Chronic Disease Management, Chronic Care Program (CCP)

Organisation: ACT Health

Contact: Elizabeth Forbes, Clinical Nurse Consultant/ Nurse Manager

General overview of your service and the main components of the service: The CCP targets frequent users of the acute sector with Heart Failure, COPD, Parkinson 's disease and other conditions by arrangement. Clinical care coordinators provide individually tailored services including self-management strategies, Advance Care Planning, education, facilitation and coordination of community and other support services. This is done through a combination of home visits and phone calls.

Aims/objectives. For patients to:

- Increase their knowledge of their chronic condition and self-management.
- Keep as well as possible by recognising signs and symptoms of a deterioration and taking steps as per prescribed action plan.
- Remain engaged with the health system and attend appointments.
- Use community and support services to maintain an acceptable quality of life at home.

Is your service a pilot or has it been mainstreamed? Mainstreamed

What is your patient demographic? Adult patients living in the community. The majority of our patients are over 50 years old.

How many staff are involved in delivering the service by discipline or health professional group?

1x CNC/nurse manager

1x Registered nurse level 2

3x Clinical Care Coordinators (open to any health professioncurrently we have 1x social worker, 1x occupational therapist, 1x dietician)

1x administration officer

Do you measure outcomes? If so what outcomes are measured?

- Number of patients on the service
- Occasions of service (number of contacts with the patient - face to face, over the phone, and indirect)
- Number of patients who have a patient centred care plan created within 4 weeks the initial home visit
- Number of patients who have an Advance Care Plan completed