DEPARTMENT OF
**HEALTH**

# Medical Specialist Visits to Remote Health Centres and Coordination of Care PHC Remote Information Sheet

## Overview

Specialist clinicians provide much needed knowledge and skills to augment the services that are offered in remote health centres. Specialists also provide a valuable source of upskilling for local primary health care (PHC) teams.

The PHC team has knowledge of local conditions as well as ongoing relationships with the clients. As such the PHC team provides the cornerstone of client care.

Care is optimised by good working relationships between visiting specialists and the PHC team. It is a quality and safety issue that careful planning and transfer of clinical information occur before and after the specialist visit.

## Planning for the Specialist Visit

1. There is communication between the visiting specialist team and the Primary Health Care Manager (PHCM) at least one week prior to the visit.
2. The Rural Medical Practitioner (RMP / GP) and the PHCM prepare a list of clients to be seen by the specialist. In addition the specialist may have their own list of clients to be seen.
3. Every client seen by a visiting specialist must have a referral letter written by the RMP for the community (preferably prior to the visit or failing that at the time of the visit).

## During the Visit

1. Wherever possible a staff member with local knowledge is allocated to work with the visiting specialist for the day.
2. Each clinical consultation is documented in the client's electronic health record (EHR).
3. Before leaving the health centre the specialist communicates to the PHCM regarding any immediate follow-up that is required for clients seen on that day.

## Following the Visit

1. The specialist provides a letter that comes in the form of an electronic message to the inbox of the RMP for the community, ideally within a two week time-frame.
2. The letter provides feedback to the referring RMP so that clinical follow-up can take place in a manner that is safe and timely.
3. The RMP 'actions' the specialist letter as needed by updating the problem list, making adjustments to the rural prescription and ensuring that recalls have been brought up to date. The RMP communicates with the rest of the PHC team regarding follow up action that needs to be taken.
4. Any documentation that is scanned into the client's EHR following the visit is accompanied by a message to the inbox of the RMP for the community so that the incoming clinical information can be witnessed and actioned accordingly.
5. Clinical notes entered into the client record at the time of the visit do not provide a substitute for a formal letter back to the referring doctor. Unless they are accompanied by an inbox message to the RMP they may not come to the attention of the PHC team.

**THANKYOU FOR YOUR SUPPORT OF CLINICAL SERVICES IN**

**REMOTE HEALTH CENTRES IN THE NORTHERN TERRITORY**


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