Latrobe Community Health case study

Implementing electronic shared care plans

The Chronic Care Model element highlighted in this case study is clinical information systems. Efficient and effective chronic care requires clinical information systems that organise individual and population data, and support the sharing of data with other care providers.

Background

Latrobe Community Health Service and Latrobe City Council have been working together for a number of years to improve coordination of care for people who are using both services.

What they did

The two organisations developed an agreement to undertake joint assessments and have a shared care plan for clients with complex needs who were accessing both services.

Occupational therapists from Latrobe Community Health Service are collocated at Latrobe City Council two days per week.

Complex clients are flagged by intake during their initial screening questions, and additional screening questions are asked.

The assessment officer and the occupational therapist use this information to determine if a joint assessment is needed.

Following assessment, a support plan is developed so that both organisations can access and contribute to it.

The support plan is developed and housed electronically using the S2S system. The S2S system is a secure platform that links to both organisations’ information systems.

The system allows practitioners from organisations using the system to view and contribute to the shared support plan.

Practitioners involved in a client’s care can see the assessment information, the practitioners involved in providing care, and any updates or changes in care.

Latrobe Community Health Service has embedded the shared support plan into organisational processes. If a shared support plan is in place, it is also used as the organisational care plan to avoid duplication of documentation.

The S2S system provides alerts in the organisational client management system that allows staff to clearly identify if a client has a shared support plan and when other practitioners have added information to the plan.

Staff can also use the system to make referrals and communicate with other practitioners involved in the client’s care.

Processes and protocols for developing shared support plans including determining who initiates and coordinates the support plan have been developed internally and with participating organisations.
Outcomes

The joint assessments and electronic shared support plans have improved information sharing and created easy access to a record of the client’s ongoing care.

The system allows other practitioners involved in a client’s care to see the assessment information, who else is involved in the person’s care, and any updates or changes in care. These processes have resulted in improved communication, streamlined referrals and reduced duplication of documentation.

The joint assessment between the Home and Community Care assessment officer and the occupational therapist supports a comprehensive assessment of the client’s needs in one visit, and streamlines the organisation and provision of service.

The joint assessment also helps make the assessment process clear for clients and minimises the number of people that they need to tell their story to.

One drawback of the system is that some other services in the region are not able to access, or are not registered on, the S2S e-support plan system, which means staff need to communicate with these organisations through written or verbal communication.

The client case study below highlights the advantages of the joint assessment and shared support plan.

Fred’s story

Fred and his twin brother were referred to Latrobe City Council for meals on wheels.

A number of issues were highlighted by Fred during a Living at Home Assessment, which flagged the need for a joint assessment.

The assessment officer organised a joint assessment with the occupation therapist from Latrobe Community Health.

Following a joint assessment, a number of issues were identified and services were put into place. These included:

- The brothers were often eating take away because they were not very organised with meal preparation. This was causing quite a financial burden. A referral was made to the dietitian and meals on wheels was organised.
- Fred was having swallowing issues so a referral to a speech pathologist was made.
- Fred indicated that he was having difficulty with personal care caused by dizziness and constant fatigue. The occupational therapist provided a shower chair/stool and energy conservation information, and trialled strategies to improve issues with getting in and out of bed. A referral to the physiotherapist was made in order to provide a home-based exercise program. Contact was made with the mental health caseworker involved in Fred’s care and the caseworker organised a chart for Fred to follow to assist with his medication.
- Fred appeared to be in severe pain and seemed very depressed, often crying during the assessment and talking of suicide – Fred stated that nobody would help him. Fred reported that he had a history of suicidal episodes.

A review meeting with all those involved in Fred’s care was held to ensure that everyone was working towards the same goals with the brothers.

During this process, the brothers indicated that they were not paying their bills and were spending a lot of money at the pokies.

Referrals were made for financial counselling and support, and to gamblers support.

An electronic support plan was put in place for Fred. This provided those practitioners involved in Fred’s care with access to the e-care planning system to see the assessment information, and allowed practitioners who were involved in Fred’s care to add any updates or changes in care to the e-support plan.

The e-support plan improved communication, streamlined referrals and reduced duplication of documentation.
Clear communication between the service providers identified the roles and responsibilities that each would undertake, which helped reduce the brothers’ problems understanding who to seek help from and how to seek help.

Fred is now doing well; he is accessing services in the community independently, attending the mental health day program and assisting his brother with the shopping. He has a more positive attitude towards everything, no longer crying and feeling sick all of the time.

The brothers have cancelled meals on wheels and are purchasing more nutritious food and cooking for themselves, and they are also managing their own housework. Fred is now taking his medication regularly and is no longer in pain.

They are still receiving assistance with financial counselling but their debts are being managed better.

The electronic support plan continues to keep everyone up to date, and services and supports are better managed with greater understanding by all in terms of what is being done when and by whom.