

# *Evidence Boost for Quality: Visiting-Specialist Services to Improve Access and Outcomes for Isolated Populations*

*Données à l'appui : Des services spécialisés itinérants pour améliorer l'accès aux soins et l'état de santé des collectivités isolées*



by CANADIAN HEALTH SERVICES RESEARCH FOUNDATION

## **Abstract**

People living in rural and remote communities often have among the greatest health needs but the most limited access to healthcare services, including specialist care. One solution for increasing access to specialist services is visiting-specialist services or specialist outreach clinics – that is, planned, regular visits by specialist physicians from their usual practice location to see patients in primary care or rural hospital settings. The evidence behind visiting-specialist services was recently summarized in *Evidence Boost for Quality*, a special subseries of *Evidence Boost*, produced by the Canadian Health Services Research Foundation to showcase healthcare issues where research indicates a preferred course of action in health services management and policy. To access archived issues of *Evidence Boost*, visit [http://www.chsrf.ca/mythbusters/eb\\_e.php](http://www.chsrf.ca/mythbusters/eb_e.php).

## Résumé

Les collectivités rurales ou éloignées ont des besoins en matière de santé souvent criants, mais l'accès aux services de santé, notamment aux soins spécialisés, y est très restreint. Le programme de spécialistes itinérants ou la clinique d'extension des services spécialisés peut contribuer à régler ce problème. Le programme ou la clinique prévoit que des médecins spécialistes se rendent à intervalles réguliers dans les milieux de première ligne en régions rurales. Les données probantes sur le programme ont été résumées dans un numéro spécial de *Données à l'appui, Données à l'appui pour la qualité*, produit récemment par la Fondation canadienne de la recherche sur les services de santé pour faire connaître les aspects des services de santé où la recherche indique un plan d'action prometteur pour la gestion et les politiques en matière de services de santé. Pour consulter les anciens numéros de *Données à l'appui*, veuillez visiter le [http://www.chsrf.ca/mythbusters/eb\\_f.php](http://www.chsrf.ca/mythbusters/eb_f.php).

---

**P**EOPLE LIVING IN RURAL AND REMOTE COMMUNITIES OFTEN HAVE AMONG the greatest health needs (WHO 1995) but the most limited access to health-care services, including specialist care (Gruen et al. 2006). This is commonly referred to as the “inverse care law,” where the availability of medical care is inversely related to the needs of the population (Tudor 1971). For example, while rural Canada makes up the majority (99.8%) of terrain and is home to roughly 20% (nine million) of Canadians (Beshiri et al. 2001), only about 16% of family physicians and 2% of specialists have practices in these areas (CIHI 2006).

Rural family physicians often shoulder a heavy workload in these areas (Wootton 2007), made more difficult by lack of access to specialist services for their patients (Telford et al. 2002). One solution for increasing access to specialist services is visiting-specialist services or specialist outreach clinics (Gruen et al. 2004, 2006) – planned, regular visits by specialist physicians from their usual practice location (usually hospitals or their own private offices in urban areas) to see patients in primary care or rural hospital settings (Gruen et al. 2004). These clinics can improve access to specialty care and health outcomes for patients — especially disadvantaged groups, since access barriers have important health consequences — while also improving collaboration between primary caregivers and specialists (Gruen et al. 2004).

## Strategy for Change

Specialist outreach clinics should be well co-ordinated and adequately resourced, and take place on a routine basis (Gruen et al. 2004) with a specialist (or group of specialists) visiting a community anywhere from once every few weeks to once a year (Gruen

et al. 2002). The specialist may see patients in a primary care office where patients usually go to see their primary care practitioner; alternatively, the clinics may be offered in small hospital emergency departments or outpatient clinics.

Many specialty areas can be covered during outreach, such as surgery, obstetrics/gynaecology, ophthalmology and oncology (Gruen et al. 2006). When clinics are conducted in primary care offices, visit schedules should be negotiated with local primary care staff. Portable equipment may be used, such as slit-lamps for conducting eye examinations or colposcopes for gynaecologic exams (Gruen et al. 2006). When clinics are conducted in hospital settings, the equipment may be hospital-owned, and case schedules are negotiated with hospital administration. Outreach clinics may last a few hours to a week, depending on the service that is provided (Gruen et al. 2008). For example, visiting surgical specialists will frequently spend half a day in a clinic and half a day in the operating room.

The most common model, described here, is a “shifted outpatients” model in which, within limits, specialists provide the same kinds of consultations, investigations and procedures as they do in their regular settings (Gruen et al. 2004). Alternatively, specialists and primary care practitioners may use outreach visits as a vehicle to permit additional activities, such as staff education and joint consultations with patients.

## What the Research Says

Research evidence from a Cochrane review shows that specialist outreach can significantly improve access to specialist care for patients (Gruen et al. 2004). While the highest-quality studies included in this review were conducted in major urban settings, such as inner cities, research in a disadvantaged rural setting showed greater improvements in access to specialist care (Gruen et al. 2006). In particular, the investigators found that improvements in access to specialist consultations and procedures in this setting came without increased primary care referrals as well as without additional demand for hospital-based care (Gruen et al. 2006).

Specialist outreach can also lead to improvements in health outcomes for patients and greater efficiency in the use of hospital-based services by reducing unnecessary referrals and investigations (Gruen et al. 2004). This is particularly the case when outreach specialists work collaboratively with or provide education seminars to local primary care practitioners (Gruen et al. 2002, 2004; Katon et al. 1997, 1999; Roy-Byrne et al. 2001; Vierhout et al. 1995). Increased collaboration and consultations may improve provider-to-provider communication and lead to more positive patient experiences (Gruen et al. 2004). Hosting specialist consultations in primary care settings may also offer such benefits as familiarity and reduced stigma for patients and fewer distractions for providers (Gruen et al. 2004).

In terms of costs, international research on collaborative management of depression in urban settings has found that specialist outreach costs more for healthcare systems when compared with typical, hospital-based specialist care (Simon et al. 2001; Von Korff et al. 1998). However, in rural settings, other international research suggests one specialist visit can save many patients the cost and time of travel (Gruen et al. 2001). In some Canadian jurisdictions, medical travel costs are funded by the health-care system. However, in other areas, patients must pay for these costs out of pocket.

## Conclusion

There are a number of proposed solutions for increasing access to specialist services in rural and remote areas – from telemedicine (interactive video consultations) (Duplantie 2007) to expanding the role of family physicians in providing specialist care (SRPC 2006; Glazebrook and Harrison 2006; Working Group of the SRPC 2001). Outreach services are a well-evaluated way of enabling patients from rural and remote populations to access specialty care without incurring travel costs and the other inconveniences associated with travel. Importantly, these clinics allow patients to have their families and other loved ones accompany them to their appointments, if need be.

## REFERENCES

- Beshiri, R., R.D. Bollman and Statistics Canada. 2001. "Population Structure and Change in Predominantly Rural Regions." *Rural and Small Town Canada Analysis Bulletin* 2(2). Catalogue no. 21-006-XIE. Retrieved May 21, 2008. <<http://www.statcan.ca/english/freepub/21-006-XIE/21-006-XIE00002.pdf>>.
- Canadian Institute for Health Information (CIHI). 2006. *Geographic Distribution of Physicians in Canada: Beyond How Many and Where*. Retrieved May 21, 2008. <[http://secure.cihi.ca/cihiweb/dispPage.jsp?cw\\_page=PG\\_529\\_E&cw\\_topic=529&cw\\_rel=AR\\_1346\\_E](http://secure.cihi.ca/cihiweb/dispPage.jsp?cw_page=PG_529_E&cw_topic=529&cw_rel=AR_1346_E)>.
- Duplantie, J. 2007. "Telehealth and the Recruitment and Retention of Physicians in Rural and Remote Regions: A Delphi Study." *Canadian Journal of Rural Medicine* 12(1): 30–36.
- Glazebrook, R.M. and S.L. Harrison. 2006. "Obstacles and Solutions to Maintenance of Advanced Procedural Skills for Rural and Remote Medical Practitioners in Australia." *Rural and Remote Health* 6: 502. Retrieved May 21, 2008. <<http://www.rrh.org.au/articles/showarticlenew.asp?ArticleID=502>>.
- Gruen, R.S., R.S. Bailie, P.H. d'Abbs, I.C. O'Rourke, M.M. O'Brien and N. Verma. 2001. "Improving Access to Specialist Care for Remote Aboriginal Communities: Evaluation of a Specialist Outreach Service." *Medical Journal of Australia* 174(10): 507–11.
- Gruen, R.L., T.S. Weeramanthri and R.S. Bailie. 2002. "Outreach and Improved Access to Specialist Services for Indigenous People in Remote Australia: The Requirements for Sustainability." *Journal of Epidemiology and Community Health* 56(7): 517–21.

- Gruen, R.L., T.S. Weeramanthri, S. Knight and R.S. Bailie. 2004. "Specialist Outreach Clinics in Primary Care and Rural Hospital Settings." The Cochrane Database of Systematic Reviews. Issue 1, No: CD003798 DOI: 10.1002/14651858.CD003798.pub2.
- Gruen, R.S., R. Bailie, Z. Wang, S. Heard and I.C. O'Rourke. 2006. "Specialist Outreach to Isolated and Disadvantaged Communities: A Population-Based Study." *Lancet* 368(9530): 130–38.
- Katon, W.J., M. Von Korff, E. Lin, G.E. Simon, E.A. Walker, T. Bush and E. Ludman. 1997. "Collaborative Management to Achieve Depression Treatment Guidelines." *Journal of Clinical Psychiatry* 58(Suppl. 1): 20–23.
- Katon, W.J., M. Von Korff, E.H. Lin, G.E. Simon, E.A. Walker, J. Unützer, T. Bush, J. Russo and E. Ludman. 1999. "Stepped Collaborative Care for Primary Care Patients with Persistent Symptoms of Depression: A Randomized Trial." *Archives of General Psychiatry* 56(12): 1109–15.
- Roy-Byrne, P.P., W. Katon, D.S. Cowley and J. Russo. 2001. "A Randomized Effectiveness Trial of Collaborative Care for Patients with Panic Disorder in Primary Care." *Archives of General Psychiatry* 58(9): 869–76.
- Simon, G.E., W.J. Katon, M. Von Korff, J. Unützer, E.H. Lin, E.A. Walker, T. Bush, C. Rutter and E. Ludman. 2001. "Cost-Effectiveness of a Collaborative Care Program for Primary Care Patients with Persistent Depression." *American Journal of Psychiatry* 158(10): 1638–44.
- Society of Rural Physicians of Canada. 2006. "Federal Solutions for Rural Health Care." Retrieved May 21, 2008. <[http://www.srpc.ca/librarydocs/Fed\\_Oct\\_2006.pdf](http://www.srpc.ca/librarydocs/Fed_Oct_2006.pdf)>.
- Telford, R., A. Hutchinson, R. Jones, S. Rixa and A. Howe. 2002. "Obstacles to Effective Treatment of Depression: A General Practice Perspective." *Family Practice* 19(1): 45–52. Retrieved May 21, 2008. <<http://fampra.oxfordjournals.org/cgi/content/full/19/1/45>>.
- Tudor, H.J. 1971. "The Inverse Care Law." *Lancet* 1(7696): 405–12.
- Vierhout, W.P., J.A. Knottnerus, A. van Ooij, H.F. Crebolder, P. Pop, A.M. Wesselingh-Megens and G.H. Beusmans. 1995. "Effectiveness of Joint Consultation Sessions of General Practitioners and Orthopaedic Surgeons for Locomotor-System Disorders." *Lancet* 346(8981): 990–94.
- Von Korff, M., W.J., Katon, T. Bush, E.H. Lin, G.E. Simon, K. Saunders, E. Ludman, E.A. Walker and J. Unützer. 1998. "Treatment Costs, Cost Offset, and Cost-Effectiveness of Collaborative Management of Depression." *Psychosomatic Medicine* 60(2): 143–49.
- Wootton, J. 2007. "Who Will Provide Secondary Care in Rural Canada?" *Canadian Journal of Rural Medicine* 12(2): 67.
- Working Group of the Society of Rural Physicians of Canada. 2001. "Joint Position Paper on Training for Rural Family Physicians in Anesthesia." Retrieved May 21, 2008. <<http://www.srpc.ca/librarydocs/JPPeng.pdf>>.
- World Health Organization. 1995. *World Health Report 1995: Bridging the Gaps*. Geneva: Author. Retrieved May 21, 2008. <<http://www.who.int/whr/1995/en/index.html>>.