Specialist and Clinical Service Providers Visits to Remote Health Centres and Coordination of Care PPHC Information

Specialist and Clinical Service Providers provide much needed knowledge and skills to augment the services that are offered in remote health centres. Specialist and Clinical Service Providers also provide a valuable source of upskilling for local 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) teams.

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

Care is optimised by good working relationships between visiting Specialist and Clinical Service Providers and the PPHC team. It is a quality and safety issue that careful planning and transfer of clinical information occur before and after the Outreach visit.

Planning for the Specialist and Clinical Service Providers Visit

1. The Electronic Health Record (EHR) recall list should be reviewed by the PHCM prior to the Service Providers visit. The RMP should be consulted and may chose to highlight high cases. In addition the Service Provider may have their own list of clients to be seen.
2. There is communication between the visiting Service Provider and the Primary Health Care Manager (PHCM) at least one week prior to the visit.
3. A current RMP referral must be available for a Specialist Outreach visit, preferably prior to the visit or failing that, an effort should be made to obtain a referral from an RMP whenever possible. Other Service Provider referrals will be made as required.

During the Visit

1. Wherever possible a driver and a staff member with local knowledge is allocated to work with the visiting Service Provider for the day.
2. Each clinical consultation is documented in the client's EHR.
3. Before leaving the health centre the Service Provider communicates to the PHCM regarding any immediate follow-up that is required for clients seen on that day.
4. Visiting Specialists are encouraged to contact the RMP for any important issues or those requiring immediate attention or action at the time of the visit.

Following the Visit

1. A comprehensive clinical note in the EHR by the Service provider is strongly recommended.
2. The Service Provider provides a letter / report 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.
3. The letter / report provides feedback to the referring RMP so that clinical follow-up can take place in a manner that is safe and timely.
4. The RMP 'actions' the Service Providers 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 PPHC team regarding follow up action that needs to be taken.
5. 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.
6. 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 PPHC team.

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

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