify 5 overarching themes for prioritisation.
- Workshop outcomes will be presented to the Network Executive Committee at their first meeting to inform the development of a work plan and the establishment of Working Groups.
Priorities

- Integration, collaboration, coordination.
- Communication and information systems.
- Access and equity.
- Innovative, community-based service models that support self-management.
- Service improvement through research and evidence.

As identified from the Chronic Care Network membership applications

Process

- Each group to review and discuss the 5 themes.
- Nominee from each group to feed back key points from the discussion.
- On butcher’s paper, each person to place a gold star against your top priority and silver star against the second top priority.
- Tally up results.
Next Steps

Linda Soars and Lissa Spencer
Co-Chairs

- Appoint interim Chronic Care Network Executive Committee
- Hold first Network Executive meeting: early Feb 2014
- Circulate Chronic Care eNewsletter
- Anticipate next Network event: July 2014
Next Steps

Executive Committee

▲ Meeting frequency: Bi-monthly
▲ Term of office: interim 12 month period with possibility of reappointment for a further 12 months.
▲ Appointment process: Panel to review nominations and appoint based on representation and skill mix.
  ● Future appointment process to be determined by the Network

Next Steps

Chronic Care eNewsletter

▲ Frequency: Bi-monthly
▲ Content
  ● Outcomes from Network Executive meetings
  ● Updates on Chronic Care Network activities and achievements
  ● Upcoming events and training opportunities
  ● New reports and resources related to chronic care
Next Steps

- Chronic Care webpage/ intranet

▲ Content
- Our people: Co-Chairs, Executive Committee and Chronic Care team
- Publications and resources
- Events
- Links

▲ Functions
- News
- Discussion board/forum
- Calendar
- Library
- Contacts

Thank You