

## KTI 1. EDUCATIONAL OUTREACH VISIT

### WHAT IS AN EDUCATIONAL OUTREACH VISIT?

#### EDUCATIONAL OUTREACH VISIT DESCRIPTION

- A personal visit done by a trained person from an off-site location to health professionals on an on-site location to teach the staff about best practices for patient care.
- These visits are done face-to-face and can be given individually or in groups.
- Feedback on the health professionals' performance can be a part of the education.
- If barriers have been assessment, the person providing and teaching the information can be tailored to fit the identified needs.
- Other terms for this intervention:
  - University-based educational detailing;
  - Public interest detailing;
  - Academic detailing;
  - Educational detailing.
- Educational Outreach Visits can be implemented on their own or in combination with other interventions (e.g. professional education, informational technology support).

#### EDUCATIONAL OUTREACH VISIT'S GOAL(S)

- To educate healthcare professionals in their practice settings with the intent that the new information will change their practice.

#### CURRENT FINDINGS FROM THE EVIDENCE

- Outreach visits consistently provide small positive changes in physician prescribing.
- Small to moderate positive changes in practice for other types of professional practice, such as providing screening tests, could be seen, but the effects varied and the reason for the variation could not be explained.

### SYSTEMATIC REVIEW OF THE EVIDENCE FOR EDUCATIONAL OUTREACH VISITS

Source: O'Brien MA, Rogers S, Jamtvedt G, Oxman AD, Odgaard-Jensen J, Kristoffersen DT, Forsetlund L, Bainbridge D, Freemantle N, Davis D, Haynes RB. Educational outreach visits: effects on professional practice and health care outcomes. The Cochrane Library. 2007 Jan 1.

Evidence from the Systematic Review	
Description of Educational Outreach Visits	<p>The characteristics and potential influence of the selected visitor were not mentioned in the studies except for the studies based on social theory. They described the visitor as having credibility with the target professionals (12 studies).</p> <p>The delivery of the outreach visits included:</p> <ul style="list-style-type: none"> <li>• One-to-one visits</li> <li>• Group visits</li> <li>• Mixture of both approaches to different professionals</li> </ul> <p>Of the 41 studies focusing on clinicians, 24 conducted visits one-to-one.</p> <p>Most trials conducted one or two visits during the duration of the study.</p> <p>If feedback was given, it was done either during the visit or mailed afterwards to the recipient.</p> <p>12 studies tailored the information taught to address the barriers to change that had been assessed in the same or a similar group of health professionals that were receiving the outreach visit.</p> <p>In 30/69 studies, the outreach visit was one component of a multi-faceted intervention that included different strategies directed at health professionals (e.g. reminders).</p>
Setting	<p>Healthcare settings: Hospitals, community, nursing homes</p> <p>Healthcare topic: Various</p> <p>Study location: North America (n=23), United Kingdom (n=22), Europe (n=14), Australia (n=8), Indonesia (n=2), Thailand (n=1)</p>
Intervention Deliverer	Trained personnel from outside the practice setting
Intervention Recipient	Physicians, nurses, pharmacist/counter attendants, residents, interns, dentists, professionals from community setting.
Quality of the Systematic Review	Low risk of bias (Assessment tool: ROBIS)
Outcomes from Systematic Review	
Quality of Studies Included in Systematic Review	<p>20 High quality</p> <p>48 Medium quality</p> <p>1 Low quality</p>
Comparisons:	<ol style="list-style-type: none"> <li>1. Any intervention that had an educational outreach visit as a component (including educational material) vs. no intervention (including educational material).</li> <li>2. Educational outreach visits alone vs. no intervention.</li> <li>3. Any intervention that has an educational outreach visit as a component vs. another intervention such as reminders or audit and feedback.</li> </ol>

	<p>4. Comparison of different educational outreach visit interventions.</p>
<p>Patient clinical outcomes:</p>	<p>Very few studies reported patient clinical outcomes.</p> <ol style="list-style-type: none"> <li>1. Any intervention that has an educational outreach visit as a component vs. no intervention. <ul style="list-style-type: none"> <li>• One study assessed educational outreach visits that included audit and feedback as well as a reminder compared to no intervention, and resulted in no significant difference for patients achieving blood pressure control.</li> </ul> </li> <li>2. Educational outreach visits alone vs. no intervention. <ul style="list-style-type: none"> <li>• 2 trials reported patient outcomes and have been summarized in comparison 1 results above.</li> </ul> </li> <li>3. Any intervention that has an educational outreach visit as a component vs. another intervention (e.g. reminders or audit and feedback). <ul style="list-style-type: none"> <li>• One study found an adjusted risk difference (RD) of 5.9% (95% CI -0.3 to 12.2) in the percentage of patients achieving blood pressure control after clinicians received an educational outreach visit including audit and feedback and a reminder.</li> </ul> </li> </ol>
<p>Health Care Provider Process Outcomes:</p>	<p>Outcomes ranged from decreases in inappropriate prescribing to increases in health management of a variety of problems encounter with patients in general practice.</p> <ol style="list-style-type: none"> <li>1. Any intervention in which an educational outreach visit is a component versus no intervention: <ul style="list-style-type: none"> <li>• For physician compliance with <u>desired practice</u> (includes prescribing and other practices), data with a dichotomous nature had a median improvement of 5.6% and ranged from 3% to 9% while data considered to be continuous had a median percentage change of 21% and ranged from 11% to 41%.</li> <li>• Results suggested that there was less variation and small effects for prescribing (median adjusted RD 4.8%, interquartile range 3.0% to 6.5% for 17 comparisons) compared to other behaviours for which there was wide variation in effects (median adjusted RD 6.0%, interquartile range 3.6% to 16.0% for 17 comparisons).</li> </ul> </li> <li>2. Educational outreach visits alone compared to no intervention: <ul style="list-style-type: none"> <li>• For physician compliance with desired practice, data with a dichotomous nature had a median improvement of 5.0% and ranged from 3.0% to 6.2% and for data considered continuous it had a median improvement of 23% and range of range 12% to 39%.</li> </ul> </li> <li>3. Any intervention in which educational outreach visit was a component compared to another intervention such as reminders or audit and feedback: <ul style="list-style-type: none"> <li>• 8 trials (12 comparisons), interventions that included educational outreach visits appeared to be slightly more effective than audit and feedback alone; however, these differences were small, but were roughly the same as the</li> </ul> </li> </ol>

	<p>differences between educational outreach visits and no intervention.</p> <p>4. Comparison of different educational outreach visit interventions:</p> <ul style="list-style-type: none"> <li>• 6 studies total; three studies varied in significance but positive effects were seen for appropriate physician prescribing, changing patient lifestyle choices, and collaboration and care practice.</li> </ul>
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## OPERATIONALIZATION OF EDUCATION OUTREACH VISITS:

Variations in the operationalization of Education Outreach Visits were sought for measures of effectiveness. However, no results were able to determine the effectiveness of the different characteristics of the interventions. Variations included:

- Application of a social marketing theory
- Aim of the educational outreach visit: persuasive, development of skills, education, organizational structure
- Frequency of visits
- The person conducting the visits

## STUDY EXAMPLE OF EDUCATION OUTREACH VISITS FROM THE SYSTEMATIC REVIEW:

Source: Cheater FM, Baker R, Reddish S, Spiers N, Wailoo A, Gillies C, Robertson N, Cawood C. Cluster randomized controlled trial of the effectiveness of audit and feedback and educational outreach on improving nursing practice and patient outcomes. Medical care. 2006 Jun 1;44(6):542-51.

STUDY INFORMATION	
Goals of Intervention	To change nurses' behaviour regarding the management of urinary incontinence for older adults.
Description of Intervention	<p>Educational Outreach</p> <p>Link nurses in the study conducted the educational outreach visits and are described as community nurses with a special interest in continence care.</p> <p>A Link nurse provided:</p> <ul style="list-style-type: none"> <li>• 1 to 3 outreach visits to each community nurse (recipients of intervention).</li> <li>• A minimum of 1 follow-up telephone call approximately 4-6 weeks after the final visit.</li> <li>• Availability to be contacted by telephone between visits.</li> </ul> <p>In addition to the educational outreach visit nurses received:</p> <ul style="list-style-type: none"> <li>• Mailed personal feedback about their self-reported barriers to providing optimum urinary incontinence care obtained from self-completion postal questionnaires at baseline.</li> <li>• Aggregated, anonymous feedback on reported barriers from</li> </ul>

	<p>other target nurses in their locality and a copy of the resource pack.</p> <p>Note* They did not receive personal or aggregated feedback on performance.</p> <p>Training of link nurses included:</p> <ul style="list-style-type: none"> <li>• 2 half-day workshops on the principles of educational outreach involving a mix of learning approaches: <ul style="list-style-type: none"> <li>○ Lecture with discussion</li> <li>○ Video presentation</li> <li>○ Observed role-play with individual and peer feedback</li> <li>○ Written materials</li> <li>○ Self-study</li> </ul> </li> <li>• The techniques of motivational interviewing were emphasized to help link nurses resolve ambivalence and support the target nurses to change.</li> <li>• The role-play scenarios were based on discussions with continence nurse specialists in the study sites.</li> <li>• Link nurses were encouraged to tailor interventions using individual nurse’s identified baseline data on identified barriers to change.</li> </ul> <p>Nurses allocated to the audit and feedback only arm received mailed personal feedback on their performance, obtained from a baseline audit before randomization.</p> <p>Feedback included:</p> <ul style="list-style-type: none"> <li>• Simple tables and text, highlighting good practice and areas for improvement, with suggestions about how to achieve the changes.</li> <li>• Anonymous aggregated feedback on other study nurses’ performance in their locality plus a resource pack (produced by the National Continence Foundation, a registered UK charity).</li> <li>• The pack contained printed educational materials on bladder function, types of UI, and advice on therapy. It did not contain evidence-based recommendation on best practice.</li> </ul> <p>Control Received the resource pack only.</p>
<b>Setting</b>	Community-based
<b>Intervention Deliverer</b>	Link nurses (community care nurses with special training)
<b>Intervention Recipient</b>	Community care nurses
<b>Quality of the Study</b>	High quality
<b>STUDY OUTCOMES</b>	
<b>Interventions</b>	1) Audit and feedback, 2) Educational outreach,

	3) Audit and feedback in combination with educational outreach, 4) Printed educational materials alone (control) in promoting improvements in community nursing practice and patient outcomes.
Health Care Provider Process Outcomes	The magnitude of any intervention effect was less than 2% in the case of audit and feedback, and less than 6% in the case of educational outreach.  Improvements were more consistently positive for educational outreach than for audit and feedback; the results were not statistically significant

Additional notes about the link nurses used in the study:

Post-intervention discussions revealed that the link nurses' combination of clinical expertise and close understanding of the realities and constraints of every day practice appeared important factors in creating an environment of confidence and trust in which change could be negotiated during visits.

The credibility of the link nurse rested heavily on whether target nurses viewed them as having greater knowledge and clinical expertise in UI care than themselves.