Annual Snapshot 2024/25

About us:

Team Care Coordination is a free service delivered by health professionals who **work with clients to:**

Provide education on chronic conditions, health care and community services

Coordinate health, community and social support services, for people with chronic health conditions aged 18 and over

Support the communication between clients, service providers and health professionals

The three most common diagnoses affecting our clients are:

590 ***Falls and frailty***

359 ***Cardiovascular disease***

224 ***Cognitive decline***

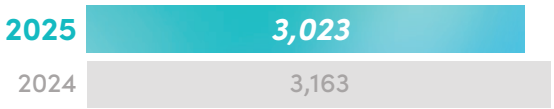
What we have achieved:

In FY2024/25 we supported

2,064 CLIENTS

- Face to face visits
- Telehealth
- Phone cases

Referrals at consistently high levels:



65% were from hospitals

35% were from GP practices

Health outcomes

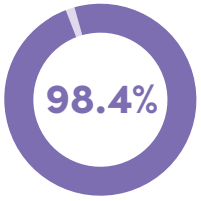
Overall the majority of clients demonstrated improved patient enablement with 91.3% reporting they were better able to cope with their chronic health condition and **76.4% of clients had their goals fully met.**

Equity

11.5% of our clients are from **Culturally and Linguistically Diverse** backgrounds and **1.7%** of clients identified as **Aboriginal and/or Torres Strait Islander.**

We service the North Brisbane and Moreton Bay regions. Our data indicates that some areas within these regions experience significantly higher levels of socioeconomic disadvantage, higher prevalence of chronic health conditions, burden of disease and mortality rates. This may contribute towards higher needs of clients residing in these areas.

Client and provider experiences:



OF CLIENTS would recommend Team Care to others

> *"We have more understanding of the aged care system now and where we stand in it."*
>
> **– Client**

> *"A very positive experience. My nurse gave us their time, generously and kindly, which continued in follow-ups."*
>
> **– Client**

> *"I felt totally at ease with my nurse - she was very helpful, and I hope to see more of her."*
>
> **– Client**

> *"The approachability of the phone staff/nurses. Friendly and reliable. TCC has been a great resource/support in my assessment outcomes."*
>
> **– Referrer**
>
> *Knowing that a professional in the community is able to 'hold their hand' to implement home services/help at home – rather than just given them all the info and leave them to it – because many persons are unable to do this for themselves."*
>
> **– Referrer**

We support people to live well at home for longer.

Refer to us:

How to refer

We accept referrals from GPs and practice nurses, hospitals through the Staying Healthy Staying Home Program, Community Providers and client self-referrals. For more information on how to refer, please go to *this website* or call the Service Navigator helpline on 1800 250 502.

Eligibility

Patients are eligible if they:

- Have at least one or more chronic complex health condition.
- Live in the North Brisbane and Moreton Bay region.
- Are not living in a residential aged care facility.

SERVICE NAVIGATOR HELPLINE (1800 250 502) is available to health professionals for advice and information about health and community services available across the North Brisbane and Moreton Bay region. In the FY2024-25

THE SERVICE TOOK 1,216 ENQUIRY CALLS from providers.