Outreach Health Services Program to Remote Health Centres PPHC Information

Overview

Health professionals covered under the Northern Territory Primary Health Network (NTPHN) Outreach Health Services Program provide much needed knowledge and skills to augment the services that are offered in Primary and Public Health Care Remote - Central Australia and Barkly Regions and Population and Primary Health Care Remote - Big Rivers, East Arnhem and Top End Regions (hereafter referred to collectively as PPHC) remote health centres focusing on the following chronic conditions:

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

Visiting health professionals include but are not limited to Podiatrists, Dietitians, Cardiac and Diabetes Nurse Educators, Exercise Physiologists, Physiotherapists, Ophthalmologists and General Physicians. In delivering services to remote communities, they also provide a valuable resource of up-skilling local PPHC teams and education for clients and their families.

The PPHC 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
- follow-up actions pre/post on any given medical outreach visit.

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

Planning for the Health Professional Visit

1. The NTPHN liaises with the Primary Health Care Manager (PHCM) to agree to scheduled dates for each visiting health professional.
2. There is communication between the visiting NTPHN contracted health professional and the PHCM at least one week prior to the visit where the NTPHN Outreach Health Services team confirms the up-coming visits and provides the PHCM with any list of clients they wish to see.
3. The Rural Medical Practitioner (RMP / GP) and the PHCM uses this list in conjunction with their local knowledge of client need to prepare a list of clients to be seen by the visiting health professional.

During the Visit

1. On arrival to the clinic the NTPHN health professional will introduce themselves to the Primary Health Care Manager and discuss the client lists and referrals for the visiting service.
2. Where possible the PHCM should allocate a staff member with local knowledge to work with the visiting NTPHN contracted health professional.
3. Documentation of all clinical consultations have to be entered in the client's Electronic Health Record (EHR).
4. Any immediate follow-up requirements for clients should be relayed to the PHCM and allocated staff member on that day the client is seen.

Following the Visit

1. In the event the health professional has recommendations for ongoing clinical management, these need to be communicated to the RMP and PHCM via an electronic message to the PCIS inbox within a two week time frame.
2. The RMP and PHCM should make reasonable efforts to ensure clinical follow-up takes place in a timely and safe manner.
3. The PHCM and /or RMP communicates with the PPHC team regarding follow up requirements as necessary.
4. Telehealth medicine is encouraged to supplement to the outreach services.
5. Feedback on the visiting provider or service can be provided directly to NT PHN through the post-visit feedback survey emailed to the PHCM or by emailing the team at ohsp@ntphn.org.au.

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

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