CHRONIC CARE NETWORK

TERMS OF REFERENCE

REPORTS TO
ACI Executive
Chronic Care Network Executive Committee

CHAIRPERSON(S)
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SECRETARIAT
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ENDORSED BY
Chronic Care Network Executive

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NEXT REVIEW
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1. BACKGROUND
The Agency for Clinical Innovation (ACI) supports state-wide clinical networks which harness the clinical expertise and practical knowledge of people working in the NSW health system. The clinical networks provide a framework for clinicians and consumers to meet across regional and service boundaries with a mandate to drive improvements in health service delivery and translate innovative ideas into sustainable system-wide change proposals.

The ACI’s clinical networks collaboratively to develop evidence-based models of care, best practice guidelines and other resources and work with partners within the NSW health system to support the implementation and uptake of these resources to achieve both improvements in and greater equity of patient outcomes across NSW.

In 2010, the NSW Chronic Disease Management Program - Connecting Care in the Community (CDMP) was implemented across NSW to provide self-management support and care coordination to people with chronic disease at high or very high risk of hospitalisation. The program aimed to enhance and integrate existing chronic diseases services to reduce potentially preventable hospitalisations. The ACI Chronic Care team supported the statewide implementation of CDMP.

The Chronic Care Network evolved from an established base of a less formal clinical network of managers responsible for the implementation of the CDMP at the local level. This group, initially convened by the NSW Ministry of Health, held monthly teleconferences to discuss and share issues regarding the delivery of the CDMP.

In recognition of the disproportionate burden of chronic disease borne by Aboriginal people in NSW, the ACI also supports the Chronic Care for Aboriginal People (CCAP) Program. This program provides the strategic direction for existing and new initiatives that address chronic care service delivery for Aboriginal people. The CCAP Aboriginal Chronic Care Coordinators meeting is the key communication mechanism between the ACI CCAP team and LHDs. This group primarily discusses CCAP initiatives and their progress.
2. PURPOSE
The purpose of the Chronic Care Network is to improve care across the continuum for people with chronic disease in NSW. It does this by enhancing and integrating care for people with chronic disease across providers, settings and time.

In order to achieve its purpose, the Chronic Care Network will consult and collaborate across the ACI and with key stakeholders including general practice, primary health care organisations, community health, Aboriginal health (including Aboriginal Medical Services), Primary Health Networks, Local Health Districts, acute hospitals, rehabilitation clinicians, medical specialists, Non-Government Organisations, consumers and residential aged care facilities.

The ACI Chronic Care Network will act in accordance with ACI values and policies at all times. These are available on the ACI website at www.aci.health.nsw.gov.au.

3. RESPONSIBILITIES / FUNCTIONS
The ACI Chronic Care Network will:

- Engage key stakeholders including health managers, clinicians, consumers, carers and other organisations to achieve its purpose.
- Strengthen relationships with primary and tertiary health care providers.
- Provide and seek advice about innovations and improvements in chronic care.
- Assist with the ongoing development and implementation of CDMP and variations in service delivery models.
- Advise on improving the responsiveness of mainstream health services in meeting the needs of Aboriginal people with chronic disease.
- Identify opportunities to better integrate services for people with chronic disease.
- Develop recommendations for improving chronic care in NSW through service integration, consideration of appropriate funding mechanisms and performance management approaches.
- Identify strategies and resources to support improved chronic care.
- Develop strategies for improving chronic care for priority populations, particularly Aboriginal people and frail elderly, and ensuring appropriate service provision.
- Advocate for the prevention of chronic disease.
- Share knowledge, information and resources about evidence-based chronic care and innovations in clinical practice.
- Develop a communications strategy to raise awareness of chronic care in NSW.
- Identify potential areas for future research and evaluation.
- Establish time-limited, task-oriented working groups from the Network membership to progress identified areas of work.

The ACI Chronic Care Network will provide expert advice and updates on its activities to the ACI Executive.

4. MEMBERSHIP
Membership to the ACI Chronic Care Network will be open to people with an interest and expertise in chronic care in NSW.

Membership will include but is not limited to:
- Chronic Disease Management Program Managers and other CDMP staff
5. STRUCTURE
The Chronic Care Network includes the following membership levels:
- Network Member: subscribed to Network mailing list, invited to attend whole of Network events and participate in Working Groups.
- Executive Committee Member: 15-16 Network Members, representative of the interdisciplinary membership, who oversee the establishment of all Network projects and activities.
- Co-Chairs: 2 Executive Committee Members who provide leadership to the Network.
- Working Group Member: approximately 12 Network Members with interest and expertise in working on specific, time-limited Network projects and activities.

The ACI Chronic Care Network will establish time-limited, task-oriented Working Groups to progress key activities identified by the Network or the ACI Executive. The Chronic Care Network will include the CDMP Implementation Group and the CCAP Advisory Group as permanent Working Groups of the Network. These groups will provide strategic advice to the Chronic Care Network and the Chronic Disease Management – Connecting Care Steering Committee.

6. CHAIR ARRANGEMENTS
Two Co-Chairs of the ACI Chronic Care Network will be elected from the Network membership. The Co-Chairs term of office is 2 years, with an option of re-election for a further term of 1 year. It is preferable that both Co-Chairs do not change at the same time to facilitate continuity.

7. GOVERNANCE
The Chronic Care Network will establish an Executive to represent the interdisciplinary membership including clinicians, consumers and managers. The Executive will comprise 15-16 Network members representing:
- Chronic Disease Management Program
- Chronic Care for Aboriginal People
- Other chronic disease initiatives
- Metropolitan, regional and rural and remote health services
- Mix of disciplines
- Consumers
Additional members may be invited to join the ACI Chronic Care Network Executive Committee as appropriate to the work plan and agenda.

8. FREQUENCY OF MEETINGS
The ACI Chronic Care Network Executive will initially meet face-to-face every 2 months, with the option to increase or decrease the number of meetings as determined by the Network. Teleconference and videoconference facilities will be available, including Webex where appropriate.

9. QUORUM
Quorum will be based on adequate interdisciplinary representation of the Chronic Care Network Executive membership. All members will receive electronic communication of meeting agendas and will have the opportunity to attend by teleconference/videoconference, and to provide input in advance if unable to attend scheduled meetings.

10. METHOD OF EVALUATION
The purpose and performance of the ACI Chronic Care Network will be reviewed at least every two years against the Terms of Reference and work plan.