

CONFERENCE ABSTRACT

Using Co-Design Process To Develop Care Options For People With Chronic And Complex Care Needs Across Four (4) Community Health Services In The

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In 2013/2014 Southern Melbourne Primary Care Partnership facilitated Assessment of Chronic Illness Care (ACIC) audits in the four Community Health Services in its region. This sparked a discussion of progress in implementing Chronic Disease Management approaches in community health. As a result in 2015, the Southern Melbourne Primary Care Partnership established a co-design process to further develop, imbed and sustain a model of care for community health to support people with chronic and complex conditions.

Through a series of facilitated workshops and using consensus decision making, clinicians, managers and primary care partnership representatives worked together with consumers to develop a common model of care. Activities included:

- Listening to client experience of care
- Mapping the client journey
- Discussing the challenges and barriers facing practitioners in delivering care
- Examining existing person centred care models
- Using client experience to design the model

The resultant Model of Care provides care options for clients when they are self-managing and when they need comprehensive assistance and care coordination. It has 'built in' fluidity enabling the client to move through care options dependent on their changing health status. The implementation of the Model will provide consumers with a consistent community health experience across the region. While partial implementation of the model has already occurred, formal implementation in all four (4) Community Health Services will occur from August.

Our presentation will include:

- evaluation of the co-design process
- proposed post-implementation evaluation framework

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