Specialist and Clinical Services Outreach PPHC Remote NT Health Guideline

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Purpose

To provide Primary and Public Health Care Remote - Central Australia and Barkly Regions; Population and Primary Health Care Remote - Big Rivers, East Arnhem and Top End Regions (hereafter referred to collectively as PPHC) remote staff and Specialist and Clinical Services Outreach Service Providers with a guideline on the management and processes related to providing outreach visits to remote health centres.

Guideline

The contribution of specialist and Clinical Services Outreach Services is an integral component of PPHC. Outreach visits provide the convenience of clients accessing the service locally, an opportunity for communication between the service provider and health centre clinical staff and upskilling opportunities for staff.

The client must give informed consent for the involvement of specialist service providers in their health management.

Specialist Outreach NT (SONT) is the business unit providing logistical coordination for visiting specialist and clinical services to remote health centres in addition to regional hospitals NT-wide. For visiting services available see the Specialist Outreach NT (SONT) webpage.

The Northern Territory Primary Health Network (NT PHN) Outreach Health Services Program also funds and coordinates many health professionals to facilitate services offered in remote health centres for clients with diabetes; cardiovascular disease; chronic respiratory disease; chronic renal (kidney) disease; and cancer. For further information on these services, see Information Sheet – Outreach Health Services Program to Remote Health Centres.

The NT PHN Outreach Health Services Program may be contacted on phone: (08) 8982 1000. These visits are on the combined Medical Services Visit Calendar.

The SONT team have a number of system tools to assist in planning and scheduling of outreach visits which enable the PPHC Service to better plan, monitor and coordinate visiting medical services:

- A combined Medical Services Visit Calendar (internet), including all SONT planned visits, oral health, hearing health and allied health organised by NT Primary Health Network (NT PHN), allowing searches by location and service type.
- Charter Point (intranet) is a real time schedule of current charters across the NT allowing searches by location enabling charter sharing opportunities.

SONT may be contacted as a liaison point for current information on Service Providers on e-mail:

SONT.DHF@nt.gov.au | phone: (08) 8999 2518

There are four distinct phases to a successful outreach service. These include:

- Annual planning: visit frequency based on a community needs analysis.
- Pre-visit planning: communication and coordination between PPHC and the service provider.
- Outreach visit: collaboration between PPHC and the service provider during the visit.
- Review, follow-up and referral status: communication between the service provider and PPHC regarding ongoing care requirements.

1 Annual Planning

A needs analysis, based on population, disease prevalence and current referral status is used to plan visit frequencies on an annual cycle. This is completed by the program area (eg Renal, Ophthalmology, etc). A proposed visit schedule is then referred to the health centre PHCM for scheduling confirmation.

Once the program area confirms the visit schedule, SONT updates the Medical Services Visit Calendar.

The PHCM / delegate should inform the RMP and PPHC team of dates of planned outreach visits by usual health centre mechanisms, eg visit schedules displayed in the meeting room.

2 Pre-Visit Planning

One month prior to the planned visit the PHCM, in consultation with the RMP and outreach program representative must review the potential client list to decide whether the outreach visit is necessary. The progam representative must notify SONT of any changes to the propsed visit plan.

When the outreach visit is confirmed, a list of clients to be seen during the visit should be agreed and confirmed with the RMP / Program area and PHCM / delegate.

Approximately two to three weeks prior to the outreach visit, SONT will finalise logistics for the trip. An itinerary with visit timing, service provider names and positions is sent to all stakeholders along with a clinic notification sent to the PHCM two weeks prior to the scheduled outreach visit.

2.1 Service Provider

The Service Provider:

- Must complete the Primary Care Information System (PCIS) Application for EHR Access and undertake appropriate training if not previously completed prior to commencing outreach visits.
- When relevant, maintain and generate a list of clients requiring ongoing follow-up.
- Utilise and promote approved clinical protocols, eg use of the Central Australian Rural Practitioners Association (CARPA) Standard Treatment Manual (STM) where possible.

2.2 Referral of Clients

It is important to maximise the outreach visit and facilitate referral of appropriate clients for review. For example - clients with a chronic disease managed by the RMP and do not necessarily require specialist review. The RMP should only refer clients who require additional Specialist input into their medical management.

A current RMP referral must be available for a specialist outreach visit. Other service provider referrals will be made as required. A referral remains current for a calendar year. This should be completed prior to the outreach visit and is provided using the EHR referral system. Ideally clients should be given the opportunity for a RMP review prior to seeing a specialist. Where this is not possible a referral should be completed by the RMP noting that they have not clinically reviewed the client themselves.

After the referral letter is written a recall is entered onto the client's EHR for that particular service provider. Some service providers may also have a list of clients requiring follow-up consultations.

A list of clients referred to the various service providers should be maintained at the health centre. This may be a hard copy of the referral stored in an outreach visit folder.

The EHR recall list should be reviewed by the PHCM and RMP prior to the service providers visit. The PHCM and RMP may chose to highlight high priority cases.

There may be instances where a client presents to the health centre during a specialist outreach visit, and it is opportune for the client to be seen. Reasonable efforts should be made to obtain a referral from an RMP.

2.3 Community / Client Notification and Preparation

Health centre staff should inform the community of the planned outreach visit and remind clients of their appointment. The visit should be promoted in the community and a notice should be displayed in the health centre. When appropriate the visit may be promoted by displaying notices at strategic positions in the community e.g. council office and community store.

To facilitate an effective and efficient visit, clients on the service providers visit list should be asked to attend the health centre prior to the outreach visit for any pre-work required such as pathology, so that results will be available for the consultation.

Note: If the outreach visit is cancelled wherever possible notices should be displayed in the health centre and community. Relevant town-based staff must also be notified as soon as practicable.

3 Outreach Visit

The PHCM / delegate should ensure the logistics of the service providers visit are attended. This includes:

- Collection from the airfield and accommodation as required.
- Consulting room/s should be allocated which has computer access to the EHRs.
- Room/s for specialised equipment eg echo cardiograph or ultrasound.
- Orientation to the health centre facility (eg kitchen, toilet, etc) as required.

To facilitate an effective outreach visit, health centre staff should ensure an efficient flow of clients for consultation, including:

- Assign a dedicated driver where possible to remind / collect clients on the day.
- Where possible assign a staff member to work with the Service Provider throughout the visit
- Provide clinical assistance as required
- Support the visiting service provider with any cultural or language issues that may arise

3.1 Service Provider

During the community visit the service provider **mus**t:

- Document the consultation in the client's EHR at the time of the consultation.
- Communicate with the PHCM / delegate if any follow-up management is required for the client prior to departing from the health centre.
- Ensure they have sufficient information for their follow-up letter / report.

Visiting specialists are encouraged to contact the PHCM and/or RMP for any important issues requiring immediate attention / action at the time of the visit.

3.2 Staff Training Opportunities

Outreach visits provide upskilling opportunities for health centre clinical staff. The PHCM / delegate should consider upskilling requirements and negotiate provision of training with the service provider where timing during the visit allows.

4 Review, Follow-up and Referral Status

4.1 Service Provider

Following the community visit:

- A comprehensive clinical note in the EHR by the Service provider is strongly recommended.
- The service provider provides a letter / report that comes in the form of an electronic message to the inbox of the RMP and PHCM, ideally within a two (2) week timeframe.
- Make recommendations regarding ongoing medical management and changes to medications where required, to be detailed in the letter / report.
- Facilitate client referral within their scope of practice where required, ensuring the RMP is aware of the referral.
- Provide copies of all specialist to specialist communication to the relevant PHCM and RMP.
- Complete the SONT Clinical Visit and Service Activity Report as required.

4.2 Planning and Travel Coordinator

SONT: Maintains the SONT Clinical Visit and Service Activity Report data for reporting purposes.

NT PHN: Service providers complete reporting requirements as per NT PHN requirements and this is sent to NT PHN.

4.3 Primary Health Care Manager / Delegate

Following the service providers visit, client management should be actioned as necessary. In consultation with the RMP, this may include:

- Recall information updated on the EHR.
- Rural prescriptions updated and sent to the relevant pharmacy.
- Patient Travel (PATS) arrangements facilitated as required.
- Telehealth arrangements as required.
- Facilitate family conferences as required.

4.4 Rural Medical Practitioner

Following the service providers visit, the RMP processes the consultation letter / report and updates the client EHR accordingly. This includes:

- Updating the problem list, rural prescriptions, recall and any other changes as required.
- Communicating the current management plan to the PHCM, PPHC team and families as needed.

Note: the PPHC Director of Medical Services provides leadership to RMP's to ensure Specialist Outreach issues are addressed and managed appropriately.

5 Electronic Health Record Systems

The EHR used within NT Health centres is the primary health record and must be used to record all client consultations. Service providers conducting consultations in these health centres **must** apply for PCIS User Access.

Specialist / other service provider letters / reports may be sent and received electronically in PCIS via a 'discharge referral' (Secure Electronic Messaging Service (SEMS) Inbox message) from the hospital. These will be received as an unassigned message.

Specialist / other service provider letters / reports received in hard copy must be scanned into the individual client record as described in Electronic Health Records Overview.

Quality Assurance		
	Method	**Responsibility**
Implementation	Document will be accessible via the Policy Guidelines Centre and Remote Health Atlas	PGC Administrators ePublications Administrators
Review	Document is to be reviewed within three years, or as changes in practice occur	Atlas Development Officer, Primary and Public Health Care Remote
Evaluation	Evaluation will be ongoing and informal, based on feedback.	Atlas Development Officer, Primary and Public Health Care Remote
Compliance		

Key Associated Documents	
Key Legislation, By-Laws, Standards, Delegations, Aligned & Supporting Documents	Primary Care Information System (PCIS) User Access Form Referral Template, available electronically in PCIS SONT Clinical Visit & Service Activity Report, *available from SONT via the above contact information* Section 250 NT MPTGA PHC Remote Guideline Electronic Health Records Overview PHC Remote Guideline Electronic Health Records User Access PHC Remote Guideline Telehealth Specialist Consultation PHC Remote Guideline Information Sheets: Specialist and Clinical Service Providers Visits to Remote Health Centres and Coordination of Care PPHC Information Outreach Health Services Program to Remote Health Centres PPHC Information Specialist Outreach NT (SONT) (internet) Medical Services Visit Calendar Specialist Outreach Northern Territory (intranet) Specialist Outreach Northern Territory (SONT) website Northern Territory Primary Health Network (NT PHN) Secure Electronic Messaging Service (SEMS) Patient Travel website NT Medicines, Poisons and Therapeutic Goods Act Primary Care Information System (PCIS) Website
References	As Above

Definitions, Acronyms and Alternative Search Terms	
Term	Description
Electronic Health Record (EHR)	a systematic collection of electronic health information about individual clients. The EHR is the **primary** health record into which client personal and health data must be entered.
RMP	**R**ural **M**edical **P**ractitioner for the community. This may be a resident RMP or an RMP fly-in / fly-out service or working off site.
Service Provider	a range of Specialist and Clinical services providing outreach visits to remote health centres.

National Safety and Quality Health Service Standards							
Clinical Governance	Partnering with Consumers	Preventing and Controlling Healthcare Associated Infection	Medication Safety	Comprehensive Care	Communicating for Safety	Blood Management	Recognising & Responding to Acute Deterioration
☒	☐	☐	☐	☐	☐	☐	☐