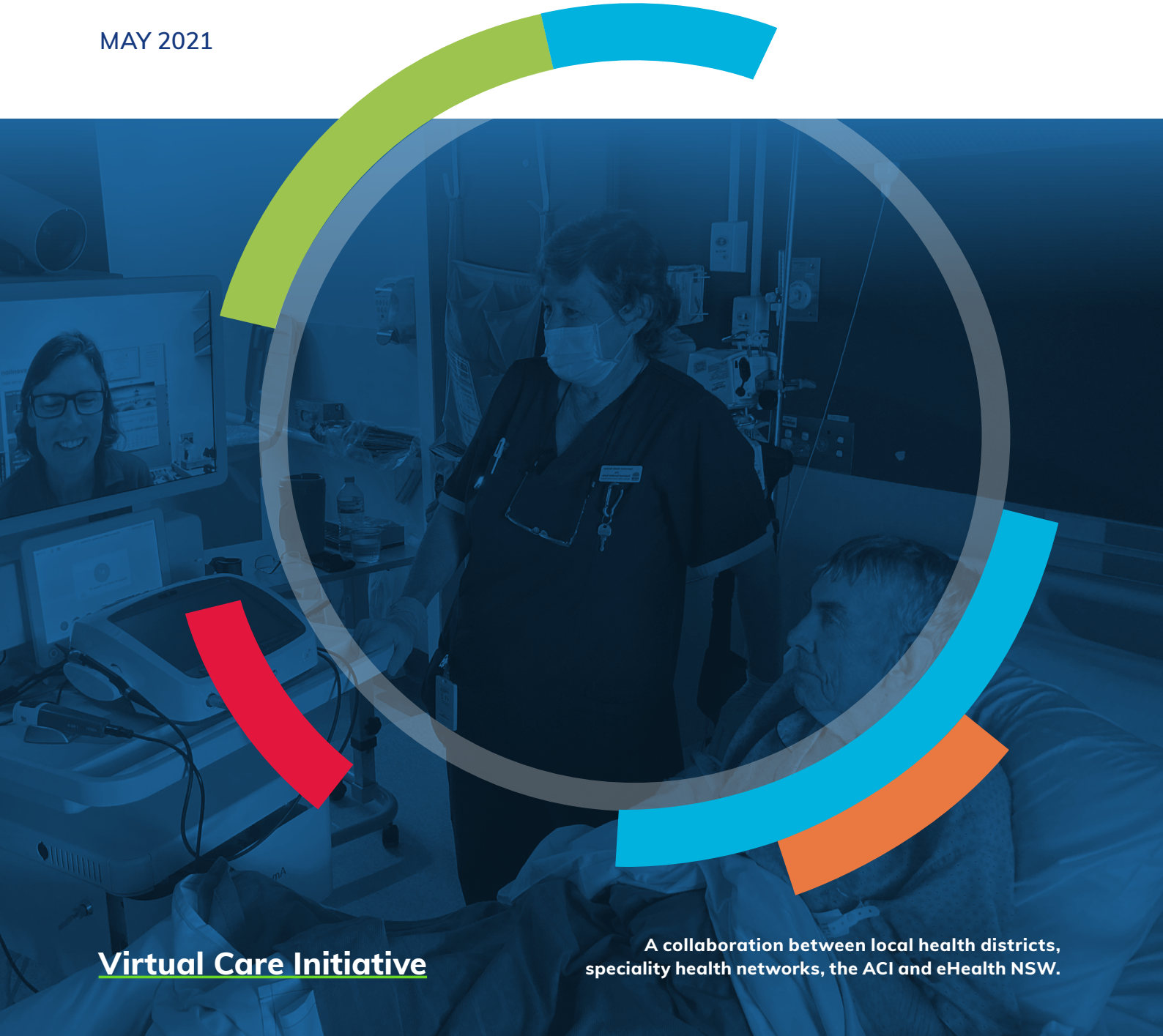
NSW GOVERNMENT

AGENCY FOR CLINICAL INNOVATION

Spotlight on virtual care: Virtual Allied Health Service

Western NSW Local Health District

MAY 2021



Virtual Care Initiative

A collaboration between local health districts, speciality health networks, the ACI and eHealth NSW.

The ‘Spotlight on Virtual Care’ reports showcase innovation and leadership in virtual health care delivery across NSW. The series aims to support sharing of learnings across the health system and outlines the key considerations for implementation as identified by local teams.

Each initiative within the series was selected and reviewed through a peer-based process. While many of the initiatives have not undergone a full health and economic evaluation process, they provide models that others may wish to consider and learn from.

These reports have been documented by the Virtual Care Accelerator (VCA). The VCA is a multiagency, clinically focused unit established as a key partnership between eHealth NSW and the ACI to accelerate and optimise the use of virtual care across NSW Health as a result of COVID-19. The VirtualCare Accelerator works closely with Local Health Districts (LHDs) and Specialty Health Networks (SHNs), other Pillars and the Ministry of Health.

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Further copies of this publication can be obtained from the Agency for Clinical Innovation website at **www.aci.health.nsw.gov.au**

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Introduction

The Virtual Allied Health Service (VAHS) at Western New South Wales Local Health District (WNSWLHD) provides virtual services to rural healthcare facilities in the disciplines of dietetics, occupational therapy, speech pathology, physiotherapy and social work.

WNSWLHD is geographically the largest local health district (LHD) in NSW. At 246,676 square kilometres, it covers 31% of NSW and provides healthcare to a population of over 278,759.

The region of the WNSWLHD has a limited number of allied health clinicians compared with metropolitan areas. Combined with uneven distribution of the workforce, there is an inequity in access to allied health services for the population.

In 2014, a review of the allied health workforce was completed, with recommendations for an equitable distribution of services based on socioeconomic determinants of health and relative health needs of communities.

The Virtual Allied Health Service (VAHS) pilot was implemented in 2017 to address this challenge by trialling virtual service delivery models in five identified disciplines. The model aimed to provide allied health services for people without local access to face-to-face allied health care, and to explore which interventions could be delivered virtually effectively.

Services are delivered in a range of settings including: Multipurpose Services (MPS), other rural health facilities and in the patient's home. VAHS service delivery is now provided in the following five disciplines:

1. **Dietetics:** video and phone calls for the treatment and intervention of people who are malnourished/ at risk of malnutrition, those with gastrointestinal issues or requiring diabetes management for inpatients and residents of the MPS.
2. **Occupational therapy:** video-based consultations, servicing MPS and rural health facility acute patients, aged care residents and community clients. Interventions include pressure injury prevention, equipment prescriptions and home modifications.
3. **Speech pathology:** video calls to provide dysphagia/swallowing assessments and intervention for people in rural inpatient and MPS rural facilities across the LHD.
4. **Physiotherapy:** video calls for treatment and follow up of MPS residential aged care residents, as well as inpatient and outpatient with a focus on managing musculoskeletal disorders.
5. **Social work:** video and phone-based consultation, treatment and intervention as well as follow up services that support the needs of people admitted in MPS and rural health facilities. Services are available to all inpatient facilities across the LHD without an on-site or outreach social worker.

The WNSWLHD Strategic Plan (2020-2025) focuses on developing and sustaining services across the region. This includes the provision of care as close to home as possible and meeting the needs of diverse communities. The VAHS is a delivery model which can help break down the barriers of distance for people, enabling access to allied health services. This is also closely aligned with the NSW State Health Plan enabling eHealth.

The VAHS is now an established model of care and represents an innovative solution to the challenges of delivering quality, efficient and effective services across a sparsely populated region.

Reported benefits of the model

Patient benefits:

- Equitable access to allied health services across the district
- Reduced waiting times
- Reduced travel time
- Improved care planning and outcomes with multi-disciplinary input
- Increased involvement of patients and their families in decision making
- Overall improvement to the patient, family and carer experience
- Supported virtual experience, removing the need to navigate the use of technology on their own.

Clinician benefits:

- Increased capability, skills and knowledge through multi-disciplinary involvement
- Extended service provision to support holistic patient management
- Enhanced relationships and trust between clinicians
- Clinicians are empowered to make key decisions
- Improved coordination of care through frequent interactions between clinicians
- Efficient referral processes for primary healthcare providers
- Positive engagement with patients and their carers
- Reduced travel time has enabled allied health clinicians to maximise their clinical time in a virtual capacity.

Service benefits:

- Increased efficiency and effectiveness of allied health services
- Maximisation of the allied health workforce, which addresses recruitment difficulties and can provide annual leave cover
- Reduced costs associated with travel and patient transfers between MPS and referral facilities
- Improved allied health governance across multiple sites
- Cost effective model that has redistributed full time equivalent (FTE) more equitably across the LHD
- Provides a more person-centred, faster and more responsive service.

'[This service] is very accessible, very good and very thorough. Without this service I would have had to travel very far [which is difficult for me] … before when I went for an x-ray it nearly killed me.'

PATIENT AT NARROMINE MPS

Overview of the model

Key elements of the model

Element	Detail
Patient population/service users	• All service users are based in rural and remote locations • Inpatients and MPS residents • Limited services provided in a community and outpatient setting.
Referral pathway	• Telephone – contact number for each discipline • Email – email address for each discipline • Electronic Medical Record (eMR) referral forms • Referrers include general practitioners (GPs), MPS and rural health facilities
Healthcare team (LHD and others e.g. NGOs and GPs)	• The VAHS core team includes: – physiotherapist – 1 FTE – occupational Therapist – 0.4 FTE – social worker – 0.2 FTE – speech pathologist – 0.2 FTE – dietitian – 0.4 FTE. • Healthcare workers to provide support at the patient end (e.g. nurses, Aboriginal health workers and allied health assistants) • Health service managers at rural hospitals.
Technology	• Pexip videoconferencing platform • Cisco DX80 videoconferencing machines at the clinician end • 'Wallie' mobile videoconferencing machines (portable videoconferencing machine) at patient's location • iPhone for nurses conducting home visits.

Services

The VAHS offers discipline-specific interventions, each with assessment and therapy models of care. All interventions are safely delivered using a virtual platform and each discipline has its own eligibility criteria and referral process.

Dietetics

- The service uses video calls and phone calls for the treatment, consultation and follow-up of malnutrition disorders for inpatients and residents of MPS' and rural health facilities.
- The service provides support to local staff for safe patient management of enteral feeding and diabetes.
- Patients accessing this service are predominantly aged 65+ with chronic conditions.
- This service aims to:
  - provide follow up for people originally treated in regional hospital and then transferred to smaller facilities
  - identify and treat malnourished residents and inpatients and those at risk of malnutrition
  - educate staff to identify, refer and care for patients at risk of or malnutrition.

Out of scope:

- Starting new tube feeds
- Supported management of people with eating disorders
- Renal diet.

Challenging virtual care misconceptions:

- A subjective global assessment, which is normally done using a physical assessment can be undertaken virtually by providing clear instructions to the nurse assisting the person at the other end. The videoconferencing equipment provides a clear picture to help the dietitian assess the level of malnutrition.

Occupational therapy

- The service uses video calls for consultations between facilities, and smart phones or tablets if virtual home visits are required.*
- The service is provided to MPS acute patients and aged care residents and limited community clients.
- This service provides:
  - injury prevention and management in MPS and rural health facilities**
  - equipment prescriptions with support from facility staff such as a nurse, Aboriginal health worker or equipment supplier. Equipment items prescribed include equipment to support activities of daily living, pressure care and mobility and transfers
  - assessment of equipment and home modifications required post discharge.***

Out of scope:

- Assessment for major modifications including 1:14 ramps. This is due to the complexity of assessing the natural environment and gradient requirements without an occupational therapist and builder on site.

Challenging virtual care misconceptions:

- Inspection of skin can be completed by video call when using the right equipment (for example, a Wallie portable videoconferencing machine used with appropriate peripheral devices) and personnel to support at the local site.
- A virtual wheelchair assessment requires a trained person to assist, such as a healthcare worker or equipment supplier.

* See home visit guide - virtual occupational therapy in Supporting documents list

** See information leaflet on the virtual pressure injury service in Supporting documents list

** See home visit measurement guide in Supporting documents list

Speech pathology

- The service uses video calls to provide dysphagia/swallowing assessments and intervention to people in rural inpatient and MPS facilities across the LHD. The key target group for this service is primarily acute patients aged 70+.
- This service aims to:
  - reduce transfer of MPS residents to larger facilities due to complications as a result of dysphagia (including aspiration pneumonia) if it is agreed their care can be managed locally
  - build the capacity of local staff to work with communication/swallowing issues.

Out of scope:

- Virtually supported management of:
  - people with severe cognitive impairment
  - people with a tracheostomy
  - people who have had a laryngectomy
  - acute onset of symptoms (e.g. neurological symptoms)
  - paediatrics
  - outpatients (under review).

Challenging virtual care misconceptions:

A swallowing assessment can be completed virtually with support. If the assessment is unclear, there is a lot of information that can be obtained from the nursing staff, the person or their family who are present at the facility.

Physiotherapy

- Provides care to MPS residential aged care patients; both inpatients and outpatients focusing on musculoskeletal disorders in rural health facilities. It is conducted entirely via video call for treatment and follow up consultations to rural sites across the LHD.*
- This service mainly sees older people referred from a Residential Aged Care Facility (RACF) and people who have been admitted to hospital due to a fall. This service provides:
  - fall prevention and strength groups in MPS/RACF
  - one-on-one virtual treatment
  - follow up inpatient and outpatient services with a clinical support person at the patient end using video conferencing for joint multi-disciplinary team (MDT) assessments.
- Referrals are provided by GPs, nurses, health service managers, or other allied health clinicians. Referrals are triaged and consent is gained prior to booking an appointment.

Out of scope:

- This service accepts all patients referred. If the referral is found to be outside of the scope of the service, an onward referral will be made to the nearest face-to-face physiotherapist.

Challenging virtual care misconceptions:

If initial instructions aren't understood this doesn't need to be a barrier. Be flexible and open in communications and try to explain things in a different way, e.g. standing up and adjusting the camera angle to demonstrate.

* See telehealth skills and capabilities for physiotherapists in Supporting documents list

Social work

- This service uses video and phone calls to provide consultation, assessment and intervention as well as follow up services that support the needs of people at rural healh facilities.
- The service is available to all rural health facilities across the LHD without an on-site or outreach social worker.*
- This service targets:
  - complex care planning
  - psycho-social barriers to discharge
  - counselling for people and their carers in areas including carer support, grief and loss, adjustment to life changes and child and family issues
  - support for patients and their families in accessing the Isolated Patients Travel and Accommodation Assistance Scheme (IPTAAS)
  - referral and advocacy (for patients and their carers).

Out of scope:

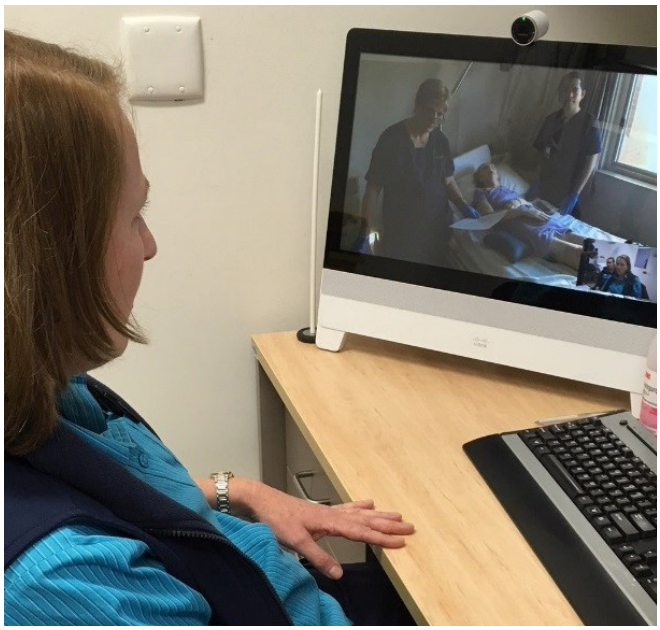
- Patients requiring care for complex mental health issues
- Presentations addressed by the VAN service.

Challenging virtual care misconceptions:

- Rapport building and communication can be just as effective virtually as during a face-to-face consultation.

Virtual MDT ward rounds

- Several rural facilities hold weekly virtual MDT rounds to enable allied health input into discharge planning.*
- The nurse manager at the patient site dials into the videoconferencing solution on the Wallie mobile unit and will take this to the patient's bedside.
- Virtual MDT ward rounds are patient-centred and involve the bedside nurse or nurse manager providing a nursing update on patients and seeking allied health input. Patients are encouraged to actively participate in these rounds in addition to carers and family members who may be present.
- Virtual MDT ward rounds may also include other virtual clinicians who are not a part of VAHS such as pharmacists and integrated care coordinators.

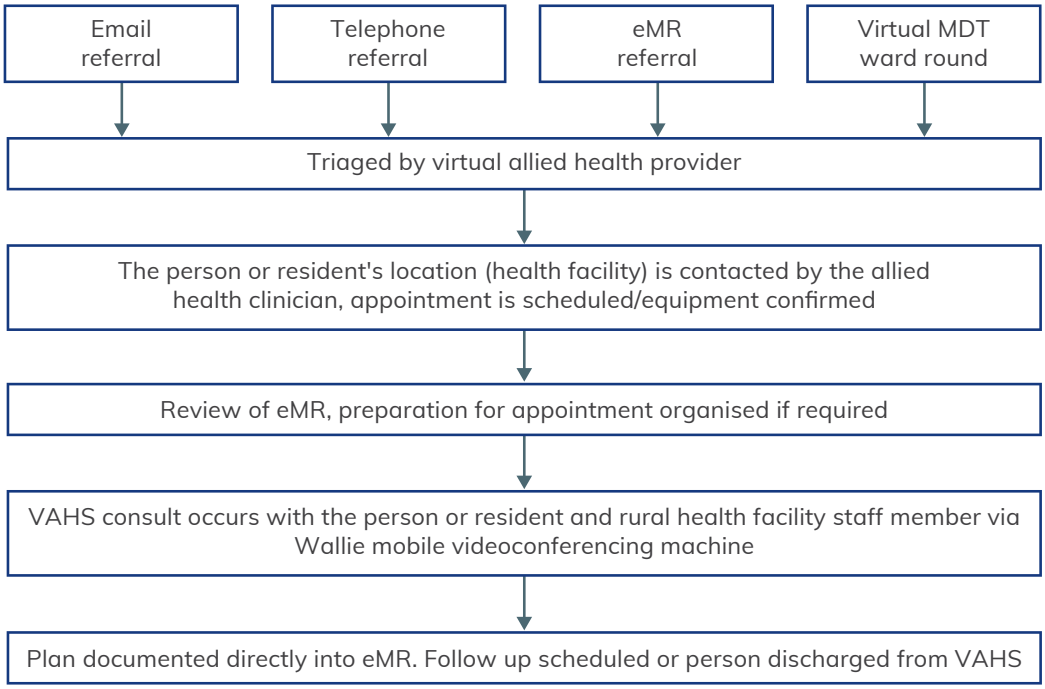


An allied health clinician from the Orange Health Service uses a Cisco DX80 to connect with nurses and a resident from Coonamble MPS.

* See virtual social work service flyer in Supporting documents list

** See virtual MDT ward round guidelines in Supporting documents list

Workflow diagram



A patient and a nurse at Narromine health facility use a portable Wallie mobile videoconferencing machine to connect with an occupational therapist.

Making it happen

This section outlines the key enablers and challenges identified by those involved in implementing this model. Addressing these factors effectively has been critical to successful implementation and these learnings can be used by other health services in the development of local models. The resources listed in the supporting documents section at the end of this report also supplement these learnings and have been identified throughout the following sections.

Local planning, service design and governance

Service planning

- WNSWLHD undertook a series of sequential reviews of allied health disciplines (dietetics, occupational therapy, speech pathology, physiotherapy and social work) over a 12-18 month period. The reviews aimed to:
  - develop strategies to enhance equity across the LHD; and
  - improve alignment of allied health services to the health needs of communities.
- An algorithm was designed to quantify communities' relative need and applied to each discipline's FTE profile. The relative need of communities was determined using weighted population sizes for WNSWLHD, including measures such as Aboriginal and Torres Strait Islander, low English fluency, remoteness and age.
- Following the physiotherapy services review, the LHD identified positions that had failed numerous recruitment attempts and combined fractions of these to create a 1.0 FTE virtual physiotherapy position. Some remaining fractional FTE could be activated if staff were later identified who could be appointed to a position. This approach provides much greater equity of access using a virtual service to meet needs across a number of communities and rural health facilities.

Service enablers

- Access to appropriate IT equipment and a reliable platform.
- Buy-in and engagement of the Health Service Managers (HSMs), Nurse Unit Managers (NUMs) and healthcare workers and patients and carers at the rural health facilities.
- Reputation is critical to promoting the value of the service. Positive outcomes and experiences from rural health facilities and patients have been shared across the LHD to build awareness and trust in the service.

Local clinical governance

- The VAHS model aligns to the usual LHD governance structures and uses the Incident Management System (ims+) to record any associated quality care incidents.
- A monthly VAHS governance meeting is held to oversee the development, implementation and evaluation of the model. It is attended by the VAHS project leads (clinical service leads) from each discipline and a sector general manager of the rural facilities. Areas reviewed include activity, patient stories, feedback, serious incidents recorded in the ims+ and electronic PREMs and PROMs.

Service model

- Each discipline has identified which aspects of their service are appropriate for virtual delivery. They have developed district-based education, patient identification, eligibility criteria and referral processes.
- There are a range of methods to refer to the VAHS. As most services focus on admitted patients, the majority of referrals are from rural health facilities. The physiotherapy service is the exception as it also accepts outpatients through GP referrals.
- Mechanisms for referral include telephone, intake email or eMR referral forms (e.g. malnutrition screening tool, pressure injury screening tool). VAHS clinicians have worked with WNSWLHD Health Information Communication Technology (HICT) to enable these referrals to be streamlined onto task lists.

- Patient safety is managed by clinicians at the facility who are present with the person during the virtual consultation.
- The VAHS was designed to support rural health facilities without an existing on-site allied health service. This clearly defined scope ensures the service continues to focus on communities with the greatest need. In some situations, VAHS will provide leave cover where required.

'The virtual physiotherapy service has helped me a lot... without this I would have had to travel three hours to Dubbo or eight hours to Sydney.'

VAHS PHYSIOTHERAPY PATIENT

Practical tips for allied health clinicians

- Awareness of the physical environment at both the patient and provider end and of others participating.
- Ensure that you can be heard and seen clearly.
- Be conscious of your own background.
- Introducing yourself and wearing a uniform and name badge is helpful as it reinforces to the patient that you are an experienced professional who is there to help.
- When conducting a virtual assessment, it is important to provide specific and clear instructions to the nursing staff and check that these have been interpreted correctly. This will increase the quality of the information that you receive.

Building engagement

Key partners and stakeholders

- The successful delivery of the VAHS model is based on the relationships the allied health clinicians have developed with HSM, nursing staff, Aboriginal health workers, catering staff, patients and family members.
- HSMs at rural health facilities play a critical role in promoting awareness and facilitating buy-in and support for the VAHS service.
- It is important to bring members of the community along on the journey. Draw upon credible stakeholders that have influence within the community (such as GPs and HSMs) to support and champion the service model.
- It is essential to work closely with the broader allied health professionals at the larger hospitals to support and assist (as required) management of the person's care.
- Virtual Rural Generalist Service (VRGS) doctors or on-site doctors at the facilities may refer to the services and need to be aware of service scope and benefits.*

Engaging with patients

- A virtual assessment will often require more time than a face-to-face consultation. It is important to allow enough time to build rapport and trust with the person and their carer(s) when providing care.
- Healthcare workers play an important role in helping the person to navigate through the experience of receiving care virtually (e.g. advising what to expect during the assessment).

* See VAHS Flyer in Supporting documents list

Staff engagement and ownership

- Establish trust and credibility with clinicians at the rural facilities, particularly with the HSM and NUM through targeted engagement and education strategies.*
- Developing a user guide for healthcare workers has helped to build knowledge and capability to support assessments for each discipline.
- It is beneficial to raise awareness of the value of the service amongst the broader clinical teams by sharing clinician and patient feedback, occasions of service data and outcome measures.
- VAHS facilities act as champions, to promote the service by sharing their experiences within the community and with other facilities.

Considerations for implementation

- Building relationships and networks with referring facilities is a factor of successful implementation.
- The model operates more efficiently when there is continuity of staff at the referring sites to support the consultations.
- Executive support and buy-in is critical in gaining support and engagement for the service.
- Commence with small number of pilot sites that are competent and already engaged with virtual modalities of care before expanding the service across the LHD. Utilise champions from existing VAHS sites to promote the service.

'The VAHS service is providing a much quicker and more responsive service to the needs of the community.'

INTEGRATED CARE NURSE, DUBBO HOSPITAL

* See VAHS postcard in Supporting documents list

Workforce, technology and resourcing

Appropriate technology

- The model uses the Pexip videoconferencing platform to connect clinicians.
- Cisco DX80s are used at the clinician end and either a DX80 or a Wallie mobile videoconferencing machine is used at the patient's location.
- iPhones are used by community nurses to conduct virtual home visits with instructions from occupational therapists (OTs).
- Phone calls are used to follow up specific queries with staff at facilities when necessary (e.g. dietitian calls kitchen staff about dietary supplements).
- Clinical documentation is completed as for face-to-face consultations, via the Community Health and Outpatient Care (CHOC) system and eMR. This is recorded by clinicians on-site in real time enabling all clinicians to access the most up to date information on the person's record.

Staffing model

- VAHS has a dedicated staffing model (outlined in table on page 2).
- Within this staffing model, 0.2 FTE project officers (clinical service leads) have been funded across each discipline to oversee oversee the service and change management processes, and to act as clinical champions.
- The part time positions that are employed within the VAHS are incorporated as part of the district's broader allied health requirements.
- Services are led by experienced allied health clinicians (Level 4+) who complete the virtual consultations.
- Allied health clinicians have been able to maximise their clinical time in a virtual capacity, as the time normally used to travel to patients has significantly reduced.
- VAHS enables nursing staff in smaller facilities to support allied health interventions in a way which would not occur in a facility with face-to-face allied health. This supports continuity of care and allows staff to develop and apply knowledge and skills in the ongoing care of the patient.

Training and development

- When this model was established, no specific training was provided on how to assess patients virtually. Clinicians have adapted clinical processes and drawn on existing skills and experience. A set of allied health virtual guidelines have since been released which may support other services.*
- Slowly increasing the scope of services over time can help to increase the confidence and experience of the allied health workforce in delivering virtual care.
- Clinicians are supported in reflective practice and continuous improvement. The VAHS team meet frequently to share experiences and draw on learnings of providing a virtual service.
- Leads from the different disciplines provide a mentoring and supervisory role for junior staff.
- Allied Health clinicians deliver training and develop resources for healthcare workers at the facilities to provide them with information on service scope and enable them to recognise when allied health input is required.

A patient and occupational therapist from the Orange Health Service completing a virtual home visit, preparing for discharge.

*See link to virtual guidelines in Supporting documents list

Funding model

- Some establishment funds were provided by the Chief Executive to fund project officers roles (clinical service leads).
- As this service is primarily an admitted service, there is no specific funding for the virtual model. The service relies on existing funding from the district budget. There are efficiencies and improved outcomes which assist with offsetting the cost of the service.
- To accurately record occasions of service, a virtual clinic was created with a different Health Establishment Registration Online (HERO) ID to the face-to-face allied health clinics
- COVID enhancement funding was used to extend services from April 2020 to December 2020. Securing ongoing funding remains a challenge.
- Funding models in WNSWLHD cross multiple streams and services at a district level and shouldn't be considered in isolation. For further information, please contact WNSWLHD.

Considerations for sustainability

- The VAHS has extended business as usual practices to smaller and more vulnerable rural and remote communities.
- The model is improving the sustainability of small rural health facilities and communities. It supports a growing specialist workforce through skill and career development opportunities in rural healthcare.

Benefits of the model

Results

In the **2019-20 financial year** the VAHS provided **2,030 occasions of service across the five identified disciplines to 1,068 people** who would have otherwise needed to travel long distances to receive care, or who may not have accessed care at all:

Discipline	Occasions of service	Patients
Dietetics	396	262
Occupational therapy	303	158
Speech pathology	217	119
Physiotherapy	956	465
Social work	158	64
Total	**2,030**	**1,068**

Hospital acquired pressure injuries were reduced to zero in Nyngan and Rylstone MPS. The reduced costs associated with treatment of stage two pressure injuries has led to a saving of $31,000 across the two sites.

As a result of increased access to dietetics, the **nutritional status of patients has improved, leading to decreased falls** at Nyngan MPS.

Benefits

1. **Improved access to allied health specialist input** for small rural health services and communities.
2. **Reduced travel time** for people, and their families to access allied health services.
3. **Reduced costs associated with travel and patient transfers** between MPS and referral facilities.
4. **Strengthened capacity of nursing staff** to assist with delivering best practice care and **increased understanding** of the scope of allied health.
5. Provides **efficient use of a limited workforce** by redistributing service provision more equitably **according to the needs of the community.**

'Without this service we wouldn't pick these things [equipment and counselling issues] up...we don't have the opportunity to think of everything when it's just a nurse unit manager and a community nurse at a facility.'

NURSE MANAGER, NYNGAN MPS

Deborah's Story

I've had lots of strokes and I'm not too good on my feet. I was scared to have a shower when I was at home alone. I was getting pretty nervous. I had to hang on to the taps to step into the shower and the hot tap used to burn my hands if I held on for too long. Sometimes I had difficulty getting up from the toilet. Pieta, my community nurse asked the OT to come and see what I needed.

I felt a bit nervous before the visit of what to expect, but it went well and I wasn't worried at all once it started. Pieta explained it to me, but I was still a bit anxious, but it went smoothly, and Sarah was easy to talk to even though she wasn't actually in my house.

The virtual OT organised a shower chair for me to sit on and had some rails put in my shower. It has made such a difference to my life. I feel I could shower all day now. I love it and I didn't have to wait long once Sarah had done the visit. I am not anxious anymore about showering and it doesn't worry me if I am alone. I am more confident now.'

Monitoring and evaluation

- The VAHS program has been implemented as intended in all five disciplines, providing services to communities and rural health facilities that have had no allocated allied health services.
- Uptake of each service has been successful in most communities. Where it was initially slower than others, positive outcomes and success stories in other facilities across the LHD led to increased uptake.
- PREMs are collected for allied health services, however the virtual component of this is not individually assessed. Qualitative patient stories offer insights into the experiences of patients specifically in relation to the virtual aspects of care delivery.
- Unintended positive outcomes from the service include:
  - Clinical support staff members at the facility taking greater ownership of the service and being proactively involved in implementing daily strategies for patients
  - High level of interest in virtual care education sessions for nursing staff at some of the smaller sites
  - For dietetics, the number of patients screened for malnutrition at the sites has increased compared to before the virtual service. A request to extend the service beyond malnutrition has also been made by several of the sites.

Opportunities

- Health applications (apps) could be used to further support the VAHS and further enhance patient management, e.g. physiotherapy exercise prescription/mobility apps and OT apps to assess home environment.
- The VAHS is a cost-effective model that is readily scalable and transferable to other LHDs with a similar geography and demography. The model's scope has expanded over recent years and now offers more holistic allied health service provision across WNSWLHD.
- As the VAHS continues to collect information regarding patient outcomes, there may be an opportunity to improve guidelines and criteria. This could support the further development of best practice guidelines and transferability to other LHDs.
- Larger metropolitan sites may also benefit from this model, as they have a more varied allied health workforce. Allied health assistants could be utilised as the support person at the patient end to assist with the virtual assessment. The scope and criteria for each discipline could also be applied to a metropolitan environment.
- This model could be extended to other services such as integrated care, high risk foot services and wound care.
- The definition of the virtual allied healthcare professional role and its scope may create strong workforce opportunities for the recruitment of clinicians across multiple districts.
- Patient outcome and experience data from VAHS consultations could be used to strengthen the evidence around virtual allied health care professional roles and benchmarking occasions of service by time and expense.

Supporting documents

VAHS information leaflet outlining service provision and contact details for each service.

VAHS postcard distributed to rural and remote health facilities to promote the service

Occupational Therapy Home Visit Guide – A guide for healthcare workers supporting a home visit assessment with a virtual occupational therapist.

Occupational Therapy Home Visit Measurement Guide – An instructional guide for healthcare workers when taking measurements on behalf of a virtual occupational therapist.

Information leaflet on the virtual pressure injury service – A document that provides a step by step process of key actions that need to be completed by the healthcare workers at the receiving facilities.

Telehealth capabilities for physiotherapists – A list of key skills and capabilities for physiotherapists related to technology and reviewing patients virtually.

Information leaflet on virtual social work service – A document that outlines key elements of the social work service with advice on how to refer.

Information leaflet on virtual MDT ward rounds – Outlines purpose and benefits of virtual MDT ward rounds and how they operate.

Telehealth Guide for Allied Health Professionals developed by AHPA

Acknowledgements

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Catherine Bourke	Social Worker
Staff at Narromine	Hospital and Community Health
Staff at Nyngan MPS	
Staff at Cobar MPS	

Patients and residents who shared their stories with the ACI team

We would also like to thank the clinicians, consumers and virtual care experts involved in reviewing the write-up of this model of care.

Glossary

MPS	Multipurpose Service
RACF	Residential Aged Care Facility
Wallie	portable videoconferencing machine
Cisco DX80	desktop videoconferencing machine
Rural Health Facility	smaller rural and remote sites at the receiving end of the virtual services
MDT	Multidisciplinary team

The Agency for Clinical Innovation (ACI) is the lead agency for innovation in clinical care.

We bring consumers, clinicians and healthcare managers together to support the design, assessment and implementation of clinical innovations across the NSW public health system to change the way that care is delivered.

The ACI's clinical networks, institutes and taskforces are chaired by senior clinicians and consumers who have a keen interest and track record in innovative clinical care.

We also work closely with the Ministry of Health and the four other pillars of NSW Health to pilot, scale and spread solutions to healthcare system-wide challenges. We seek to improve the care and outcomes for patients by re-designing and transforming the NSW public health system.

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NSW GOVERNMENT

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