

STRATEGY 2015



Everyone's Community Health and Care

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The RDNS SA profile ...

115 years of community health service to South Australians

45,000 occasions of service each month

Cover Gawler/Barossa to Victor Harbor and across the Adelaide Hills, and Queensland

\$50 million per annum in revenue

Government funded programs and fee for service

Specialist services in Diabetes, Wound care, Palliative Care, Continence, Mental Health, Disabilities, Gerontology, HIV/AIDs, Homeless, Immunisation

More than 630 staff

Clinicians are Allied Health, Care Workers and Nursing

Registered Training Organisation providing Education to more than 300 students each year (and growing)

Internationally renowned Research Unit that has held all category 1 research grants

Our ambition is to **reshape in-Community Health and Care in Australia** improving the **quality of life** and **lifestyle choices** of those who require support to continue to **live independently**

We **grow by providing services** through governments, partners and direct to individual clients

This in turn generates funds that enable us to **extend services to individuals and communities who are disadvantaged**— in pursuit of our ultimate goal - that **every Australian has access to health and care support where and when it is needed...**

On their own terms

“ A wellness, rather than dependent and sickness model”

Our corporate goals are ...

The leading health and care provider in Australia

The leading health and care contributor to disadvantaged Australians

The leading health and care employer in Australia

Gain financial independence

Strategy 2015 is our Pathway to achieving these corporate goals

Drivers for change...

Newly constructed forward thinking Board

Changing landscape of Health and Care at both State and Federal levels

Passion to move from sickness model

Reducing market share and feedback from stakeholders

Being clearer on reason for being

Survival



RDNS SA has changed...

We are a flexible and responsive health service focused on wellness outcomes delivered in a primary care setting

We have a new model of care that gives people a greater choice in health and care support

We ensure clients who are aging and/or have chronic conditions have access to flexible care packages

We provide services that deliver the best possible outcomes

We have reviewed our Board and Governance structures

We have embraced new **Values** and created a **Culture** where entrepreneurialism and agility thrives

We use our strong Research function to inform model of care and service provision

We diversified our workforce

Model of care...

Innovative services

Care across the lifespan

Strategic direction
Supportive policies & procedures
Clinical pathways

Professional development
Continuing education
Clinical decision making

Keeping people healthy at home

Care across the continuum



RDNS SA on the move...

Regional & National expansion of Healthcare,
Education & Training Services

Delivery of Education & Training products to an
International market

Launch into South East Queensland in November 2009

Launch into Sunshine Coast October 2010

Plans for NSW expansion late 2010



RDNS SA on the move...

Established world first 'Virtual Hospital' telehealth service delivering home nursing services utilising videophone technology. Plans in place to expand coverage

Successfully trialled Integrated Community Care for Older People (ICCOP) model of care demonstrating reduction in unplanned ED presentations and hospital admissions and bed days saved

Received 2009 Federal Minister for Ageing Award for excellence in Aged Care – *Excellence in Innovation in Information Technology* for 'Mobility Solution'

Future

- Health Coaching
- Strengthening Paediatrics

Examples of delivery in action ...



ICCOP...

Partnership between:

RDNS (3 Clinical Practice Consultants)

RDNS Direct – 24 hour Contact Centre

Adelaide Western GP Network

3 GP Practices (currently 17 GPs and growing)

TQEH (Emergency Dept and Geriatrician)

AIM

NOT to duplicate services

Goal ...

To assist clients who are indentified as having complex health care needs **AND** who are deemed at risk of unplanned hospitalisation

Early intervention to prevent further deterioration

Designed to link clients to appropriate services within their own community

Right Care, Right Time, Right Place



Clients ...

65 years +

ATSI 45 years +

Multiple complex health problems

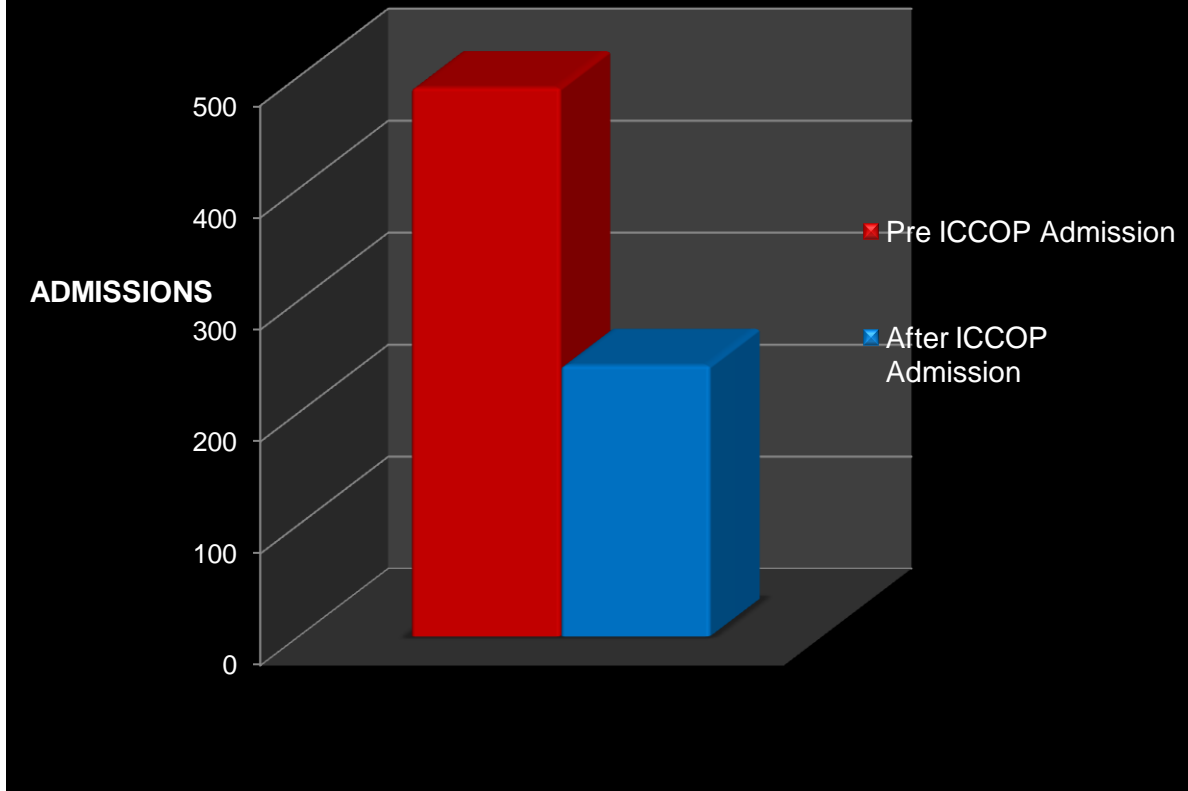
Frequent presentations to TQEH (or at risk of)

Patients of GP Clinic involved in the Program

Are not receiving other similar services e.g. DVA, EACH

Willingness of client/carer to receive the service

ADMISSION PRESENTATIONS FOR ICCOP CLIENTS



E Record ...

ICCOP - Integrated Community Care for Older People



[My Account](#) [Create client](#) [Administration](#) [User admin](#) [Drop down admin](#) [Logout](#)

Practitioner

<Any>

CNC

<Any>

Deceased

Not deceased

Discharged

Active

Apply

First Name ▲

Surname

Progress Notes

Care Plans

Event Notifications

Agnes

Spear

View

15/08/2009 - 1:06pm

View

New

12/08/2009 - 9:32am

ICCOP

Outcomes

37% reduction in total bed days.

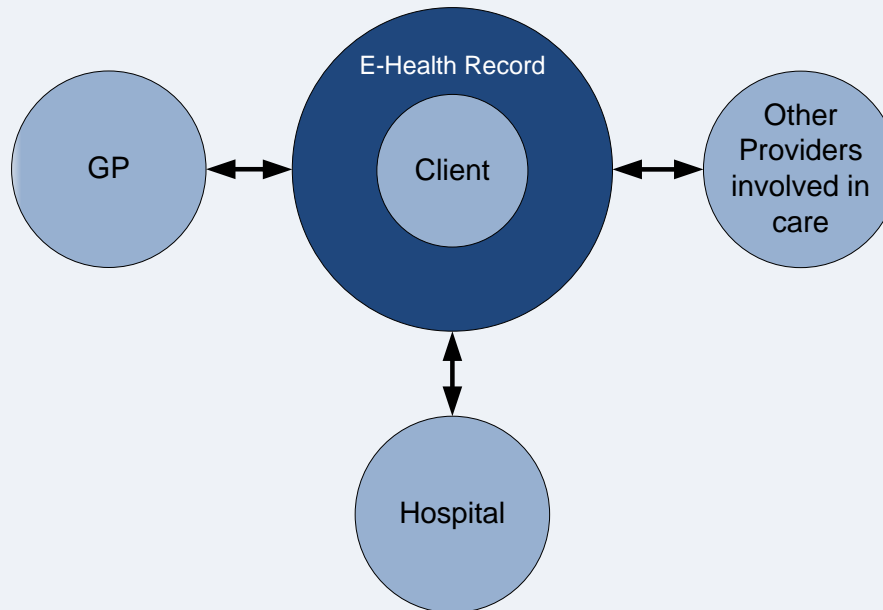


Diagram 1: Client centred care via eHealth.

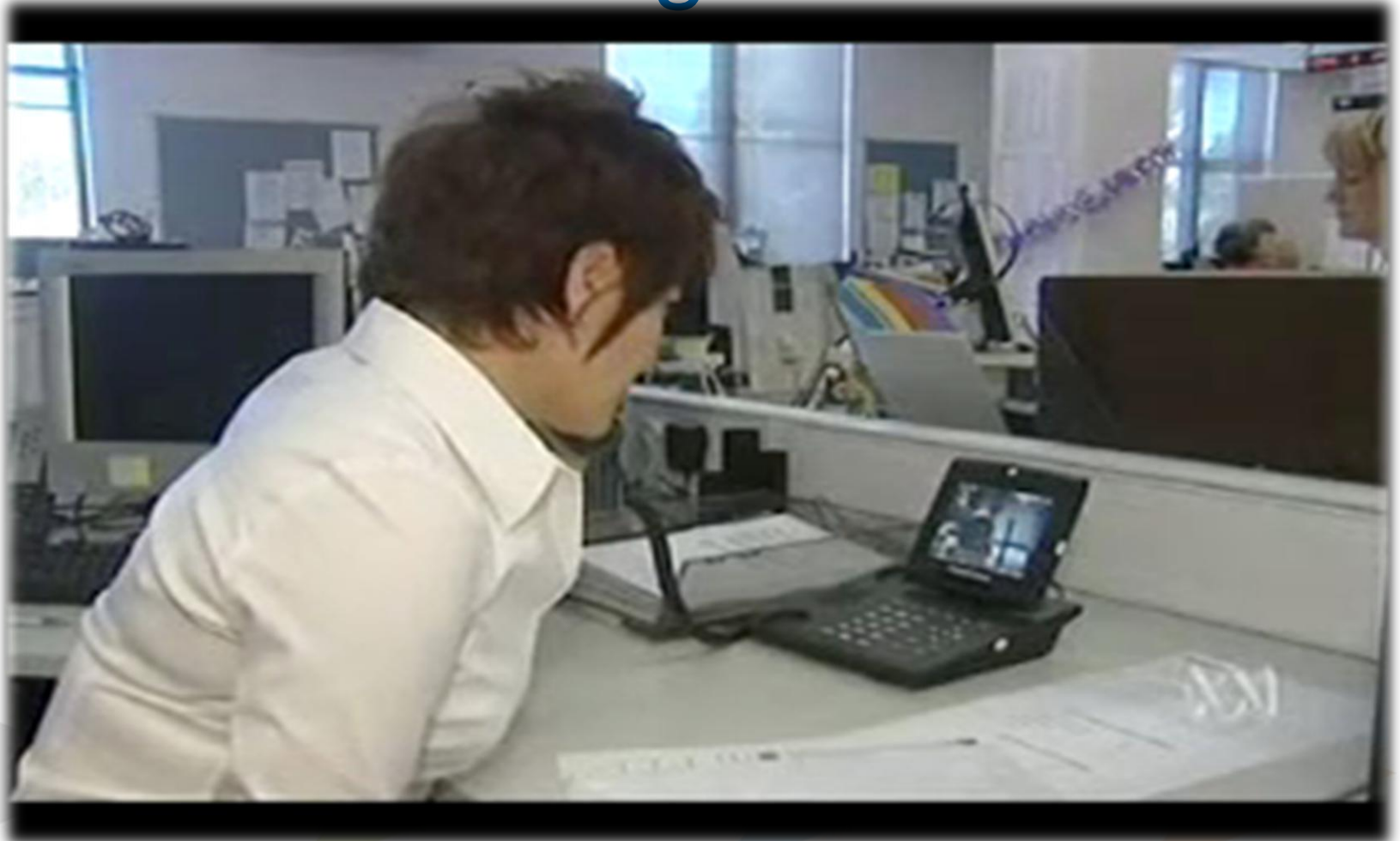
Tele-health



Remote Monitoring



Health Coaching



Virtual Hospital ...

Improved service continuity at all times

Less **intrusive** for client

Increased **client control** over medication management

Increased medication compliance – especially **DOT clients**

Extremely **effective for clients** with mental health conditions, cognitive impairment or a history of poor compliance with treatment regimes



Issues and Challenges ...

The over emphasis focus on Hospitals, Increasing beds, and governance in the reforms **rather than hospital avoidance strategies**

Lack of focus to date on community/primary health care

The **gaps** in relation to **mental health solutions**

The importance in a period of change we strengthen the vital link between **acute and the primary health care sector**

The importance of **investment** in health matching demographics and chronic disease trends

Development and trial of new services models with **rigorous evaluation**

The need to **partner** whilst at the same time being in competition – for the **benefit of “patient”**

Issues and Challenges cntd ...

Achieving **agility and responsiveness** in a highly regulated environment

Moving existing workforce to **multi and trans-disciplinary teams** and client needs rather than professional tribes

Nurse Practitioners being seen as a **partner** rather than threat

Critical need to get somewhere with **Ehealth** – ICCOP example “shared, secure, clinical information”

Consolidation of the sector

Emerging **International** players

Uncertainty in our funding streams

Opportunities ...

Broadly

To invest in affordable **technology** that is appropriate to client / patient needs

Enriched Clinical Governance – improved public health monitoring

Better interface between health and aged care

Care Coordination – Call Centre, chronic disease management, lifestyle change, pharmaceutical compliance, hospital avoidance

Broadening of professions and professional boundaries



Closer to home ...

Hospital in the Home

Support to rural and remote communities

Increased data, reporting, trending evidence for what we do and effectiveness

RDNS more than “nursing on wheels”

Moving beyond the State boundaries

Growth, Impact, and Influence through acquisition, organic growth and partnering

Engaging general practice as part of our DNA

Closer to home ...

To partner with GP's

- Clinics
- Workforce
- Technology- health coaching , call centre support
- Clinical Governance



QUESTIONS

