

IMPLEMENTING NURSING OUTREACH

A toolkit to help improve access to
services for vulnerable populations



WHAT IS THIS TOOLKIT?

This toolkit has been produced to provide strategies and tools that may be useful to practices, PHOs and DHBs considering implementing nursing outreach.

It is the result of a research project examining nursing outreach and its impact in 15 practices in a range of settings around New Zealand. The research was funded by the DHB Research Fund. All quotes are from nurses interviewed for this project.

We would like to thank all research participants for their time and feedback on earlier drafts. We also wish acknowledge the generous support of BestPractice in providing the practice tools we have developed in this work to all practices in NZ at no cost.

CBG HEALTH RESEARCH LIMITED

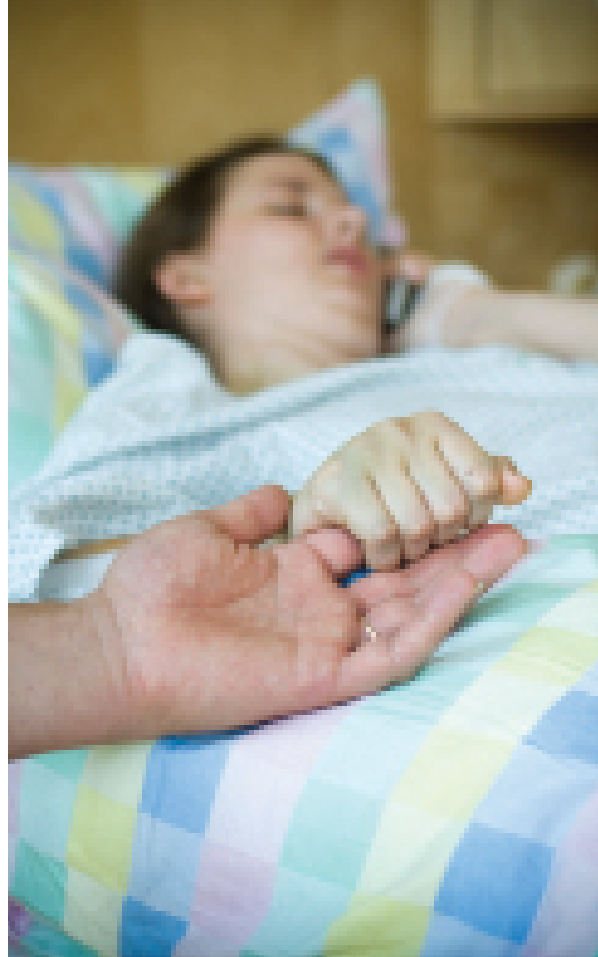
www.cbg.co.nz

PO Box 45173

Te Atatu

Waitakere 0651





QUICKLINKS

WHY DO NURSING OUTREACH	8
WHAT IS A REASONABLE CASE LOAD	20
WHAT SORT OF TRAINING DO WE NEED	24
WHAT SHOULD WE DO BEFORE SENDING AN OUTREACH NURSE	30
HOW DO I OBTAIN A LIST OF PATIENTS THAT MIGHT NEED A HOME VISIT	33
HOW DO I PRINT A HOME VISITING FORM	34
HOW SHOULD I ENTER DATA FROM A HOME VISIT	37
WHAT SORT OF REPORTING SHOULD WE USE	41

CONTENTS

BACKGROUND	4	DELIVERING NURSING OUTREACH.....	29
IMPROVING ACCESS TO PRIMARY CARE	5	Patient eligibility	30
Models of access	6	Recall or outreach?.....	30
How nursing outreach breaks down access barriers.....	8	flexibility and discretion.....	31
Benefits of outreach	9	Using PMS tools to support outreach	33
Relating with other services	10	Socio-economic aspects of nursing outreach..	36
How should nursing outreach be delivered? ...	12	Documentation	37
Targeting and maximising the value of nursing outreach	13	Reintegration of patient to practice	38
SETTING UP A NURSING OUTREACH SERVICE.....	15	MONITORING AND EVALUATION	40
Community focus and engagement	17	Quality monitoring	41
Allowing for the impact of external factors	17	What can go wrong	43
Cleaning up practice register	19	How to avoid programme pitfalls.....	44
Tight integration with the practice team	19		
Resources required	22		
Other staff	24		
Tools and equipment	24		
Training	27		

BACKGROUND

The New Zealand Health Strategy recognises that improving the overall health of New Zealanders requires a focus on improving the health of people with the poorest health. Introduced in 2000, the Strategy proposed a major reorientation in the way health services are delivered in order to address health inequalities. In particular, it proposed the development of inter-sectoral and population-based health care approaches.

In primary health care, this approach was implemented through the Primary Health Care Strategy (PHCS). Three key policy shifts which were introduced in 2002:

- Government funding for primary health care was increased so patients' fees to use primary health care services could be reduced.
- Primary Health Organisations (PHOs) were introduced as local non-governmental organisations to deliver primary health care to an enrolled population.
- Public funding of primary care shifted from fee-for-service subsidies at the practitioner level to capitation funding of PHOs.

Evaluation of the Primary Health Care Strategy [1] showed that the expected changes in primary care delivery were achieved. Patient fees were reduced (particularly for the high-needs groups which were originally targeted by the PHCS) and consultation rates increased. There was also an increase in the number of services delivered by nurses.

Overall, however, the changes observed were modest, considering the large investment required to implement the PHCS.

The evaluation of the PHCS also recognised that improvements in health status for people with the poorest health would likely require strategies in addition to those introduced by the Strategy; high patient fees, for example, were not the only barrier to health care for some patients.

To explore ways that PHOs could further improve the delivery of primary care to high-needs populations, in 2002 the Government allocated \$2.4 million to a Reducing Inequalities Contingency Fund. This was

aimed at developing innovative services to reduce inequalities in health [2].

Thirty-five projects were funded and evaluation of these projects concluded that two interventions in particular had considerable potential to address non-financial barriers to access to primary health care:

- Nursing outreach (when delivered in close association with practice-based clinical services).
- Practice-level training to improve acceptability of services to vulnerable groups by providing friendly, culturally appropriate, non-judgemental care.

In 2007 the DHB Research Fund called for proposals for research into further improving access to primary care. The research had two components:

- Evaluate existing initiatives.
- Conduct primary research, through a trial or intervention, to develop effective mechanisms to improve access for vulnerable populations.

The request for proposal emphasised that any intervention should be generalisable and that existing research should not be duplicated.

CBG proposed a research programme which began with the findings of the earlier evaluation of projects to reduce inequalities strengthened with a review of other studies on improving access.

CBG's programme then implemented and evaluated a nursing outreach intervention which included a practice training component on improving the delivery of care. Four DHBs, five PHOs and 15 associated general practices participated.

The research programme produced a literature review, a stocktake of over 650 projects to improve access to services and this toolkit to provide guidance on implementing the trialled interventions, including a set of tools that can be used at the practice level.

IMPROVING ACCESS TO PRIMARY HEALTH CARE

IMPROVING ACCESS TO PRIMARY HEALTH CARE

Nursing outreach involves nurses providing health care away from the practice, typically in a patient's home. This can overcome a number of access barriers, and provide valuable information about a patient's true health needs and social situation.

MODELS OF ACCESS

When designing an intervention to improve access to health services, it is useful to consider the reasons why people are not accessing health care services in the first place.

As part of this project CBG undertook a review of the literature describing theoretical perspectives to access, and describing the evidence that these factors affected access, internationally and within New Zealand. This review can be downloaded from www.improvingaccess.co.nz.

One approach to understanding barriers to health care services is to utilise a modified version of the model developed Penchansky and Thomas [3,4], which has been used by New Zealand researchers [5,6,7] The model identifies five barriers:

- Availability – there is an inadequate volume of services
- Accessibility – services are not close enough to users - physically or functionally (eg transport is not available)
- Accommodation – services are not organised to meet needs of patients (e.g. opening hours)
- Affordability – users have difficulty paying for care
- Acceptability – services are not provided in a welcoming practice environment or in a culturally appropriate manner

There is overlap between some dimensions but overall these categories offer more precision than some other models of access. This list goes a long way towards creating measurable dimensions of access and reflects the aims of New Zealand's Primary Health Care Strategy.

However, there are still some reasons why people don't utilise services that are not captured by this model. The components can be called "predisposition" and "appropriateness".

"Predisposition" is a feature of Anderson's Health Behaviour Model [8] and describes the readiness of a person (or part of the population) to seek health care. It may be operationalised as a probability of seeking care. For example, if an individual is not predisposed to obtaining care, it does not matter what other barriers exist, while an individual determined to obtain care may overcome significant obstacles.

Appropriateness refers to the appropriateness of care received. A distinction can be drawn between access to the health care system and access within (or through) the system. This is sometimes referred to as secondary access.

Adding predisposition and appropriateness to the above list results in a framework with seven components to consider when thinking about features of the health care system which can affect access.

SEVEN COMPONENTS AFFECTING ACCESS TO HEALTH CARE

- Predisposition – the population knows about services and wants to use them
- Acceptability – the user has a positive experience with the service
- Accessibility – services are within geographical reach
- Accommodation – services are organised to meet the needs of users
- Affordability – there are no financial barriers to accessing care
- Availability – services are adequate (in volume and type) for the population need
- Appropriateness – once users are engaged with the health care system is the right care delivered at the right time

While these components can be distinguished there is likely to be significant interaction between them. It is clear that "predisposition" will be influenced by the other components of access. Individuals and their families / whānau will be less disposed to seek care if previous attempts were rebuffed for lack of appointments, if times were inconvenient, if costs were high, if the subjective experience was demeaning or if treatment was ineffective.

In considering aspects of access these interactions must be remembered. In a review of models of access by Ricketts and Goldsmith [9] attention is drawn to fact that "access is a dynamic process where there is the potential for individuals and families to learn and modify their behaviour."

Dixon-Woods et al [10] suggest that would-be users of the health system take advantage of its "permeability"

to navigate between barriers, and manipulate the system to advance their candidacy for care. Service providers adjudicate on their suitability. When there is a mismatch between the "perceptions, priorities and competencies" of (particularly) disadvantaged people and service providers, "vulnerabilities" are created and appropriate care may not be received.

In New Zealand Buetow has discussed the process of seeking health care using as an example his work on access to primary care by asthmatic children. [11] He draws attention to: the distribution of decisions overtime and among members of social networks; the influence of "proto-decisions"; and the contribution of both mental and social events. In another paper, he notes that non-attendance, which may be irrational from a professional perspective, may well be rational from the point of view of the non-patients, and that effective responses must start by recognising this. [12]

The www.improvingaccess.co.nz website also provides a stocktake of over 650 projects to improve access in New Zealand, mapping each project to these dimensions, and providing a range of descriptive data about each intervention, including the nature of the intervention and cost data when available. [13]

There is good evidence in New Zealand and internationally that barriers to care exist in all seven categories and that access is impeded particularly for the economically disadvantaged, minorities and adolescents. [14,15,16] In New Zealand access is poorer for Maori and for Pacific people, particularly when considered in relation to need. [17,18]

Different components of access are most important in different health systems. In general however, poor access, and access differentials, appear to be less of a problem in countries with universal, free, health services. [19,20]

HOW NURSING OUTREACH BREAKS DOWN ACCESS BARRIERS

The increased subsidies for patient care in the Primary Health Care Strategy enabled GPs to reduce fees, reducing financial barriers to access. However many other barriers were not addressed. Table 1 shows barriers that outreach nursing can help overcome, compared with merely reducing patient costs.

By providing health care in the home, nursing outreach can overcome geographic barriers to accessing health services, such as lack of transportation and geographic isolation.

Other barriers to care can be identified by developing a more complete understanding of a patient's needs and resources. An outreach nurse may be able to acquire a much improved understanding of a patient's capacity for self-care, and therefore make a more accurate assessment of appropriate medical and nursing interventions.

Traditional practice-based primary care may lack the time to explore these issues in the required depth, and sometimes the practice environment itself is too uncomfortable for effective health care delivery.

An outreach nurse may require multiple contacts with patients, usually in the patients' homes, to establish

the relationship. The next step may be acting in an advocacy capacity, or accompanying a patient to a contact with a health service.

It may take some time for some patients to start using services, and once they are receiving services it can be very easy for them to disengage again, unless the service continues to meet their needs.

Successful nursing outreach employs nurses who have a clear understanding of the communities in which they work. Occasionally, solving access issues requires a systems level response, involving improved intersectoral collaboration, working with other social services agencies or changing the way health services are delivered.

Outreach nurses are continually collecting information about the needs of individuals, families / whanau and about entire communities. When outreach nurses services are strongly linked to practice-based clinical teams this information can be used to help practices improve health care delivery design systems, or suggest new approaches.

TABLE 1. ACCESS BARRIERS ADRESSED BY LOWERING FEES VS OUTREACH

BARRIER	LOW COST/FREE GP VISITS	NURSING OUTREACH
Clinic setting frightening	No	Yes
High fees / unpaid bills	Yes	Possible
Unwilling to ask for help	No	Yes
Concern other agency may be contacted	No	Possible
Language difficulties	No	Possible
Worried about NZ residency status	No	Possible
No access to transport	No	Yes
Clinic not open at convenient time	No	Yes



OTHER BENEFITS OF OUTREACH

Apart from the delivery of specific services and the opportunity to gain insight into the true health and social circumstances of a patient, nurses identified some other less obvious benefits to nursing outreach:

Better preventive services

A major component of many outreach services is the delivery of overdue preventive health care such as immunisations, cervical screening and facilitating access to mammography. When delivered successfully, a major benefit of the nursing outreach services is in early intervention to slow the natural progression of known chronic disease.

Timely response to unexpected events

Because of their skills and training, nurses are able to respond to a wide range of unexpected events, accurately assess clinical situations and communicate more effectively with doctors and hospital services than some other home visiting services.

Encouraging quality care

From a management and human resources point of view, the contractor/provider can benefit from having a dedicated, quality-orientated workforce. Just by itself

this can help focus providers on quality measurements and improve familiarity with tools.

Mitigating workforce shortages

Nurses from one trial site described outreach nursing as critical for meeting the needs of their community when their regions struggled to find permanent GPs. Outreach nurses provided a highly mobile and directable service that could meet the needs of widely dispersed high needs patients more efficiently than any single clinic setting.



A combination of low cost or free GP visits and targetted nursing outreach can address most access barriers.

Outreach nurses can use personalised face-to-face approaches to gain access to vulnerable populations.

Successfully engaging underserved populations usually involves an extended period of trust building. An outreach nurse will typically require multiple contacts with patients, usually in patients' homes, to establish that trust.

The benefits of nursing outreach can be extensive and, when successfully delivered, include reengagement of patients with primary care services, prevention of disease and disease progression, ability to respond to a wide range of unexpected events, accurate assessment of clinical situations and improved communication with other clinicians and hospital services.

Perhaps most importantly nursing outreach provides an opportunity to assess and address the broader social derterminants of health.

RELATING WITH OTHER SERVICES

A nursing outreach visit may start with the initial goal of addressing an outstanding healthcare need and re-engaging a person or family with a general practice. But, in reality, outreach nurses often become closely involved in the social circumstances of patients and their families and act as caseworkers or central coordinators of care. A nurse may intend to provide a particular clinical service but once he or she arrives at a patient's home, the plan changes.

The types of services nurses provided in our trial in 15 practices included making sure patients have prescriptions and lab test forms, following-up non-response, assessing health status in the home, acting as a lead care coordinator, providing multiple interventions, and managing complex health and social issues.

"Outreach work is vast and varied. Sometimes it's just getting a blood sample but then it's sorting out the problems of a complex family with multiple needs and you end up as the coordinator of their care, helping them go to appointments, acting as an advocate, social worker."

This expanded role occurs because of the very benefits that nursing outreach provides:

- ° The home environment presents situations aside from the initial medical condition that must be addressed.
- ° An unexpected health situation exists with the patient.
- ° The geographic nature of the region demands a flexible approach to the services.
- ° The outreach provider or contractor determines that nursing outreach is a good "first contact" opportunity to engage families new to the area or who haven't previously been seen by the health care services.



RANGE OF ACTIVITIES

In completing outreach work, nurses are required to assume roles related to the provision of social and education services. However, nurses are not trained for these roles, nor do they necessarily have ready access to tools and information needed to perform these roles.

The outreach nurse can struggle to effectively navigate the path to securing help with social welfare benefits, other financial assistance, transport, mobility and care assistance. Problems gaining access to social and education services can commonly limit the outcomes sought by nursing outreach service.

"It can take hours trying to get transport or social worker involvement. Who do I need to speak too – when can they do the assessment – they can't get into the centre? "

Primary care nurses have always had a role in coordinating services to improve the wider determinants of health such as poverty reduction and improved housing, although there is wide variation in the extent to which nurses have the knowledge or time to engage in this work.

"The role involves social work, advocacy, advising on social situations. We are crossing the boundaries and going into the education and social sector – something that we are not always qualified to do."

HOW SHOULD NURSING OUTREACH BE DELIVERED?

Nursing outreach is probably best delivered at a PHO level, although it could also be implemented in larger practices, for example at Integrated Family Health Centres if there are sufficient case loads. The multi-disciplinary nature of some of the interventions outreach nurses can deliver means that Whānau Ora providers will be natural providers of nursing outreach.

Establishing a nursing outreach programme comes with challenges, including required resources and finances. Larger organisations are usually best placed to meet these requirements.

Advantages of the PHO-based programme

- Most practices will have small numbers of truly hard-to-reach patients. It may not be financially viable for a single practice to maintain its own nursing outreach service. By pooling resources with other practices, such systems can become viable. This approach has been used by PHOs to deliver, for example, IT support and chronic-care management for diseases such as diabetes.
- Where PHOs have experience working collaboratively between practices, it would be relatively easy to expand the services provided by the PHO to include nursing outreach.
- This toolkit describes the importance of integrating nursing outreach with the clinical practice team.



Accessing other social services can take up a lot of nursing outreach time.

Contracts with nursing outreach providers should usually address processes for liaison and referral to other social service agencies.

It could benefit everyone – the contractor and the funder – to explore options for multi-sectoral funding.

In order to achieve successful integration even in a large PHO, it is recommended that a nurse work closely with a limited number (approximately five to 10) of practices.

- Outreach nurses have the opportunity to work at the population, rather than practice, level. While a practice nurse or a rural health nurse may need to fit outreach into an already busy work schedule, an outreach nurse employed by a PHO to cover more than one practice has dedicated capacity to complete nursing outreach. The PHO-based outreach nurse is a fresh face for the patient and family. This can be both emotionally and clinically refreshing; the outreach nurse provides a new look at cases from outside the practice perspective. Because the nurse isn't perceived as a member of the practice, he or she tends not to get involved in practice or patient politics.
- The financial mechanisms already exist to pay PHOs to deliver services such as nursing outreach. Some DHBs have not been able to utilise Services to Increase Access (SIA) funding to date, but SIA funding is likely to be appropriate for most nursing outreach services. Services could include home care for patients with common chronic illnesses (such as diabetes and asthma) where rapid changes in health status are possible and provision of preventative care in the home, such as cervical screening and immunisations.

Disadvantages of working through a PHO-based programme.

- Non-practice nurses are unknown to the patients and families; they have no past history or relationship with the practice staff and, consequently, require more time to build trust and rapport with patients and practice staff.
- Nurses who are employed by programmes which serve more than one clinical practice must juggle time and work and share capacity across practices which have differing needs. They must be able to negotiate different practice systems and methods of working.
- Nurses can be faced with practices which do not have effective recall systems and practices which see outreach as a remedy for their lack of recall systems.
- Some practices may resist giving access to patients' records to nurses not employed by the practice.

- Some general practices have traditional methods of working. If the PHO comprises a high number of solo GPs who follow more conservative models of general practice, they may be resistant to new models of health care delivery; they may perceive outreach as new and experimental and be reluctant to become involved in anything that is not 'tried and tested'.
- Some general practices in the PHO may fear that nursing outreach will increase demand on the clinical practice. Some practices fear that the outreach service will result in increased GP time demand from people who are already bad debtors and/or who have mental health needs that are difficult to cost-effectively address within the current GP payment structure.



Nursing outreach is probably best delivered at a PHO level, although it could also be implemented in larger practices, for example at Integrated Family Health Centres.

Whānau Ora providers may be natural providers of nursing outreach.

TARGETING AND MAXIMISING THE VALUE OF NURSING OUTREACH

In order to get value for money budgets and reach patients who will most benefit from nursing outreach, funders and outreach service providers must clearly define the patients and groups to target through nursing outreach.

Nursing outreach is a successful way to access hard-to-reach patients in the vulnerable populations. However, it is an expensive option, costing as much as \$200 per visit. It must be considered an absolute last resort to re-engage patients. It should be used only after all recall and other outreach methods have been attempted and failed.

Targeted patients and groups are likely to differ depending on region, demographics and public health needs. However, once groups of patients have been targeted, those individuals eligible to receive nursing outreach services should be identified through Practice Management System (PMS) queries. As described later in this toolkit, some patients will be identified by physician referral.

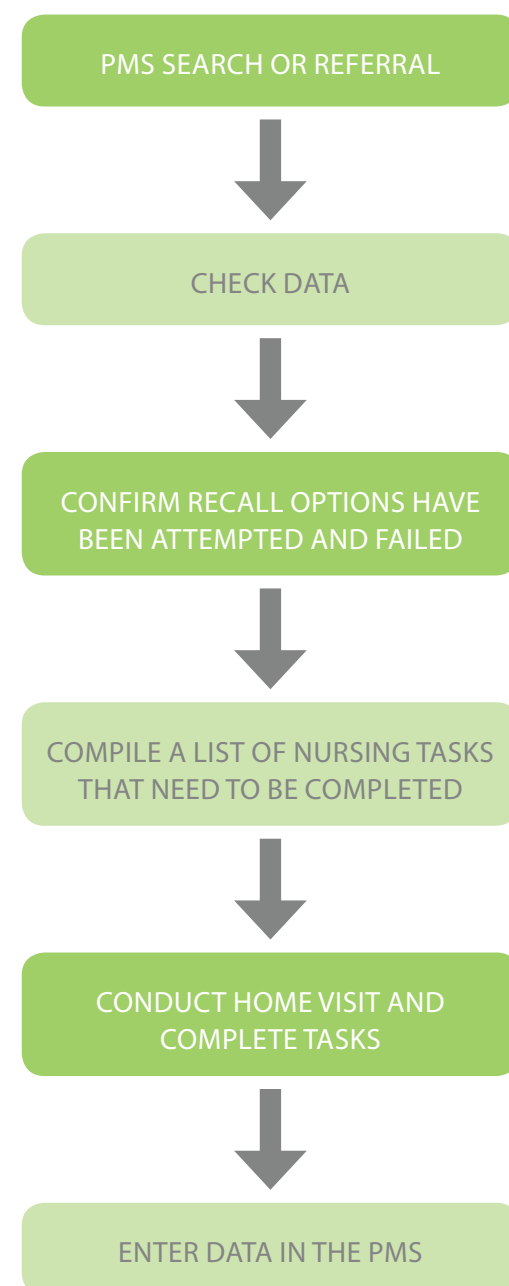
The PMS query can be customised to meet specific criteria set up for each particular nursing outreach programme. For example, it can identify patients who have not attended the clinic in the past six months and who also have overdue immunisations, medications and/or diagnostic tests and who have not responded to recall attempts.

The nursing outreach flowchart, however, is identical for all nursing outreach programmes.

MAKING THE BEST USE OF A VISIT

Care provided during outreach visits is most often driven by the reason for referral. This is logical, but the benefits of nursing outreach include providing undelivered basic health care and responding to unexpected issues.

Because of the expense involved in extending nursing outreach services, it is not a sensible use of resources to make a major investment in time and transportation to visit a patient who is potentially geographically isolated, to establish trust and rapport and then not deliver appropriate or complete health services.



Contracts should be written so that nurses providing outreach services have the resources and facilities available to maximise the health gains from each patient contact.



Nursing outreach should be considered as a resource intensive intervention to be used in special circumstances.

Outreach criteria which specify who is eligible for a nursing outreach visit should be explicit in the nursing outreach contract.

Basic steps when developing contracts for nursing outreach:

- Identify the group(s) which will be targeted and the eligibility requirements for patients
- Clarify recall systems which will be used prior to outreach
- Stipulate that recall documentation will be completed prior to outreach

SETTING UP A NURSING OUTREACH SERVICE

SETTING UP NURSING OUTREACH

Nursing outreach should be designed to meet the needs of the practice population and be tightly integrated with normal clinical practice. Delivery should be finely tuned to the communities to be served.

COMMUNITY FOCUS AND ENGAGEMENT

Targeting vulnerable populations in the community

When establishing a nursing outreach programme and developing the associated contracts, the contractor and provider may choose to target a specific community or population rather than launch a general nursing outreach programme.

A good starting point is to research care delivery deficits using available data from primary care and to list known barriers to access. It can then be useful to examine the profile of non-users to determine which health needs could be met by nursing outreach.

Once a particular targeted population and/or community has been successfully serviced by the nursing outreach programme, the contractor may choose to expand the contract to include other patients/communities/needs.

ALLOWING FOR THE IMPACT OF EXTERNAL FACTORS

Providers and contractors of nursing outreach should make provision in their contracts, plans and practice management for external factors which affect

the ability of services to provide nursing outreach.

Public health, environmental and economic forces all have the ability to impact nursing outreach. Depending on the circumstances, nursing outreach demand and delivery can see either a sharp spike or a severe decrease in demand.

Nursing outreach activities were hindered, for example, during the H1N1 influenza pandemic. During this outbreak, some outreach nurses were required to abandon some outreach activities in order to help with the management of suspected influenza cases and the community response to the threat. If an outbreak is significant to the targeted population, however, the demand for nursing outreach may increase during an outbreak.

"I was involved in swine flu – visiting suspected cases and managing their families' response and trying to manage the associated community hysteria."

During times of adverse weather conditions such as flooding or road closures, nurses delivering outreach services may not be able to access rural areas. On the other hand, an environmental impact such as an earthquake may find nursing outreach demand increases for an extended period as patients cannot access primary care facilities for their chronic disease management.

"People were stranded – no way in or out – and we literally could not get to them. It took four weeks to repair the damage to some of the roads."

Unemployment associated with recession and other economic factors increases barriers to accessing primary care for many families. This, in turn, increases the demand for nursing outreach.

Successful nursing outreach programmes are a collaborative effort between the contractor, the provider and the clinical practice. Success comes through clear communication and explicit expectations.

CLEANING UP PRACTICE REGISTER

Outreach contracts should be written so that nursing outreach is used only after other methods have failed to facilitate engagement with vulnerable patients.

Nursing outreach should be initiated at a professional's discretion and through the use of the PMS queries to identify eligible patients.

Contracts are most often negotiated on expected rates of outreach visits. This expected rate may be determined by queries of practice data. There may be some work to do to clean-up practice registers to allow efficient targeting of outreach services. On going maintenance of minimum levels of practice data accuracy should be a condition of each nursing outreach contract.

The practice data clean-up could include:

- Checks on enrolled / active status accuracy
- Audit of disease registers and correction of disease coding errors

- Complete ethnicity coding data
- Identification of all the methods used to identify those eligible for outreach visits

TIGHT INTEGRATION WITH THE PRACTICE TEAM

It is not a sensible use of resources to make a major investment in time and transportation to visit a patient who is potentially geographically isolated and to establish trust and rapport with that patient (and potentially their family) and then not deliver all possible appropriate services. For people with infrequent contact with the health system, the potential of every contact should be realised.

Prior to developing a nursing outreach project, the contractor and provider should establish ways in which the service will be fully integrated into the wider general practice team.

Systems are needed which combine the work of outreach nursing providers with those of other professionals at the practice. Without a formal framework within which to operate, the rights and responsibilities of the nurses providing nursing outreach services are not clear. The relationship between the nurses providing nursing outreach services and providers of other outreach – for example Community Health Workers – also needs to be clearly established.

Outreach nurses need the assistance of practice staff for the triage of the PMS-generated lists but this can be perceived as a burden for the clinical practice staff.

Outreach nurses, if not properly supported and resourced, may resist pursuing practice staff for assistance in identifying new patients for their roster; the outreach nurse provider may not want to add to their own workloads or those of the clinical staff.

Frustration can result if an outreach nurse is simply given a list of patients to visit but not provided with additional information or background knowledge about the patient's family, social and environmental circumstances. As outlined in other parts of this toolkit, not all information about a patient is always coded (or coded correctly) in the PMS; additionally, a primary care provider will often not include information about 'hunches' or the condition of a patient's mental health. This information should be communicated to the nurse providing nursing outreach services.

"Lists don't work – we are dependent on those who know the patient to provide the referral. They have the information and can decide about the visit."

In many cases it can take time for practice staff to understand how to effectively use and value the outreach service. However, once that occurs, the value of the outreach service can impact upon the functioning of the entire practice. One practice involved in the research which led to this toolkit found that having the outreach nurse as part of the clinical team inspired them to look at their practice, its recall systems and other processes to see if there was a better way for them to do things.

Integration is a two-way street

Outreach nurses are dependent on the clinical practice to provide them with referrals to the patients and details of the patient's history, but the clinical practice is also dependent on the outreach nurse for regular and rapid feedback and for assistance in re-integration of the patient back into the practice.

Outreach nurses should when possible attend team meetings and work closely with a patient's nurses and GPs. The service agreement should include a requirement for two-way collaboration between the nursing outreach provider and the clinical practice.

Reimbursement

Depending on circumstances, the cost of a nursing outreach activity can range from \$30 to more than \$200. Most nursing outreach contracts structure costs according to nurse time plus travel cost; including overheads and equipment, training, etc increases the overall cost of the service.

In the nursing outreach research, nurses in general were unsure about the average cost of a nursing outreach visit. Estimates of average cost ranged from \$30 to \$230 per home visit.



Only after a practice has cleaned up its register should the contract begin. This ensures that nursing outreach is properly targeted and not being used as a premature step in the recall process.

Contracts should include a clause requiring the ongoing maintenance of accurate baseline data, including disease register data and ethnicity coding.

Nursing outreach is more likely to be successful if it is closely integrated to with routine practice processes.

The patients that are eligible for outreach should be specified in contracts.

Outreach contracts should promote the effective use of outreach when all other recall methods have failed to facilitate patient access.

Contracts should specify the expected rate of outreach visits, based on accurate data from the practice.

While patient eligibility requirements and criteria for nursing outreach should be specific, the contract should allow for exceptional discretionary visits. All practices in our trial gave examples of cases where outreach was entirely appropriate but did not meet existing criteria.

A PROJECT MANAGER
DURING THE SET-UP PHASE
OF THE NURSING OUTREACH
PROGRAMME CAN
PROVIDE BENEFITS FOR ALL
STAKEHOLDERS.

RESOURCES REQUIRED

A successful nursing outreach programme employs the right nurses and provides them with the right tools and equipment.

Staffing levels

Staffing levels need to be adjusted to reflect the size of the PHO and practices served by the nursing outreach provider and variables such as the demographics of the community, target of the DHB and the geography and terrain of the region.

There is a large variation in the number of calls, visits and other activities accomplished per FTE nurse each week, depending on patients' needs, travel distances and time spent on other tasks.

- In general, visits take between 15 and 60 minutes, depending on the reason(s) for the visit.
- In most cases nurses are able to make an appointment but where there is no phone or response to a letter, they can cold call with good effect – there is the potential for inefficient use of time.

While guidelines can be given, employment arrangements for outreach nurses dictate capacity to complete the work. PHO-employed nurses should be afforded more time to engage practice staff in the outreach work. Practice-based nurses require protected time to complete outreach activities.

"I complete four to five visits in two and a half days"...

... a PHO-employed nurse who works across two practices and has limited management support and no activity requirements specified in the service contract.

"We have done about 30 visits in the last couple of months. To be honest I have been busy with other things. We are one practice nurse down and we are just trying to fit this in when we can"...

... practice nurses with no activity requirements specified in the service contract.

"About four to five visits a day. Most weeks it would be 20 to 30. Our PHO contract requires that number of visits. I have to follow up all DNAs and all those

who don't have a CVD risk measurement and now immunisations and screening"...

... practice-employed nurse with number of outreach visits specified in the service contract.

While it is expected that nurses working in outreach will have exemplary and up-to-date nursing skills, because of the nature of their work, they must also be proficient in other areas.

Clinical skills

Depending on region, nurses may have a large set of standing orders under which they practice. Some rural health nurses work in isolation and provide all the health needs for the area. Nurses in this type of situation require broader training than those working out of a local practice who regularly visit patients with a single, particular medical need.

Independence

Having the skill to work independently is very important for the successful outreach nurse. For PHO-based nurses, it is the skill to work with many different practices. The outreach nurse needs to be able to juggle independence but be able to respond to a number of "supervisors".

Flexible mind-set

Practice-based outreach nurses often work part-time in the practice and then work under the outreach nurse contract out of the office. Not all individuals are able to shift roles smoothly; those who do so are flexible in their thinking and work style.

Nurses who work for PHO-based outreach programmes also need to be able to "shift gears" and work across many practices, each with its own personality.

Sensitivity and emotional intelligence

Nurses must have the skills to provide care away from the clinical setting.

Working in the home environment, nurses are exposed to socio-economic problems which cannot be ignored and which may not be obvious in the clinic setting. Involvement in these issues is time-consuming and sometimes requires nurses to navigate situations they are not necessarily qualified to address. The transition from socio-economic platforms of engagement to health care is not always smooth or possible – working in the home environment can leave nurses feeling reluctant or unsure about how or when to approach health issues.

"You have to prove yourself when you get in there – show that you are going to help to get their trust. Sort out their benefits so that they can pay for care. You can't plough in there asking to take their blood pressure – not right away!"

Well connected

Nurses should have good local networks and connections in the community. Ideally, nurses are known to – and understand – the community. It has been suggested that having a nurse who is matched in terms of ethnicity, age and gender will further improve success. This is particularly true if the individual can speak the language of the community. For example, breaking down barriers to access in a predominantly Pacific Island community requires a nurse who is able to speak the language(s) of that community.

For providers which are not practice based, nurses need to have good links with GPs who want to provide quality care. This will help the nurse engage with the medical practice.

Sharing between practices

Without doubt, the cost of visiting people in their homes is high – up to \$200 per visit – and, realistically, most practices have few very-hard-to-reach patients. If a home-visiting nurse is shared between practices, the cost can be shared and will, overall, be proportionately less.

There are approximately 1300 active general practices in New Zealand with an average practice size of three GPs. The potential impact of each practice having access to its own outreach nurse to improve chronic care management and provide immunisations could be large. Funding each practice to have an outreach

nurse (with a transport allowance of \$10K) has been estimated as costing approximately \$70M (REFRICF)

A shared-services model offers savings and increased efficiency for nursing outreach operated through a PHO or a private practice.

During the research which led to this toolkit, nurses employed by PHOs worked across a number of practices. These nurses seemed to have the advantage of protected time to deliver the service as compared to practice-employed staff who were likely to be prevented from completing outreach by other workloads.

PHO-employed nurses estimated that one FTE outreach nurse could work across ten to 15 GPs or a patient population of 20,000 to 30,000. However, these nurses sometimes struggled to gain the trust and buy-in of practice staff and, as discussed earlier, integrating the outreach nurse with the clinical team is crucial for success. Consequently, even in a large PHO, it is sensible for a nurse providing nursing outreach to work closely with smaller groups of practice, with attention given to effective practice liaison.

OTHER STAFF

The contractor and provider must be realistic about personnel rates and costs beyond the nursing staff.

Management overhead

While there are examples of practices which can smoothly integrate new initiatives into their businesses, most providers do not have sufficient spare management capacity to implement new projects.

The provider may find it useful to hire an interim project manager to set up the nursing outreach programme, both at the provider and clinical levels.

Clinical liaison is key for the necessary integration of nursing outreach with GPs and nurses delivering care within a practice.



Administrative support and supplies

A wide range of complex administrative tasks must be performed in order to run a primary care service. Following up patients using other providers and (increasingly) finding locum or replacement doctors and nurses means new projects such as nursing outreach risk having a low priority compared to what are considered essential activities. However, administrative support must be guaranteed for a nursing outreach programme to be successful.

☐ TOOLS AND EQUIPMENT

In order to run an efficient and effective nursing outreach service, nurses need necessary tools and information at their fingertips.

Information

As described in section 1C, nursing outreach is often socio-economic in nature and the types of services nurses provide extend from chasing non-responses to providing test advice; from assessing health state to acting as lead facilitators; from providing multiple interventions to addressing complex health and social issues.

Achieving these tasks often depends on the action(s) of services which are beyond the control of the nurse. In completing outreach, nurses require assistance.

Gaps in, and problems gaining access to public, social and education services, commonly impede the outcomes sought by nursing outreach and in some cases heavily consume the nursing resource.

Some nurses – particularly those who have a long history in a region – have a personal knowledge based around local services. Informal directories compiled by individuals (in particular, ones which remain ‘in the nurse’s head’) are not necessarily complete and are unlikely to be utilised by others.

“Really it’s in my head. I now know who to go to at social welfare, which organisations offer drug and alcohol rehabilitation, who does counselling, how the women’s refuge works... but it’s in my head.”

Nurses need up-to-date and complete directories of local services; it is time-consuming and expensive for them to find and compile information that is not complete, readily available or easily accessible. Contracts must contain guidelines for how nurses will be armed with necessary information.

Information technology (IT)

The outreach nurse spends much of his or her time on the road but requires a computer for accessing patient records and entering data. This can be either at the practice or via a laptop with a remote wireless connection to use on the road. If the laptop option is chosen, the nurse requires a suitable wireless USB stick. The outreach nurse also requires IT support.

Clinical staff often code medical records incorrectly. For a successful nursing outreach service, adequate resources must be allowed for ongoing IT and PMS training and assessment in outreach contracts. This is a recurring theme throughout this toolkit.

Contractors should be aware of resistance by some staff to using the PMS and template forms and build into contracts not only training time and costs, but the time and resource to create specific forms and assessment tools for the delivery of their programme (and reporting requirements).

Set-up costs

Roll-out requires strong clinical buy-in and flexibility. The time required for set-up and finding experienced local staff is likely to be longer than anticipated. Contracts need to provide for the establishment phase of the nursing outreach programme, including advertising and promoting to the community and the GPs. Clinical practice staff needs to be on board; this can be time and resource intensive.

Smooth establishment phases occur for programmes which have culturally competent, experienced local staff, GPs who support the programme and allow themselves the necessary time for the set-up phase. One programme reported that set-up went well because it spent two years in the development and planning process and liaising with the community before the programme was established.

Physical and logistical requirements

Providers of nursing outreach will commonly be expanding their existing services. Physical space to

accommodate extra practice personnel may seem too obvious to mention, but it is often an overlooked need and must be considered when setting up a nursing outreach programme.

Telephone – landline and mobile phones

In the office environment, the nursing outreach programme needs access to a landline. When the nurse is not in the office, administrative support for answering that phone must be provided. As the nurse is often out of the office, the nurse also requires a mobile phone.

IT and Patient Management System equipment and support

The outreach nurse will spend much of his or her time on the road and not domiciled in the practice. However, he or she will require access to a computer terminal for accessing records and entering data. A laptop that can be taken to the field and be remotely connected to the practice’s server might be a good option. If the laptop option is used, a wireless USB stick would be a way for the nurse to access the server remotely.

Transportation to off-site visits

Transportation for the outreach nurse is an obvious need but in all projects researched for this toolkit, the estimated amount of travel was less than that actually required. Additionally, most services planned to replace mileage reimbursement systems with the provision of a vehicle.

Training and continuing education

Outreach nursing providers may need to provide funding and time for nurses’ training and continuing education.

Clinical equipment

Nurses operate out of the office and may need clinical equipment above and beyond that available in the clinic.

Promotional funds

Because nursing outreach will be a new service and one that aims to meet the health needs of

hard-to-reach patients, a provider may need to promote the availability of the service to the community it wishes to reach. This is especially important for subsets of the population whose barriers to treatment might mean that the practice does not know the patient exists in the area or that he or she has a medical condition requiring care.

TRAINING

Correctly using IT systems in the PMS will help ensure the success of the nursing outreach programme. Investing time and resource into training is a very good investment.

A recurring theme throughout the research for this toolkit was the lack of IT knowledge of many health workers. Primary care project implementation can be assisted by an “IT health check” by a knowledgeable health IT professional, familiar with a provider’s PMS. As discussed above, maximising each contact of nursing outreach is dependent on correct usage of the PMS.

It is unusual for providers to effectively use available functionality in their PMS systems. Providers which write their own databases or use a spreadsheet for



Following registry clean up, an estimate of the number of patients in a population needing outreach can be made. Because of the need for flexibility, an additional 15% should be added to the number of eligible patients.

Based on eligible patient numbers and appropriate staffing rate for a programme’s regional considerations (approximately one FTE can visit 20 – 30 patients per week), staffing needs can be calculated.

In addition to exemplary and up-to-date clinical nursing skills, nurses employed in outreach must have other talents, including a high level of emotional intelligence, be well connected in the community and be independent and flexible in their work style.

The cost of visiting people in their homes is high – up to \$200 per visit. Realistically, most practices have few very-hard-to-reach patients. By sharing a nursing outreach programme between practices, the cost can be shared and will, overall, be proportionately less.

Nurses need up-to-date and complete directories of local services; it is time-consuming and expensive for nurses to find and compile information that is not complete, readily available or easily accessible.

On-going IT and PMS training and assessment must be included in the contract in order for the nursing outreach programme to be successful.

Contracts need to provide for the establishment phase of the nursing outreach programme, including advertising and promoting to the community and the GPs.

In order to run an efficient and effective nursing outreach service, nurses need necessary tools and information. Contracts must contain provisions for necessary equipment and support, including administrative staff.

tracking clients usually use inefficient techniques that do not allow easy reporting or information retrieval.

While running queries, opening attachments and saving results may initially present difficulties for some providers, over 24 months the general level of IT literacy and usage should improve noticeably. Involvement with the outreach and IT usage process will result in significant up-skilling.

During this time, providers should become aware of the facilities available in their PMS for recording different items of service. This can be a major IT challenge prior to implementation of an outreach programme (or proper use of the PMS). It is necessary to identify which services have been provided through outreach funding and this sometimes requires the use of coding.

A web-based template for incorporating an outreach nurse into the primary care service would be valuable if made available to PHOs, providers or directly to practices.

CULTURAL COMPETENCE TRAINING

Nurses and all members of the clinical practices engaged with nursing outreach should have high levels of cultural competence. Although some nurses will already have the necessary skills it is usually a good idea to refresh these with training, and skills evaluation.

This training should include topics such as: cultural competency; reducing structural barriers such as appointment times and the challenges of the practice environment; appropriate staff attitudes; improving staff understanding of Māori culture and the local Māori community; improving staff understanding of other cultures and communities; and ensuring equal access and outcomes for health care to reduce inequality in health care for their Māori and under-served patients.

SUGGESTIONS FOR TRAINING

- Include expert advice on the impact of cultural beliefs on health states and perceptions and use of general practice services.
- Provide education on face-to-face and telephone engagement of people and teaching about Māori family structure and its importance.

- Invite practices to provide insight into their existing knowledge levels and practice friendliness strategies.
- Tailor the offering to build on existing problems, strategies, knowledge and practice.
- Ensure course attendees receive expected learning outcomes which highlight how the course will help to build on existing strategies and knowledge.
- Use courses that are recognised for professional accreditation (CNE / CME)

“The focus should be on how we can access and engage people on the phone and face to face...” and ... “how can we deal with X who is clearly uncomfortable bringing her family to see us?”

CONSIDERATIONS FOR TRAINING

The distractions of a busy practice can interrupt training sessions. Staff can be resistant to training, non-responsive and confrontational, particularly if the training facilitator is not seen as knowledgeable or a cultural expert. The time involved for the course must be in relation to the outcome, must be perceived as having value and the delivery style must be conducive to group interaction. When setting up a training programme, it is important to remember that language must be appropriate and correct for the audience.

DELIVERING NURSING OUTREACH

A sample cultural awareness training structure

Practice training modules:

- ° Practice friendliness – what is nice
- ° Preferences – how people differ
- ° Whānau – role of family and friends

Cultural competency training modules:

- ° Getting into someone's home
- ° Building and sustaining rapport
- ° Am I doing it right? Am I helping the right people?

Clinical training modules:

(topics selected based on prevalence within the high-needs, under-served and Māori population)

- ° Standing orders and cardio-vascular disease
- ° Depression and asthma/COPD
- ° Diabetes



The entire practice staff – GPs, receptionists, practice nurses, health-promotion staff and practice managers – should be included in some nursing outreach training and have a working knowledge of nursing outreach and its benefits to the practice.

Assuming adequate quality training, contractors and providers of nursing outreach could expect that IT capacity and literacy would rise over the first 12 to 24 months of nursing outreach.

Within a practice, there is likely to be a range of interest, experience and enthusiasm for cultural awareness training. Prior to course participation, practices should be invited to provide insight into their existing knowledge levels and practice friendliness strategies.

Cultural competency training should:

1. Include expert advice on the impact of cultural beliefs on health states and perceptions and the use of general practice services.
2. Provide education on face-to-face and telephone engagement of people from different cultures.
3. Invite practices to describe their existing knowledge levels and practice friendliness strategies – many practices already have very good systems.
4. Take into account existing cultural accreditation, knowledge or practice and tailor training to build on existing problems, strategies, knowledge and practice.
5. Be delivered by an experienced group facilitator who is also a recognised expert.

DELIVERING NURSING OUTREACH

Nursing outreach is an effective strategy for improving access. However, it requires a significant investment and should be targeted to patients whom it can help most.

PATIENT ELIGIBILITY

The criteria for access to nursing outreach will vary according to the community and the barriers to access experienced by its vulnerable populations.

Nursing outreach should be initiated by the practice or PHO through the PMS queries, information known to clinical staff and other health providers.

Data sources that can be used to select potential patient for outreach services include:

1. Recently discharges from hospital (electronic discharge summary sent to PMS; PMS queries)
2. Overdue immunisations, diabetes care or other chronic disease follow up identified within a practice (PMS queries)
3. Palliative care requirements (referral from a practitioner; PMS queries)
4. Targeted health issues, eg CVD risk assessment not done, eg as part of PHO performance Programme (PMS queries)
5. General health checks, social issues, sexual health and youth issues (PMS queries)
6. Did not attend secondary care appointment (list provided by the hospital)

7. Avoidable hospital admission (list provided by the DHB)
8. Chronic Care Management (CCM) programme (list of those eligible from PHO)

RECALL OR OUTREACH?

Once patients have been identified as requiring follow-up care, a clear recall plan needs to be followed prior to nursing outreach being initiated. This must be specified in the contract.



In practices which lack effective systems and the capacity to recall patients, outreach nurses may be asked to visit patients who may otherwise have responded to a telephone or posted letter recall. In these situations, the outreach nurse may find it difficult to identify and assess recall attempts through the PMS notes.

Some clinical practices may consider the nurse outreach (and community health worker) part of the recall process.

“We use [referring to recall process] phone, texts, CHW and the outreach nurse visits and letters.”

It is worth noting that outreach contracts could inadvertently contain clauses which would encourage the use of nursing outreach for all patients in a certain category. For example, a contract may read, “provide visits to all those who do not have a current cardio vascular risk assessment”. It may be beneficial to reword the contract along the lines of “provide visits to those who do not have a current cardio vascular risk assessment and who have not responded to recall efforts”.

FLEXIBILITY AND DISCRETION

Nursing outreach is sometimes completed for reasons which are not apparent in the PMS. Providers need freedom and encouragement to use nursing outreach for patients and situations which fall outside the rules.

While the contractor will want to ensure that nursing outreach usage is appropriate and that contractual – and health – goals are being met, if a provider can decrease the incidence of hospital admissions by using nursing outreach beyond strict PMS guidelines, for example, the practitioner should be encouraged to do so.

Some patients will visit the doctor for an acute issue but will have fallen behind on chronic care; their visit will trigger an outreach visit.

In other cases, referrals are made on the basis of a professional’s personal knowledge, or suspicion, about a family’s circumstances. This information is not necessarily recorded in the PMS, and may include:

- Availability and cost of transport in the area
- Individual attitudes which precipitate personal and idiosyncratic barriers to access,

such as patient preference for a test or screen to be completed by a person who is not known to them.

- People who are temporarily living away or have recently returned home
- Those who are casually using other services
- Suspicions about home environment
- People who do not have the resources to provide care for themselves or their dependents.

“The doctor asked me to find out about their living circumstances. You see things that are not evident when they come to the practice, washed and scrubbed, like the poverty, depression, withdrawal, support systems and relationships.”

“Sometimes the GP is restricted for time – they have seen the person but they want them followed up for education and to look at the home environment.”



Outreach may be used inappropriately if referrals are not screened or if referrers do not fully understand the purpose of the nursing outreach service.

Some steps can be taken to reduce inappropriate use:

1. The outreach criteria should be made available and explained to each referrer.
2. All referrals should be subject to further investigation using clinical records and drawing upon practitioner knowledge.
3. Referrals should be checked by a senior manager responsible for the implementation of the service in accordance with the outreach contract.

Contracts must be clearly worded to avoid confusion between recall and outreach.

Nursing outreach should be initiated after all recall efforts have been attempted and failed. Evidence of recall efforts should be recorded in the PMS.

In exceptional cases providers should be able to use nursing outreach for patients and situations that fall outside the rules.

“Transport in our area is limited. The GP knows who can and can’t get here or there. He does not always record that.”

Mental health

Outreach nurses find a high number of those referred to outreach have mental health issues.

In many cases this is not coded in the PMS, either because the practitioner suspects the mental health issues and/or they are reluctant to label the person on the basis of what could be an acute episode.

“Our GPs don’t record everything that is in their heads about a family. They tell us to visit them because they suspect something is wrong at home. They don’t want to record that suspicion in the PMS, especially if it is a mental health issue.”

Community concern

Rural health nurses working with high-needs populations in isolated areas sometimes outreach to non-enrolled people, specifically to new families who have come into the area but have not registered with a practice. Outreach in this situation can lead to enrolment in a medical practice and long-term medical care.

Sometimes a home visit is completed because of community concern for the family, such as the situation depicted in the quote below. In other cases the nurses themselves judge that the family may have unmet needs because of their appearance or chosen place of residence.

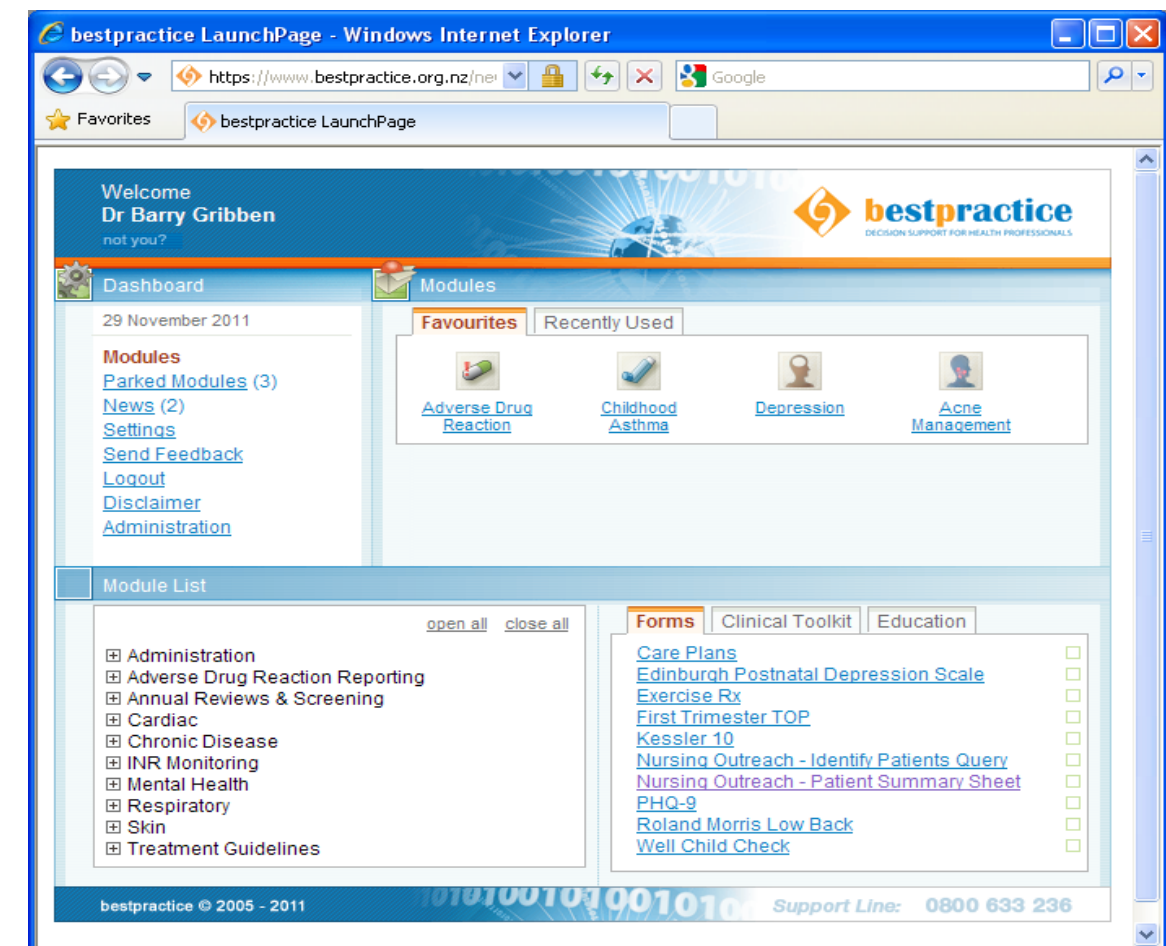
“We visit sometimes because of concerns that they [referring to the community] have through what they see in real life – what the person looks like, how they behave.”

USING PMS TOOLS TO SUPPORT OUTREACH

We have developed two PMS tools to help practices implement nursing outreach. All practices in New Zealand can have Best Practice installed for free. If your practice doesn’t have Best Practice installed please call 0800 633 236.

CREATE PATIENT LISTS

To assist practices identify which patients might be candidates for nursing outreach practices can run the “Identify possible outreach patients” query. The Best Practice dialog box can be accessed from a shortcut on your toolbar or with a keyboard shortcut (MedTech shift-F3, MyPractice xxx).



Choose the “Patients overdue chronic care” module. The module will run automatically and produce a list of patients that have asthma, ischaemic heart disease or diabetes and have not been seen at the practice for over six months. The list can be saved anywhere. You can work through this list and check patient status – for example patients with asthma do not have any evidence on ongoing problems, even though they have an asthma diagnosis. Most patients with IHD or DM require ongoing care once diagnosed.

PRINT A HOME VISITING FORM

If you have decided a patient needs a home visit you may find a summary form useful. This can be printed by choosing “Home visiting summary”, scrolling to the bottom of the form and choosing “print”. The form is pre-populated with current measurements so you can see what is of date. You might like to print prescriptions and lab test forms before the home visit. There are summaries of prescriptions, screening questions for depressions and space for social situation assessments.

Home Visit - Patient Summary Sheet			
Family Name	<input type="text"/>	NHI	<input type="text"/>
First Name(s)	<input type="text"/>		
Address	<input type="text"/>	Gender	<input type="radio"/> Male <input type="radio"/> Female
	<input type="text"/>	Date of Birth	<input type="text"/>
	<input type="text"/>	Phone	<input type="text"/>
Ethnicity	Please Select <input type="button" value="v"/>		
Last recorded results			
Height (cms)	<input type="text"/>	Date	<input type="text"/>
Weight (kgs)	<input type="text"/>	Date	<input type="text"/>
BMI	<input type="text"/>	Date	<input type="text"/>
BP	<input type="text"/> / <input type="text"/>	Date	<input type="text"/>
Smoking status	<input type="radio"/> No <input type="radio"/> Past <input type="radio"/> Recently quit <input type="radio"/> Yes <input type="radio"/> Not known		
Diabetes status	<input type="radio"/> No <input type="radio"/> Type 1 <input type="radio"/> Type 2 <input type="radio"/> Other <input type="radio"/> Not known		
Visit results			
Height (cms)	<input type="text"/>	Weight (kgs)	<input type="text"/>
BP	<input type="text"/> / <input type="text"/>		
Smoking status	<input type="radio"/> No <input type="radio"/> Past <input type="radio"/> Recently quit <input type="radio"/> Yes		
Diabetes status	<input type="radio"/> No <input type="radio"/> Type 1 <input type="radio"/> Type 2 <input type="radio"/> Other		
Past History			
Immunisations due	<input type="text"/>		
Last lipid result	<input type="text"/>		
Last glucose result	<input type="text"/>		
Reg Meds last 12 mnths	<input type="text"/>		
Medical History	<input type="text"/>		
DNA's last 12 mnths	<input type="text"/>		
Contacts last 12 mnths	<input type="text"/>		
Depression Screening			
Have you often been bothered by feeling down, depressed or hopeless?		<input type="radio"/> Yes <input type="radio"/> No	
Have you often been bothered by little interest or pleasure in doing things?		<input type="radio"/> Yes <input type="radio"/> No	
Is this something with which you would like help?		<input type="radio"/> Not applicable <input type="radio"/> Yes <input type="radio"/> Yes, but not now <input type="radio"/> No	
Any referrals required	<input type="text"/>		
Used other providers recently?	<input type="text"/>		
Any access problems?	<input type="text"/>		
<input type="button" value="Print/Save"/> <input type="button" value="Cancel"/>			

RECORDING DATA

When back at the practice it is important for monitoring and evaluation, including on-going service planning, to record that an outreach visit was undertaken. There are two ways this might be done. Some practices might want to set up a screening term eg “OUTRCH” or it may be easier to add a new consultation type. In MedTech this can be done under setup > clinical > consultation type. You only have one letter, and the description must be 20 characters or less. You might want to distinguish different types of nursing outreach (visit, phone consult, special clinic)

Type	Description
A	A/Hrs Consult
C	Consult In Surgery
H	Home Visit
O	Other
T	Telephone
X	Nursing Outreach Vis

Nursing Outreach Vis (X)
Main | Audit
Code: X
Description: Nursing Outreach Vis
Inactive: ☐

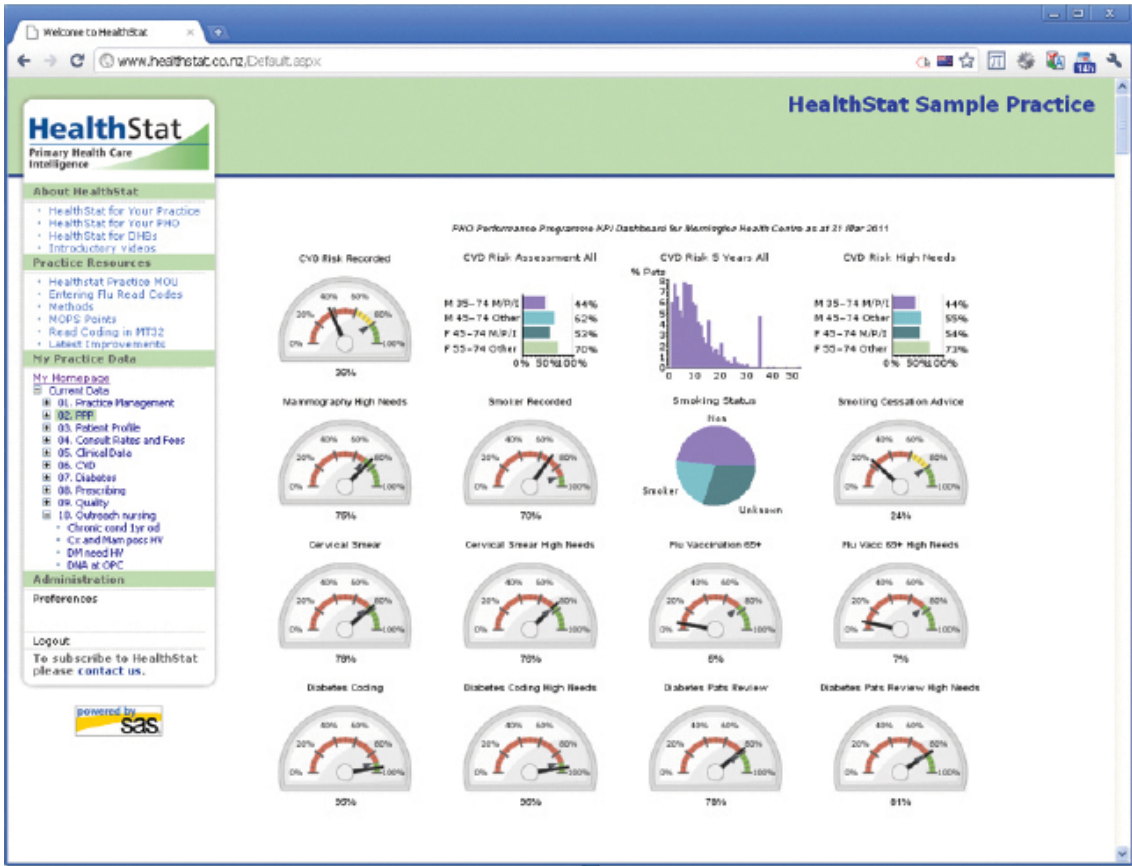
Once a consultation code has been set up it can be applied to a consultation using the “More” tab of the standard consultation note window.

New Consultation
Main | More | Audit
Provider: Barry GRIBBEN (BG)
When Seen: 05 May 2011
Consult Type: Nursing Outreach Vis (X)
Accident: ☐
Status: Confidential
Inactive: ☐
BG
Details

When data is recorded like this it is very easy to track service delivery and analyse outcomes.

POPULATION HEALTH TOOLS

Many practices now use population health tools, such as HealthStat, Drinfo or Best Practice Intelligence. HealthStat now provides easy access to groups of patients that need care, and subsets of these that have not been seen for the last six months. When used with the MedTech CAT tool practices can generate lists for patients and further filter them, for example to focus on certain ethnic groups or patients that have not been seen for longer periods.



SOCIO-ECONOMIC ASPECTS OF NURSING OUTREACH

An outreach nurse is exposed to an environment neither the doctor nor practice nurse would encounter without a home visit.

Exposure to the home environment can leave nurses feeling reluctant or unsure about how or when to approach health issues. Nurses may feel that when visiting a home, he or she is faced with socio-economic problems which cannot be ignored. The resulting involvement in these issues is time-consuming and sometimes requires nurses to navigate situations which they are not necessarily qualified to address. (This is addressed in other sections of this toolkit, specifically under relationships with other services and resources required.)

“You cannot ignore no clothes on the children, no food in the cupboards, and then you’re hooked. That leads into the court case next week – what he is doing and what she is doing, trying to get social services to help and benefits assessments. It would be wrong to talk about their overdue diabetes check unless you could see they had ulcerated legs! I talk about the problems that you can see and they are usually about money.”

The transition from socio-economic platforms of engagement to health care is not always smooth or possible. Nurses sometimes perceive that the offer of health care should not be made until the socio-economic problems are resolved. Nurses may be uncertain about the timing of such offers – but these are the reasons they are there.

Building trust takes time but, once achieved, working in the home offers opportunities to provide health care that otherwise may not be provided (or accepted). This includes immunisations, smears and enlisting members of the family or household who have not yet registered onto the patient register.

DOCUMENTATION

Reporting nursing outreach activity in the clinic and field needs to be easy to understand and easy to use. Rapid feedback between clinic and field is imperative to maximise patient care and to minimise missed opportunities.

Clinical and nursing outreach staff need training and the incentive to properly use the PMS for documentation of all nursing outreach activity. Only then will the nursing outreach programme be successful, efficient and cost-efficient.

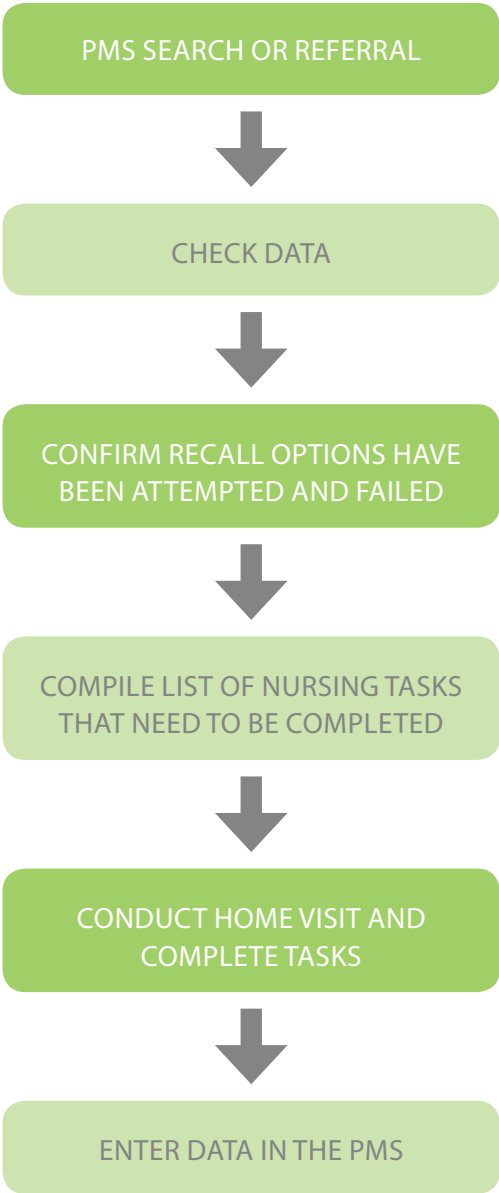
Some nurses enter clinical information, such as smoking status, into free text fields without identifying the data so that the PMS cannot update the retrievable record. Others complete telephone referrals or outreach care and record information in a personal diary or with other software, such as Word, and provide hard copies for the clinical practice.

“I write reports in the document manager and Word and give the GPs a hard copy.”

These habits are counter-productive for the sustainable use of the PMS and the recall function for nursing outreach.

a) In the clinic
Most nursing outreach is driven by referral from a practitioner who has recently seen the patient or a family member.

Correct documentation in the PMS is essential for patients to be accurately identified, treated and reintegrated into the practice. This must begin in the clinic so that lists generated of potential outreach recipients are correct.



“The PMS picked up children who have been coded as having asthma but in reality they have received ventolin for bronchitis or some other acute episode and they do not have asthma and shouldn’t have that code.”

b) In the field

Contracts must stipulate that nurses providing outreach use the PMS correctly and code activities appropriately.

In the research leading to this toolkit, one in five of the nurses did not correctly code outreach activity because they did not fully appreciate the necessity to do so. For example, one entry might be used to represent multiple visits completed for that patient. When this became evident in the data, the nurses concerned were provided with further training from an IT nurse specialist.

“I admit, I don’t know how to use the one-page summary reports but also they are not on the computer that I am using. They are set up on another computer.”

If data is kept in personal diaries or in some other format, the error in the PMS can be corrected and nurses can retrospectively code the activity. However, if nurses are coding calls and “other” activities, it is not always possible to correct the information due to a lack of accurate alternative records.

Nurses providing outreach services must be contractually obligated to code all activity in the PMS. Likewise, those in the clinical practice must code activity in the PMS for patients involved in nursing outreach. If there are aspects of a patient’s care that for one reason or another (as mentioned earlier) the practitioner does not want to document, he or she should verbally communicate this with the nurse providing outreach services.

REINTEGRATION OF PATIENT TO PRACTICE

The clinical practice and outreach nurses need to have a clear understanding of their levels of involvement in patient care. This should be included in the contract agreement and will help with all aspects of patient care, particularly when it comes time to reintegrate the patient into the practice.

The outreach contract should contain guidelines on boundaries for professional practice and the role of the outreach nurse. It should also contain guidelines covering at what point hand-over and reintegration into the practice will occur.

When considering the outreach process, there can be a risk that some vulnerable families become dependent on the outreach service as a primary means of care. When this happens, nurses can become the main provider, rather than a facilitator of access to services.

“With me, they could get free care. Before I knew it, I was visiting every couple of days. I started picking up the scripts, attending court – going to the housing department – acting as a social worker, teacher and friend. It’s hard not to become too involved. Definitely doing the social workers’ job for them.”

Nurses described a wide scope of practice for outreach nursing with few standards and no definitive boundaries for practice, in particular for level of involvement or point of hand-over to others.

“I aim to get them back into using services but it is not always possible in one visit. Usually I can address the reason for the visit, like take the blood or check BP or give them a script.”

Some outreach nurses viewed their role as addressing outstanding acute health care needs and re-engagement of the person or family with general practice services as quickly as possible. Others view the role as a more intensive involvement in health, social and education issues and seem to be acting as a caseworker/central coordinator of care. The spectrum includes chasing non-response to test advice, assessing health state, acting as a lead facilitator and provider of multiple interventions and addressing complex health and social issues.

“Outreach work is vast and varied. Sometimes it’s just getting a blood sample but then it’s sorting out the problems of a complex family with multiple needs and you end as the coordinator of their care, helping them go to appointments, acting as an advocate, social worker. Getting really involved and doing lots of visits.”

The contractor and provider must be aware of the challenges associated with reintegration.

The trust built between the nurse and the family does not always transpose into a relationship between the family and the general practice. In many areas, access to a general practice is limited by the number of GPs available and surgery opening hours. In general, families are happy to receive nursing outreach because it is free and some will continue to avoid practice engagement because of the cost involved.

In other words, while nursing outreach breaks down barriers for patients and families, it does not remove the barriers – some families will be dependent on outreach services.

While there is a risk of losing contact with vulnerable patients if reintegration is handled poorly, it is – imperative that the contractor, provider, nurse and clinical practice all agree on the importance of timely reintegration of the patient into the practice. Effective coding of outreach visits into the PMS and regular updates with the outreach nurse and clinical staff can go a long way in achieving this.



Contracts should require clinical and nursing outreach staff to correctly use the PMS queries to identify eligible patients and to document the clinical care patients receive.

Nurses providing outreach services must be contractually obligated to code all activity in the PMS.

It is possible to assess the impact of a nursing outreach programme rapidly – but this can happen only if the PMS is used correctly.

Contracts should include requirements for regular, accurate and detailed information and feedback on service activity and results.

Contracts should contain guidelines covering at what point hand-over and reintegration of patients into the practice will occur.

MONITORING AND EVALUATION

MONITORING AND EVALUATION

By following the simple procedures for data entry outlined in this toolkit monitoring and evaluation is relatively straightforward.

▣ MONITORING

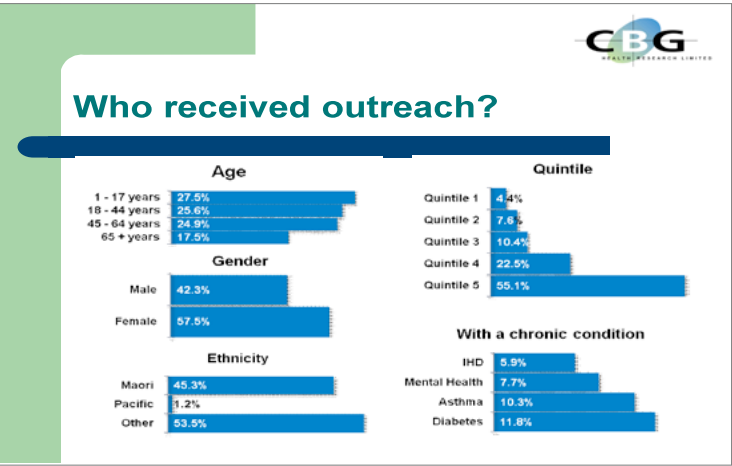
Nursing outreach, combined with low-cost or free GP visits, can address almost all barriers to access for vulnerable populations. However, as stated throughout this toolkit, nursing outreach can be an expensive intervention. It needs to be targeted to those most able to benefit. The requirement for computerised monitoring and evaluation should be included in contracts.

Contracts should stipulate both the expected number of patients that will receive outreach in a practice or PHO and the expected number nursing outreach visits per patient. Contracts should also specify at what intervals reports should be submitted and what benchmarks should be met throughout the year. With computerised systems automatic monthly reporting is easy to implement, and is currently available.

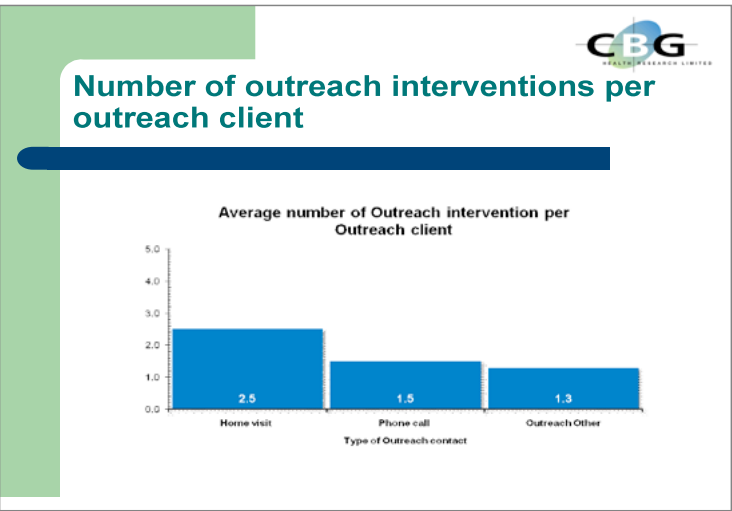
SIMPLE DATA ENTRY

The key to monitoring is data entry. This should be as simple as possible. The minimum requirement should be coding a patient contact as outreach. This identifies (1) that a patient received outreach at all, and (2) that a specific contact occurred on a given date. Because all other information is already recorded in the PMS simply recording that a visit was for outreach (and its date) will usually mean that an organisation will be able to meet all reporting requirements.

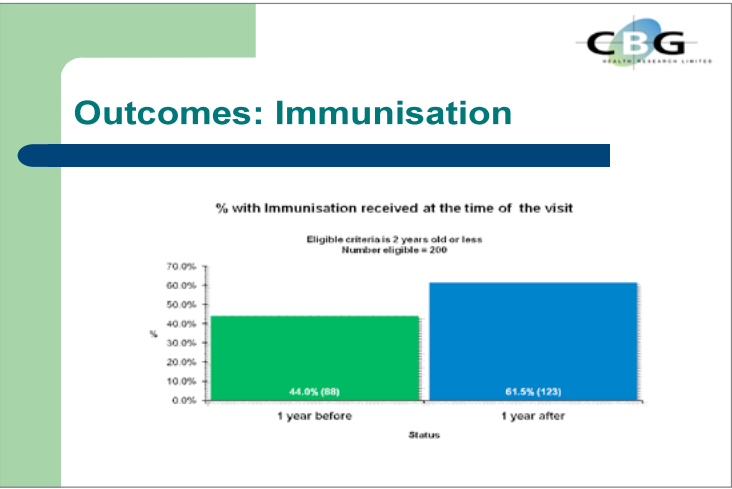
If the very simple data collection described earlier is implemented we can report who gets outreach by simply reporting demographics for any patient that ever had a consultation coded with an outreach code. Be careful to remove duplicates! HealthStat, MedTech CAT tool or other third party tool can do this automatically.



By counting the number of consultations with an outreach code by patient identifier (patientid in MedTech or MyPractice) a report of the number of outreach contacts can be easily produced.



By examining patient data before and after the first recorded outreach visit the impact of outreach can be assessed. The before analysis can be run retrospectively – all data in the PMS is dated. This analysis could be repeated at regular intervals (perhaps quarterly) to monitor the impact of the nursing outreach programme.



PMS reports can help the contractor and provider analyse whether the service is providing nursing outreach to the population identified in the contract. The first report on the facing page shows some targeting by deprivation (quintile) and need (chronic disease status).

Reports on type of outreach service can be useful in determining if preliminary recall efforts are being undertaken before initiating home visiting.

Differences in rates of clinical activity can be compared between the before and after intervention periods within a practice as well as across practices. Control patients (those not in the target population) can provide a measure of background changes.

Simple qualitative research (personal and group interviews) can increase understanding of quantitative data, collecting information about staff experiences of setting up and running outreach services, integration to the clinical practice and the delivery to the patient.

When a nursing outreach contract is written, it should include expected outcomes, a requirement that volumes of service and outcomes will be measured using automatic processes, if possible, and the frequency for reporting. Monthly reporting is already provided by some third party tools if practices and PHOs can not do this themselves.

Frequent reporting ensures services remain properly targeted and gives early warning of possible problems in service delivery.

WHAT CAN GO WRONG

Common reasons for things going wrong include unrealistic expectations, not doing the basic preparation for reporting and community liaison, lack of practice knowledge about the purpose of the programme, and not providing adequate resources.

Common problems
During the establishment phase of a nursing outreach programme, common problems include:

- The time required to hire experienced local staff is longer than expected
- The programme experiences a change in management/venue and/or staff
- The nursing outreach programme has a lack of focus; it works across too many sectors
- There isn't enough advertising or promotion to break down barriers and gain acceptance in the community
- Difficulty getting GPs on board

Once the programme is operating, new problems can arise.

- The nursing outreach programme assumes the responsibility for other areas of care. While it is important that each visit be maximised and much of nursing outreach is socio-economic in nature, a nursing outreach programme is at risk of becoming a delivery mechanism for social services.
- As noted earlier some clinical practices use nursing outreach as "part of" their recall process. This can be protected against by requiring documentation that all recall options have been exhausted prior to an outreach nurse making a home visit.

- Some patients become dependent on the nursing outreach programme as provider of their primary health care. This tendency and desire is inevitable to a point, but a robust system for reintegration into the primary practice will help minimise the problem. Outreach nurses and clinical staff must work to provide a united front against patients who resist returning to the practice or risk losing their engagement.
- Practices resist using the PMS correctly, with subsequent inefficient use of nurses' time.

HOW TO AVOID PROGRAMME PITFALLS

The nursing outreach programme must be adequately resourced.

The nursing outreach programme can fall apart if it revolves around one person and there is no service when that person is on annual leave, is ill or leaves the programme.

The nursing outreach programme risks its success if it is targeted to a particular population but the personnel are not accepted by that population. This can be avoided during setup, with consultation with target groups if possible, and careful selection of nurses that will provide outreach.

Build contracts that are multi-sectoral

Work with other services in the contracting organisation (for example the PHO or DHB) to support nursing outreach access to hard-to-reach families within the geographical area.

Integrate outreach initiatives such as home visits, transport provision, centre-based activities and clinics with walk-in facilities which are easily accessible and can offer a one-stop-shop approach to care.

Be aware of the reasons clinical practices may decline involvement with outreach services
Practices do not wish nurses not employed by the practice to access patients' records.

The general practice has a more traditional method of working. The PHO comprises a high number of solo GPs who follow more conservative models of general practice and may be resistant to new models of health care delivery.

The practice has the perception that the outreach service is new and experimental. These practices are reluctant to become involved in anything that is not "tried and tested".

The practice fears that nursing outreach will increase demand on the general practice. Some practices fear that the outreach service will result in increased GP time demand from people who are already bad debtors and/or who have mental health needs which are difficult to cost-effectively address within the current GP payment structure.

The contractor and provider should be aware of potential challenges in the delivery of a nursing outreach programme. Table 2 outlines potential issues and makes suggestions on how to avoid specific problems.

Table 2. Potential problems in the delivery of nursing outreach services.

ISSUE	POSSIBLE STRATEGIES
Reluctance to code activity.	<p>Outreach contracts should require coding of all outreach activity in the PMS. The provision of monthly feedback can let practices know how they are performing against expected number of patient contacts. This feedback could be provided to practices automatically using practice queries or third-party products such as HelathStat or DrInfo.</p> <p>Nurses should be provided with guidelines to help with interpretation and use of any agreed consultation codes or screening terms. Fewer, non-overlapping codes are better than detailed code sets.</p> <p>Using practice tools such as MedTech's Clinical Audit Tool or queries from the My Practice query library, practice level reporting can be broken down by provider to identify nurses that need help coding.</p>
Outreach care is not well targeted	<p>Outreach contracts should specify what care will be delivered during outreach. an dto whcih patient groups. This list should be created in consultation with the service provider. Practices should be able to deliver outreach to patients that do not meet these requirements, but this shodulberare and monitored.</p> <p>Trainings should ensure all providers at the practice know how to use the PMS, including new staff and locums.</p>
No follow-up at individual patient level	<p>Outreach patients should be reviewed after contact to assess the need for further intervention, including more outreach contact. Lab tests that were requested should be followed up. Recalls can be entered to ensure patients got lab tests done. If visits are coded in the PMS these codes can be used to identify outreach patients for review.</p>
Missed opportunities at outreach contact	<p>Use Best Practice form to summarise patient needs before each visit. Ideally all outreach nurses should be skilled in the following areas:</p> <ul style="list-style-type: none"> Immunisation Cervical smear taking Diabetes review Medication review and administration of standing orders CVD risk assessment Depression screening Referral tracking through PMS use and national data checks in some areas, phlebotomy
Loss to the referral process.	<p>Outreach contracts should require the service provider to have in place a system of referral tracking.</p> <p>Nurses should be provided with a manual to guide the referral procedure. They should be trained to use the system, tested on their ability to do so and provided with ongoing feedback on the end result.</p>
Lack of access to IT resources and capacity issues.	<p>Outreach contracts should require the service provider to illustrate that they have the required IT resource to support the outreach service. This would include nurses being provided with good access to computers and protected time for record keeping.</p> <p>Nurses should be provided with an IT manual and trained to use the IT systems, tested on their ability to do so and provided with feedback on their results.</p>

REFERENCES

NOTES

1. Cumming J, Mays N, Gribben B. Reforming primary health care: is New Zealand's primary health care strategy achieving its early goals? . Australia and New Zealand Health Policy 2008; 5:24
2. Gribben B. 2007. Improving Access to Primary health care: A evaluation of 35 reducing inequalities projects. Wellington: Ministry of Health.
3. Penchansky R, Thomas JW. The Concept of Access: Definition and Relationship to Consumer Satisfaction. Medical Care. 1981;19(2):127-40
4. Thomas JW, Penchansky R. Relating satisfaction with access to utilization of services. Med Care. 1984 Jun; 22(6):553-68.
5. Gribben B. Do access factors affect utilisation of general practitioner services in south Auckland? N Z Med J. 1992 Nov 11;105(945):453-5.
6. Gribben B. Satisfaction with access to general practitioner services in south Auckland. N Z Med J. 1993 Aug 25;106(962):360-2.
7. Buetow S, Richards D, Mitchell E et al, Hight M. Attendance for general practitioner asthma care by children with moderate to severe asthma in Auckland, New Zealand. Soc Sci Med. 2004 Nov;59(9):1831-42.
8. Aday, L. and R. Andersen, Access to Medical Care. 1975, Ann Arbor: Health Administration Press.
9. Ricketts, T. and L. Goldsmith, Access in health services research: the battle of the models. Nursing Outlook, 2005. 53(6): p. 274-280.
10. Dixon-Woods, et al., Conducting a critical synthesis of the literature on access to healthcare by vulnerable groups. BMC Medical Research Methodology, 2006. 6(35).
11. Buetow, S., Distributed Decisions: the example of child access to primary health care. Sociology 2005. 39(1): p. 107-120.
12. Buetow, S., Non-attendance for health care: When rational beliefs collide. The Sociological Review, 2007. 53(3): p. 592-610.
13. <http://www.improvingaccess.co.nz>, Accessed 23 Sep 2011
14. Howden-Chapman P, Blakeley T, Blaiklock AJ, Kiro C. Closing the health gap. N Z Med J. 2000;113:301-302
15. Kawachi I, Kennedy BP. Income inequality and health: pathways and mechanisms. Health Serv Res. 1999;34:215-277
16. Pearce N. Economic policy and health in the year of the family. N Z Med J. 1994;107:379-81
17. Ministry of Health. Monitoring ethnic inequalities in health, Public Health Intelligence Occasional Bulletin No 4. 2001, Wellington: Ministry of Health.
18. Ministry of Health. A portrait of health: key results of the 2002/03 New Zealand Health Survey. Wellington: Ministry of Health; 2005. Available online. URL: [http://www.moh.govt.nz/moh.nsf/0/3D15E13BFE803073CC256EEB0073CFE6/\\$File/aportraitofhealth1.pdf](http://www.moh.govt.nz/moh.nsf/0/3D15E13BFE803073CC256EEB0073CFE6/$File/aportraitofhealth1.pdf) Accessed 25 Sep 2011.
19. Starfield, B. 1991. Primary Care and Health. A Cross-National Comparison. Journal of the American Medical Association 266:2268-71.
20. Starfield, B. 1994. Is Primary Care Essential? Lancet 344:1129-33.

CBG HEALTH RESEARCH LIMITED

www.cbg.co.nz

PO Box 45173

Te Atatu

Waitakere 0651

