Contact us

To discuss a referral or for more information contact our Service Navigator on 1800 250 502.

Team Care Coordination

t 1800 250 502
f 07 3630 7808
e info@brisbanenorthphn.org.au

Team Care Coordination is managed by Brisbane North PHN and is supported financially by Metro North Hospital and Health Service.

TEAM
CARE
COORDINATION

Healthcare coordination for patients with chronic complex health conditions

Information for GPs

Phone us on **1800 250 502**

Team Care Coordination supports patients who have chronic complex medical conditions to improve or maintain their health and wellbeing at home.

Patients can access Team Care Coordination via referral from their GP or on discharge from a public hospital in the North Brisbane and Moreton Bay region.

Patients who do not require urgent complex clinical services but who may benefit from support at home may be eligible for support under Team Care Coordination.

The role of a Team Care Coordinator

Team Care Coordinators are registered nurses who have a wealth of knowledge about local public, community and private healthcare services.

Our Coordinators conduct comprehensive assessments in the patient's home and work with patients and their carers to arrange support as identified and agreed at the assessment.

Our Coordinators can be included as a nominated health professional in a Team Care Arrangement.

Team Care Coordinators can assist with:

- in-home assessments
- referrals to allied health, hospital and community services
- accessing equipment and home help services
- post-hospital discharge
- coordinating access to long-term support programs
- educating patients about self-management services available to them to improve or maintain their independence at home.

Our Coordinators liaise with not just the GP and patient, but hospitals and other health and social services the patient may need.

Team Care Coordinator Sue King said, "When we visit a client to do an assessment, we can also see how the patient is coping at home."

"A simple piece of equipment can aid a person's independence and safety or a regular support or respite visit can make a world of difference to those caring for people living with health problems.

"We also provide a lot of information to patients so they are aware of organisations that can help them, like home safety services, community transport options, programs that help people manage chronic disease and even information about the Carer Allowance," Sue said.

Cost

There is no cost for eligible patients to access Team Care Coordination.

Consent

Patients must provide written consent to participate in Team Care Coordination. This will be done with the Team Care Coordinator once the patient has been referred.

The Team Care Coordinator will provide written consent information to the patient or their carer and ensure they understand the conditions of participating in Team Care Coordination.

Ceasing care

Patients remain with Team Care Coordination for as long as it takes to put in place the services indicated in their plan.

The average time patients spend with Team Care Coordination is 3-6 months however, if an individual's circumstances change, they can be re-referred to Team Care Coordination.

Patients can withdraw at any time from Team Care Coordination. They will need to complete a withdrawal form.

Eligibility

Patients are eligible for Team Care Coordination if they:

- have at least one chronic complex medical condition that is likely to be present for more than six months
- are living independently in the community (not in a residential care facility)
- don't already receive a high level Home Care Package.

Referring

All referrals are processed centrally by the Team Care Coordination central intake. There is no limit to the number of referrals.

GPs can refer to Team Care Coordination if they work within the North Brisbane and Moreton Bay region, including parts of the Somerset region. To refer:

- advise the patient of intention to refer to Team Care Coordination and gain their agreement
- complete and send referral and health summary to Team Care Coordination:
  - » **eReferral**: send via secure messaging to teamcare (MM4030000FT)
  - » **Fax**: fax referral letter and patient health summary to secure fax 07 3630 7808.

eReferral forms

eReferral templates can be imported from www.brisbanenorthphn.org.au

What happens after I refer my patient to Team Care Coordination?

Upon referral to the program, one of our Team Care Coordinators will:

- acknowledge receipt of the referral
- advise the patient's GP of the referral (if referred on discharge from hospital)
- make an appointment with the patient for an in-home assessment (or at the patient's general practice if preferred)
- provide the patient's GP with a written report of the assessment
- provide a report to the patient's GP at three months.

Helping you navigate local services

Our Service Navigator helpline (1800 250 502) provides health professionals with advice and information about health and community services available throughout the North Brisbane and Moreton Bay region.

Service Navigator can provide information about allied health and hospital services, community and home support, and government health-related assistance schemes.

Our Service Navigator operators are registered nurses who understand care coordination, chronic disease management and the local health system.