

Team Care Coordination is a service available to General Practitioners offering a coordinated, team approach to managing patients with chronic and complex conditions.

Team Care Coordination offers you an extra pair of hands and a greater sense of wellbeing and support for your patients.

“My GP told me that Team Care Coordination would be able to help me stay in my home.

I have been supplied with a personal alarm. The dietician has made an appointment and I now have taxi subsidies.

My daughter feels less stressed because my GP and my Team Care Coordinator are working together to keep me well.”

—Lyla, Team Care Coordination participant

TEAM[®]
CARE
COORDINATION



Ph 1800 250 502
(freecall)

Team Care Coordination is managed by GPpartners Ltd and is supported by public and private health funders.

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*GPpartners catchment – All suburbs north of the Brisbane River including Pine Rivers (now part of Moreton Bay Regional Council); west to Bellbowrie; and east to Sandgate.



Health care coordination for people with long term health conditions.

TEAM[®]
CARE
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Thinking outside the box.



- Team Care Coordination is an independent program managed by GPartners Limited, a division of general practice.
- Funding from Queensland Health provides us with the flexibility to subsidise some treatments and services for patients.
- Our Team Care Coordinators work with you, your patients and your practice team however, they are not a replacement for any member of your team.
- Team Care Coordination keeps the GP informed about their patients care and progress.
- Team Care Coordination compliments services already in place for your patients.
- Team Care Coordination is supported by the Health Record eXchange (HRX), a shared electronic health record system.

Our Team Care Coordinators will work with you to assess patients with chronic disease and to plan and organise the services they need.

How to get involved

GPs who work within GPartners catchment area* can participate. You and your practice team must be willing to commit to the Team Care Coordination program, including:

- identifying eligible patients
- undertaking care plans for eligible patients
- working with our Team Care Coordinators
- using the Health Record eXchange (training provided)
- allowing Team Care Coordinators access to your patients and their records.

Patient eligibility

Patients are eligible if they:

- have at least one chronic or complex medical condition that is likely to be present for more than six months
- understand the broad purposes of the program or have a guardian, statutory health attorney or an Enduring Power of Attorney for personal matters, who does.

Patients who are residents of aged care facilities or who are already receiving certain packages of community care, may not be eligible for the program.

About our Team Care Coordinators

- Team Care Coordinators are Registered Nurses who have extensive experience in the community and in general practice.
- Our Coordinators can undertake patient assessments (at home or in the practice) and can source and arrange services identified in their care plan.
- Team Care Coordinators act as a liaison between the patient, their GP, hospitals and other health services.
- Team Care Coordinators become a trusted part of the patient's care team and can help them to better understand how to manage their conditions.
- Our Coordinators have excellent knowledge of both community and private providers—from home nursing, allied health and domestic services to transport, communication aids and dog-walking!
- Our Coordinators can train your staff to ensure your practice can sustain a team approach to caring for patients with chronic illness.