# Annual Snapshot 2023/24

## About us:

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

Provide disease, health and community service information

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:

***Falls and frailty*** ***Cardiovascular disease*** ***Cognitive decline***

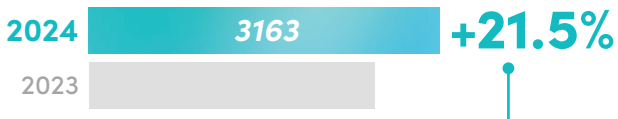
## What we have achieved:

In FY2023/24 we supported

**2,070 CLIENTS**

- Face to face visits
- Telehealth
- Phone cases

**Referrals have continued to grow:**




**65%** were from hospitals

**31%** from GP practices

**4%** from Queensland Ambulance Service

### Health outcomes

Overall the majority of clients demonstrated improved patient enablement with 82% reporting they were able to cope with their chronic health condition and **79% 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. The higher proportion of clients in these areas may reflect the higher needs of the clients in these areas due to socioeconomic disadvantage, higher prevalence of chronic health conditions, burden of disease and mortality.*

# Client and provider experiences:


**OF CLIENTS**
would recommend
Team Care to others

*"I feel safe showering and living on my own now."*

**– Client**

*"The TCC team were professional, caring and exceptional."*

**– Client**

*"Team Care Coordination provides a high impact service to the most in need patients I care for. When all else fails...I refer to Team Care and you never disappoint. No other service addresses this gap in care for the most vulnerable members of our community."*

**– Provider**

*"The nurse was very kind, considerate of my feelings and explained everything well."*

**– Client**

*"Rapid, personalised assessment and support for patients, particularly those who are vulnerable."*

**– Provider**

# 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 medical 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 FY2023-24 **THE SERVICE TOOK 1084 ENQUIRY CALLS** from providers.