DEPARTMENT OF
HEALTH

Outreach Health Services Program to Remote Health Centres PHC Remote Information Sheet

OVERVIEW

Allied health professionals covered under the Health Network Northern Territory (Health Network NT) Outreach Health Services Program provide much needed knowledge and skills to augment the services that are offered in remote health centres focusing on the following chronic conditions:

- Diabetes;
- Cardiovascular disease;
- Chronic respiratory disease;
- Chronic renal (kidney) disease; and
- Cancer

Visiting allied health professionals include Podiatrists, Dietitians (Private and Primary Health Care), Cardiac and Diabetes Nurse Educators, Speech Pathologists, Occupational Therapists, Exercise Physiologists and Physiotherapists. In delivering services to remote communities, they also provide a valuable resource of up-skilling local Primary Health Care (PHC) teams and education for clients and their families.

The PHC team has knowledge of local conditions and ongoing relationships with the clients and provides the cornerstone of client care, which includes:

- the ongoing self-management of the day to day care of clients; and
- follow-up actions pre/post on any given medical outreach visit.

Service delivery is optimised by good working relationships between outreach Health Network NT allied health professionals and the PHC team. To meet quality and safety standards, multidisciplinary team care planning and transfer of clinical information to the PHC team occurs before and after the specialist visit.

PLANNING FOR THE ALLIED HEALTH PROFESSIONAL VISIT

1. The Health Network NT liaises with the Primary Health Care Manager (PHCM) to agree to scheduled dates for each visiting allied health professional. NT Department of Health Primary Health Care Dietitians, who deliver services under the Outreach Health Services program will communicate directly with PHCM.
2. There is communication between the visiting Health Network NT contracted allied health professional and the PHCM at least one week prior to the visit.
3. The Rural Medical Practitioner (RMP / GP) and the PHCM prepare a list of clients to be seen by the allied health professional. In addition, the allied health professional may have their own list of clients to be seen.

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NORTHERN TERRITORY GOVERNMENT

DURING THE VISIT

1. The allocation of a staff member with local knowledge is provided, where possible, to work with the visiting Health Network NT contracted allied health professional for the visit. The PHCM will determine the most appropriate staff member to support the visiting service.
2. Documentation of all clinical consultations is entered in the client's electronic health record (EHR).
3. Before leaving the health centre, the allied health professional communicates any immediate follow-up that is required for clients seen on that day.

FOLLOWING THE VISIT

1. In the event the allied health professional (with particular emphasis for the Cardiac and Diabetes Nurse Educators) has recommendations for ongoing clinical management, ideally within a two week time-frame, they will:
    - **PCIS -** provide an electronic message to the inbox of the 'RMP' and a copy to the generic 'PHCM' inbox for the community.
    - **EACS -** utilise the 'Visiting Service Provider Clinical Item' to record information during the consultation and e-mail recommendations to the RMP for the health centre and a copy to the PHCM generic e-mail account.
2. The message provides feedback to the RMP so that clinical follow-up can take place in a manner that is safe and timely.
3. The RMP reviews the client / client EHR and 'actions' the Allied Health Professional recommendations as needed. The RMP communicates with the rest of the PHC team regarding follow up action that needs to be taken.
4. Telehealth medicine is encouraged to supplement to the outreach services.

THANKYOU FOR YOUR SUPPORT OF CLINICAL SERVICES IN REMOTE HEALTH CENTRES IN THE NORTHERN TERRITORY