Complex Chronic Disease Team (CCDT)

The Complex Chronic Disease Team (CCDT) provides a range of services for adults with chronic and complex health conditions. The aim is to provide coordinated and integrated care that improves and supports individual clients to optimise and manage their health and wellbeing within their community.

The service provides access to a multidisciplinary team (medical, nursing and allied health) who will undertake a comprehensive assessment, develop an individualised client care plan and deliver interventions that meet the diverse needs of clients referred. Services provided include the following:

Complex Needs Service

The complex needs service focusses on clients whose care needs require greater than usual levels of health care management due to a range of interacting physical, psychological and social factors. The Complex Needs Service provides comprehensive and coordinated, specialist multidisciplinary and medical assessment to identify the client's current care needs and develop an individualised care plan. Interventions focus on addressing factors that limit the client's wellbeing and ability to manage their complex care needs and linking clients with sustainable longer term supports.

The Complex Needs Service has an extensive team of health professionals providing specialist care including:

- Dietitians
- Neuropsychologists
- Occupational therapists
- Pharmacists
- Physiotherapists
- Psychologists
- Social Workers
- Speech Pathologists
- Nurses
- Geriatricians
- General Physicians

Clients referred to this service are those that experience:

- High risk of deterioration or rapid functional decline due to difficulty managing their chronic health conditions
- Complex multidisciplinary needs that cannot be effectively managed via GP, community services or outpatient clinics
- A pattern of frequent emergency presentations and hospital admissions
- Vulnerability due to poor psychosocial support and with complex socioeconomic needs

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The Complex Needs Service operates out of the North Lakes Health Precinct and Nundah Community Health Centre, offering appointments face to face in the clinic or client's own home* or via telehealth.

**Home visits are limited and will not be provided to high-risk clients or environments.*

General Physician consultation services are provided for clients requiring a coordinated management approach due to multiple interacting comorbidities and polypharmacy.

Geriatrician consultation services are provided for clients requiring a comprehensive geriatric assessment with a coordinated medical and multidisciplinary management plan to address issues such as cognitive impairment, falls, incontinence and polypharmacy.

Exclusion Criteria

Clients who reside in a Residential Aged Care Facility or those with established comprehensive care packages (e.g. NDIS, level 3 or 4 Home Care Packages) with access to required multidisciplinary supports are not suitable for referral to the service*.

**Referrals for multidisciplinary healthcare needs not provided by the comprehensive care package may be considered for the Complex Needs Service and/or Specialist Medical Clinics.*

Other exclusion criteria include clients requiring:

- single discipline intervention – we recommend clients discuss accessing My Aged Care or Medicare rebates for certain allied health services with their GP
- maintenance therapy
- ongoing intensive rehabilitation interventions
- immediate intervention or acute care management
- a seven day a week service
- primary care needs relate to drug and alcohol dependency or mental health issues
- palliation

Cardiac Rehabilitation

The Cardiac Rehabilitation service provides an integrated education and exercise program for clients following a recent (within 6 months) cardiac event including NSTEMI or STEMI, Coronary Artery Bypass Grafting, Cardiac Valve Surgery or clients who have medically stable Heart Failure.

The program is conducted over 6 weeks and includes the following:

- Exercise program – once or twice weekly in a gym setting or via telehealth in the client's own home*
- Education program – varying topics related to health, diet and fitness
- Access to multidisciplinary allied health team for identified needs/goals (as per Complex Needs Service)

** Clients will be assessed for suitability for home based virtual care delivery and only offered this option if clinically appropriate*

The service is available at various locations throughout the Metro North catchment

Exclusion Criteria

Referrals are not accepted for atrial fibrillation, permanent pacemaker or angina as the primary cardiac condition. Consultation with the client's GP to develop a cardiovascular Chronic Disease Management Plan is recommended.

Pulmonary Rehabilitation

The Pulmonary Rehabilitation service provides an integrated education and exercise program for clients with a pulmonary diagnosis who are medically stable and would benefit from group-based exercise sessions. Client groups include COPD, Bronchiectasis, Interstitial lung disease, Pulmonary Fibrosis or pre transplant.

This program is conducted over 8 weeks and includes the following

- Group exercise session – once or twice weekly in a gym setting or via telehealth in the client's own home*
- Education program – varying topics related to health, diet and fitness
- Access to multidisciplinary allied health team for identified needs/goals (as per Complex Needs Service)

** Clients will be assessed for suitability for home based virtual care delivery and only offered this option if clinically appropriate*

The service is available at various locations throughout the Metro North catchment

Exclusion Criteria

Referrals are not accepted for clients who have completed a Pulmonary Rehabilitation program in the past year or post acute general respiratory illness (e.g. pneumonia without a history of COPD or chronic respiratory condition).

When will my client be seen?

All referred clients are prioritised according to their needs. Following referral, a letter will be sent to the client and GP advising of their initial appointment.

Is there a cost?

There is no cost for services provided by the team.

How do I refer?

Referrals are made via the Community and Oral Health Central Referral Unit (Tel: 1300 658 252). Referrals are accepted from hospitals, General Practitioners and other Queensland Health community services.

For Complex Needs Service and Pulmonary Rehabilitation, please:

- complete refer (electronic referral) if you are a MNHHS employee, or
- use GP referral system for GPs, or
- complete a paper referral form if you are an external referrer, including other HHS employees and fax to 3360 4822 or call CRU on 1300 658 252

For Cardiac Rehabilitation, please:

- refer via QCOR (electronic referral) if you are a QH employee, or
- call CRU on 1300 658 252 if you are an external referrer

For all referrals, please attach recent investigations and clinical assessments