Outreach visits to improve dementia care in general practice: a qualitative study

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Abstract

Background. Outreach visits reflect newer developments in adult learning theory, where the learner is actively involved in the session. Previous studies have indicated a positive effect of outreach visits on GPs’ behaviour. However, the empirical role of the facilitator in the visits is poorly described.

Objective. To explore general practitioners’ perception of the outcome of a facilitator programme about dementia, in relation to central aspects of the facilitator’s communicative role during the visits.

Method. Observational studies, and focus group discussions with participating general practitioners (3 groups, 19 participants) as well as with facilitators (4 participants) in Vejle County, Denmark.

Results. Facilitators drew both on a ‘factual’ knowledge of dementia and a more ‘experience-based’ knowledge when conveying programme messages. They described themselves as ‘carriers of experience’. All general practitioners described an outcome of the programme, and all wished to receive a future visit by a facilitator on new topics. The outcome was described not as ground-breaking medical news, but as practical effects in terms of knowledge of dementia, motivation for working with dementia, structured assessment and management of dementia and critical reflection of established practices regarding dementia. Some general practitioners remained critical as to whether this outcome justified the resources used in the programme. The experience-based dialogue was described as central to the outcome as it linked factual knowledge to clinical practice.

Conclusion. This study confirms that outreach visits contribute to the integration of factual knowledge in clinical practice, but it also underscores the importance of addressing tacit communicative practices during facilitator visits and their implications for the outcome of the programme.

Keywords: continuing medical education, dementia, learning, outreach visits, primary care

Introduction

Do general practitioners as professionals have sufficient knowledge to handle the tasks they face? And how can they continuously maintain high-professional standards given current developments and the rapid expansion of clinical evidence within all medical fields? The creation of continuing medical educational activities and the development of learning theories geared to the needs of general practice may be seen as a response to these questions.

Different strategies of continuing medical education have been introduced with variable success; passive strategies of education, such as conferences and distribution of guidelines, have generally proved less successful than strategies that involve a combination of methods as well as an interactive dimension, such as outreach or peer visits [1–7]. Outreach visits refer to the use of a trained person (facilitator) who meets with the providers in their practice settings to give information and assist implementation [1]. This strategy reflects current developments in adult learning theory, where it is argued that learning must be based on the learner’s specific needs to have an effect [8–10].

Outreach visits are potentially suitable for general practice, as they can address a broad range of issues and the concept of a facilitator is becoming increasingly popular in general practice. However, the facilitator’s role and methods remain poorly understood [11–12]. Although some studies have addressed the contents of the visits and the facilitator’s role—for instance the facilitator’s ‘technical skills’ (listening, questioning, encouraging participation, summarizing etc.) or ‘communicative style’ (for instance appearing ‘friendly’ and ‘non-threatening’)—less attention has been devoted to the facilitator’s ‘empirical’ role during the visits and the learning processes involved in the programmes [11–13], i.e. not the prescribed or ideal type role, but the ‘actual and practical role of the facilitator’ that unfolds during the visits.

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Aim of this paper may be stated as 2-fold: (i) to describe the outcome of a facilitator programme from the general practitioner's perspective, and (ii) to explore how the communication between facilitator and general practitioners contribute to these outcomes.

Material and methods

The facilitator programme was introduced in Vejle County in 2005 as part of a multifaceted training programme targeting dementia in general practice. Four facilitators, themselves general practitioners, were employed. The facilitators together with local gerontopsychiatrists produced a leaflet containing the main messages on dementia to be conveyed during the visits (Table 1). All general practitioners (233 in 112 practices) in the county were offered one facilitator visit. One hundred and sixty-two general practitioners (70%) in 89 practices (79%) accepted the offer.

The study consists of two parts and draws on the following qualitative methods:

Observational studies

Observation [14] was carried out with the facilitators in general practice. Purpose of the observations was to gain insight into the communication between the facilitator and the general practitioners as it unfolded during the visits, supplementing the interviews where retrospective views on the visits were provided. Facilitators contacted the general practitioners over telephone for consent prior to the visits. Eight visits were observed (two with each facilitator). The practices

Table 1 The facilitator programme

| Background | The introduction of the programme was based on (i) a questionnaire sent to all general practitioners in the county regarding their attitude towards a possible facilitator programme (ii) experience with a similar programme in a neighbouring county (Aarhus, Denmark) (iii) a background paper concerning the literature regarding learning in general practice. The programme was introduced as part of a programme of continuing medical education regarding dementia. The background for choice of topic was (i) many general practitioners had in the questionnaire pointed at dementia as a relevant topic for outreach visits (ii) the Quality Improvement Committee for general practice in Vejle County had expressed a wish to implement the national guidelines in the programme and a guideline on dementia was on the way (iii) the Ministry of the Interior had granted money for education in dementia. The facilitator programme was initiated on this background but was planned to continue with a new theme every year. |
| Training of facilitators | The four facilitators were trained at two two-day courses. The first 2-day course concerned practicing communication skills (with the help of an actor and a coach/psychologist, recommended by other counties who had experience with outreach visits). The second 2-day course concerned discussing the topic (dementia) with the local gerontopsychiatrists, and deciding the important aspects of diagnosis and treatment of dementia to be addressed during the outreach visits. |
| Invitation | The facilitator or a secretary made phone calls to all practices in the county in order to make an appointment for the outreach visit. |
| Setting | The facilitator saw the general practitioner in the general practitioner's own practice. In partnership practices, general practitioners were offered one visit per general practitioner or one visit for all doctors in the practice. Irrespective of the number of participants, the visit duration was 1 h. General practitioners were reimbursed for 1 h. |
| Content | The facilitator would bring an information leaflet developed in collaboration with local gerontopsychiatrists about important aspects of dementia in relation to diagnosis and treatment in general practice. The facilitator's main messages: (i) The good referral (including Activities of Daily Living and prescribed medicine) (ii) The collective agreement (including referral to CT scan) (iii) Practical problems (including names and phone numbers of dementia consultants/nurses, information to relatives, annual application for reimbursement for Alzheimer patients' medicine, and acute medical treatment). The leaflet was a supplement to the visits, and although all messages in the leaflet should be addressed during the visits, the facilitators had methodological freedom as to when and how the issues were addressed. The facilitators had not discussed any uniform standard as to when, how or even if the leaflet was given to the general practitioners. The facilitator was instructed to be open to other questions about the subject facilitated (dementia) or about other topics relevant to clinical work in general practice. The facilitator could follow-up on un-answered questions and call back at a later time. |
observed were strategically sampled (practice type, gender and age) in an effort to gain insight into the variety of communication practices that could unfold during the visits.

Focus group discussions

Eighty-eight of the general practitioners who received a facilitator visit (representing 70 practices) were invited by mail to participate in a focus group discussion about the programme [15]. They were strategically sampled (age, gender and practice type), in order to gain an insight into a variety of general practitioners’ experiences. Twenty-three general practitioners from different practices accepted the invitation (three cancelled, one forgot the appointment). Three focus group discussions were organized with the 19 participants 2–6 months after the visits, and one focus group discussion was carried out with the four facilitators.

Each 2-h focus group session was held at the Unit for General Practice in Vejle, and conducted by an interviewer and an assistant moderator whose main role was to observe interaction, take notes and provide summaries during the sessions for member checks of the content of the discussion [15]. An interview guide containing three major topics was used: (i) motivation and barriers for using the outreach visit, (ii) thoughts about the facilitator’s roles and structure of the visits and (iii) perceived outcome of the visits. The guide was developed in collaboration with a research team, consisting of general practitioners and medical anthropologists.

The interviewer and observer was an anthropologist with no prior experience with outreach visits and no relationship to the general practitioners of the study. The assistant moderators were general practitioners from the county who had been working with research and education in general medicine. They had previously performed the outreach visits in relation to a different research project.

Data were collected as part of a qualitative evaluation of the outreach visits, where the aim was to gain insight into the general practitioners’ perception and perceived outcome of the programme. The interview guide and framework guiding observations were inspired by current learning theories, in which the learning dimensions in the visits were central; focus was on how the visits as a form of communication related to the clinical everyday world of the practitioner, and not so much on the pedagogical structure of the visits [8–10].

Analysis

In-depth notes were taken during the observations, and the focus group discussions were tape-recorded and transcribed. The transcribed material was supplemented with notes on the internal communication in the groups from the assistant moderator’s notes and analysed as part of the data.

Data from both sources were analysed using a qualitative content analysis procedure; searching for significant terms, phrases and expressions that describe the experience, perceptions and role of the facilitator in the visits, which were then divided into categories of content [16–17]. Validity was ensured through a constant interplay between generating an idea or category and bringing it back to the data where that idea was revised, supported, or refuted—ensuring that the categories created were based upon the expressions of the participants. Further, anonymized transcripts, as well as extracted summaries and central themes were presented to the research group—a technique offering the assurance that the interpretation is found convincing by other investigators who have reviewed the source material [17].

Results

This paper presents the results of the study relating to the facilitator’s communicative role during the visits and to the general practitioner’s perceived outcome of the programme.

Communication during the visits

Although the general practitioners were generally positive towards the facilitator programme, during the focus group discussions, many expressed barriers towards using the programme due to lack of energy and time to engage with more in their everyday practice. This general lack of energy to engage with new demands in practice was likewise an underlying issue in much of the communication as it unfolded during the observed visits, where the facilitators often had a central role in helping the general practitioners find the motivation to engage with the messages of the programme.

The facilitators often drew on their own practice experience and on other general practitioners’ experience in the observed communication, for instance by suggesting ways of applying the guidelines, by presenting the messages as part of the general practitioner’s normal activities, or by identifying with the problems the general practitioners encountered (Table 2); and sometimes they would even draw on personal knowledge, for instance of family members with dementia. This dialogue about practice and experience in relation to programme messages was the primary focus of the communication during the visits and the main instrument for making messages accessible and relevant to the general practitioners. This was also highlighted by the facilitators themselves in the focus group discussion, where they described their primary role as ‘carrier of experience’

‘...Somehow, one carries around in the whole area some experience—I think [that] is one of our primary tasks, that exchange of experience, that we somehow carry some experience around [...] it is difficult to put it into more precise words [...]’

In the visits, the facilitators thus made use of both their factual knowledge of dementia and a more experience-based knowledge in which the specific general practitioner’s needs and background were central and the general practitioner thereby became actively involved in the session. This implied that some of the communicative choices were shaped by the general practitioner’s interests, and equally important, by their lack of interest in raising specific issues. These communicative choices unfolded, for instance in the choice of which messages to prioritize in the light of the general practitioners’ background and resources. Facilitators at times chose to
prioritize some topics in favour of others, especially when the general practitioners clearly expressed no interest or motivation for certain topics (Table 3).

**General practitioner perception of outcome**

Many of the general practitioners had initial trouble answering questions on specific outcome of the visits in relation to dementia; however, four interlinked themes emerged from the focus group discussions, which were confirmed in the data from the observations:

(i) Increased 'knowledge' about dementia. The information given was described not as ground-breaking, but rather as information of a more practical nature (Table 4, Quotation a);

(ii) ‘Motivation’ for self-instruction on the topic of dementia; many general practitioners were well prepared in the observed visits having for instance re-read guidelines, and following the visits had formulated clear practice instructions regarding dementia (Table 4, Quotation b);

(iii) Implementation of a **structured assessment and management** — i.e. knowing precisely 'what to do when' in relation to patients with dementia (Table 4, Quotation c):
Table 4 General practitioners perception of outcome—main themes and illustrative quotes

Increased knowledge of dementia

Quotation A: ‘She [facilitator] came with a scheme of practical skills, and [...] I thought; well I often lack specific questions to ask them [patients] when they come—what can they do, what can’t they do? I thought; I will use the scheme next time they come, because it was so [...] precise, practical and down to earth, and that is what I often lack [...] many of the practical things, to pick up the phone and call—I never even considered that one could ask about that...[C3]’

Motivation for self-tuition on the topic of dementia

Quotation B: ‘Well, we have actually made a list of instructions in our clinic—not while the facilitator was there, but it was the kick-start we needed to start formulating a paper on how we would handle this issue in the future. It is something we did ourselves. It was actually good, it meant that we got started [...] one gets kicked in the behind, so one starts working on some sort of instruction that one feels good about and now we know have to handle the patients without always being a step behind—so I think; well that is of course satisfying, when that is done. You feel good about yourself [laughs]—so in that sense it [the visit] was good, so maybe if we got more visits by the facilitators on different topics, if it has the same effect, then it works well...[D3]

Implementation of a structured assessment and management

Quotation C: ‘My examination of a patient has become more structured; now I have a quite precise way that I do it, [...]. I have always done everything I should—tables and blood tests, but it is more structured now. Instead of stumbling: “what is it I do now?” I now know which way to go to do it. Then there are also some details—like the results of the MMSE [Mini-Mental State Examination]—which are in place now. And some very small details, like remembering the date of the CT scan in the referral—those small things, [...]. So for me, even if I on the whole was ok at it before, I now know everything is in order. When I refer a patient, I think I have done a good job, I am satisfied with what I do, satisfied that what I have done is sufficient—so I have actually gained a lot [from the visit] [E1]

Small talk

Quotation D: ‘I think it was because of the informal part of the session [...], where we focussed on our specific problems—there I got maximum value for money. I received the information leaflet, which included lists of blood samples and so forth [...]. Then in the end, I guess you learn it [...] but I look it up, like you can look it up on the PC [...] you can look up those hard facts. But the things I have encountered; you do the MMSE [Mini-Mental State Examination] test, but how do you interpret it, if it is just slightly off? How are the lines drawn in the drawing? [...] Well, those are my problems; I had them solved and that is just perfect! I think I really gained a lot from the programme, also considering that I had attended many meetings both at the hospital and in the county’ [E1]

(iv) Finally, another, though less easily conceptualized, benefit was described by many. This was often initially referred to as ‘small talk’ or ‘the social bit’: ‘Even if it wasn't the intention, then [...] the social bit meant a lot’ [A1]. When probed, the general practitioners described the ‘social’ dimension as referring to a communication that encouraged ‘reflection’ over practice in relation to dementia. This reflection addressed both their practices and the degree to which such practices were satisfactory: ‘It is good to see that what I have been doing so far isn’t totally wrong’ [B2]. Similar statements were often repeated by the general practitioners during the observed visits. Further, the reflection related to grey areas in the treatment of dementia, for instance when guidelines could not be followed strictly (Table 4, Quotation d).

According to the general practitioners, the clearer structure and critical reflection on established practices regarding dementia made it easier for them to implement the programme messages, brought about changes in their examination routines, helped ensure that the work was done properly and contributed to a general satisfaction with their work.

Despite the fact that many general practitioners initially had trouble naming a specific outcome, most general practitioners felt that they had benefited from the programme. All general practitioners would accept another visit, and many who initially reported that they had been critical were subsequently positive about the programme. The experience-related dialogue and reflection, often referred to by the general practitioners as ‘small talk’ or ‘the social bit’, was described as central to all four aspects of outcome, and this differed from the outcome of other continuous medical educational activities. However, six general practitioners in the focus groups remained critical as to whether the use of resources was justified by the outcome of the programme.

Discussion

The general practitioners were generally positive about the facilitator programme, and all described benefits from the visits. However, it was initially difficult for many to formulate specific
statements capturing outcome. Many used words such as ‘small talk’ and ‘the social bit’ to describe the aspects of reflection and motivation for the implementation of new structures.

The communicative encounters observed often included a strong motivational component in which the facilitator drew on their experiential knowledge in the discussion with the general practitioners. The facilitators themselves described their primary role as ‘carriers of experience’ and this illustrates a significant aspect: programme messages cannot be separated from practice and the experience of applying the knowledge in everyday life.

The facilitator programme reflects new developments in adult learning theory, where it is argued that knowledge is always interpreted and contextually applied. The previous inclination to view health care professionalism as an expression of contextually detached scientific evidence has been replaced by a more contextual view of knowledge [10, 18–21]. Current learning theories (as opposed to education theories) emphasize the practice-embedded nature of knowledge and highlight at least two aspects of learning: the information itself and a motivational component whereby the information is drawn into the learner’s world [8–9].

A key role for the facilitator was to boost motivation by making knowledge accessible and relevant for practice, for instance by normalizing, trivializing and prioritizing the messages according to the given context. The facilitators drew on knowledge in a dual sense: they were applying specific dementia guidelines rooted in evidence-based research; and they drew on experience-based and tacit knowledge—the generally accepted, taken-for-granted, background knowledge that is rarely, if ever, put into words [22–23], captured in the communicative practice between colleagues and other health professionals and emerging during social interaction [24]. Both aspects are crucial for understanding the full role played by the facilitator. It is more than being an educator.

Some aspects of effective facilitator communication roles have been thoroughly described, for instance the communicative behaviour and technique [12], whereas some of the more tacit communicative dimensions remain largely unexplored. From a learning perspective, these tacit practices deserve attention because communicative choices become a determinant for programme outcome—for instance the contextually determined prioritization of utterances that help the general practitioners find motivation and that make the messages accessible in practice. These communicative choices may also help to explain why the general practitioners initially felt that they gained no new knowledge from the programme and why some general practitioners remained critical as to whether the outcome justified the resources put into the programme.

The data collection methods complemented each other: the focus groups gave insight into the general practitioners’ perception of the visits, the observations gave insight into the communication as it unfolded during the visits. Observations were central for the understanding of the perceived outcome in relation to the empirical role of the facilitator—an understanding that cannot be captured retrospectively through interviews alone.

The assistant moderators were general practitioners from the county, and as Vejle county is relatively small, the assistant moderators were at times known by the general practitioners before the focus group discussions. This could introduce a potential bias in the opinions voiced; however, many of the general practitioners also expressed negative opinions about the programme and would therefore seem not to be particularly hampered by the presence of the assistant moderators. In the observation studies, bias on the interaction was minimized through the clarification of the purpose of having an observer present and a clear agreement that the observer did not actively participate in the formal dialogue between facilitator and general practitioner [14].

The study was conducted in a specific setting with a limited number of participants, and it addresses outcome and communication within this specific setting. Attempting to transfer findings from one setting to another is problematic in qualitative studies, and it may even be argued that attempting to create generalizations is contradictory to the overall aims of qualitative analysis. While the specific contents of our findings are unique to the setting, what may be transferable to other settings, are the overall processes and concepts that lie at the heart of the communication in a more general sense [25]. Such transfer would seem to be important in the light of the increased attention learning environments are now paying to aspects of experiential learning, reflective practice and social interaction as a necessary supplement to purely objective, evidence-based approaches [10]. However, more empirical studies of the communication processes are warranted given the wide variety of aims and organizational diversity of facilitator programmes in general practice today.

**Conclusion and perspectives**

It is well established that the learning occurs best in which the learner’s needs and background is considered and learning is interactive [19, 21, 26]. The facilitator in primary care is an example of how current adult learning theories translate into practice: the learner is actively involved in the session and, to some extent, defines the areas of learning. In the implementation of facilitator programmes, it is thus central to address the general practitioners’ specific needs and background. It would also be relevant to consider new initiatives in outreach visits like the Maturity Matrix which emphasizes organizational aspects rather than medical topics but is based on the practices individual needs [12]. Furthermore, the introduction of new forms of continuing medical educational activities such as a facilitator programme demands close attention to how the programmes are presented to the general practitioners, in order to help the general practitioners find the motivation to engage with the programme. Finally, by their very nature of being interactive forms of continuing medical education, facilitator programmes involve aspects of communication drawn from everyday social interaction, a more tacit knowledge form; communication that often takes the form of a dialogue and gives room for reflection. While it may be tempting to dismiss this dimension as
unimportant to the factual knowledge to be conveyed, in a learning perspective precisely this dimension is crucial as it links knowledge to practice. To understand the outcome of the facilitator programmes, it is vital to address the communication between the general practitioners and the facilitator in detail, not only the communicative expressions and techniques, but also the communicative ‘practices and choices’, and the implications this has for the outcome. In the implementation of the programmes, focus must be placed on how it can be ensured that facilitators make the right communicative choices during visits without compromising the information given, and how facilitators are best prepared for the task of conveying tacit knowledge together with evidence in order to motivate and support implementation of new initiatives in primary care. Furthermore, it may be relevant to address what background is necessary for a facilitator, hereunder whether other health care professionals acting as facilitators are able to convey the necessary tacit knowledge to general practitioners concerning medical topics.

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References


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