Received: 1 March 2022 | Revised: 19 September 2022 | Accepted: 26 October 2022

DOI: 10.1111/ajr.12946

ORIGINAL RESEARCH

AJRH National Rural Health Alliance WILEY

Indicators for effective visiting primary care services: A case study

Laura J. Healy PhD[1] | **Gavin Beccaria DPsych**[1] | **Peter McIlveen PhD**[2]

[1]School of Psychology and Counselling, Faculty of Health, Engineering and Sciences, University of Southern Queensland, Toowoomba, Queensland, Australia

[2]School of Education, Faculty of Business Education Law & Arts, University of Southern Queensland, Toowoomba, Queensland, Australia

Correspondence
Laura J. Healy, School of Psychology and Counselling, University of Southern Queensland, West Street, Darling Heights, Toowoomba, Qld 4350, Australia.
Email: laurahealy.tnp@outlook.com

Funding information
Outback Futures, Grant/Award Number: Contributor to USQ Postgraduate Research Scholarsh; University of Southern Queensland, Grant/Award Number: Postgraduate Research Scholarship

Abstract

Objective: The objective of this study was to assess the clinical utility of a model of seven principles for effective visiting primary care services and to determine how it could be conceptualised as a tool for evaluation.

Setting: The research was undertaken in the context of visiting primary care services with an agency, Outback Futures, selected as a case study.

Participants: Three executive staff with Outback Futures participated in the research.

Design: The case study design involved data collection by four group interviews conducted between July and November 2021. The interview data were analysed using thematic analysis.

Results: This case study is additional evidence for the clinical utility of the model of seven principles. The results reinforce the importance of a community-focussed approach to assess the impact of visiting service organisations on rural and remote communities. A comprehensive approach to evaluation is required to justify the investments made and safeguard the health and well-being of rural and remote residents. A self-assessment protocol has been established from the model for use by visiting services. Furthermore, three themes were drawn from the data: *relationship is fundamental, the importance of co-design*, and *being effective as a visiting service is challenging*.

Conclusion: The model is appropriate for the case study organisation, and has clinical utility and implications for other visiting services. A self-assessment protocol has been developed. Future research should apply the model and protocol self-assessment tool in an effort to construct a consistent and credible approach to evaluation of visiting primary care services.

KEYWORDS
evaluation, health, outreach, remote, rural

1 | INTRODUCTION

Visiting primary care services operate to reduce disparities in access and outcome for residents of rural and remote areas.[1,2] There is great variation in the type of visiting primary care services in operation, including differences in the type of practitioners involved, the organisation's model of service delivery, and the focus of interventions (e.g., well-being, diabetes, specific injuries or illnesses, generalised primary care).[3] Furthermore, literature pertaining to visiting primary care services is sparse and inconsistent, particularly that which describes assessment of impact or evaluation.[2–4] The lack of research and models for service evaluation have implications for residents of rural and remote areas.

Health services based in communities, whether they be metropolitan or rural in location, ideally target their services toward the needs of their respective communities. Models for evaluation of the impact of visiting primary care services should account for the contextual nuances of rural and remote communities. The model of seven principles for effective visiting services[2] has potential utility for evaluating services. That model was recently revised[2,5] to enhance its credibility. The revised model based on a Delphi study is depicted in Figure 1.

Comprehensive definitions of each principle are published elsewhere[5]; therefore, concise summaries are provided for the current study. *Feasibility* refers to the funding and expected sustainability of the visiting service to continue operating in the select rural and remote region. *Justification* requires visiting service organisations answer the question, "on what grounds are you justified to deliver services in X location at Y time?" Example responses could include the health and demographic data from residents in the area and statistics of services available on the ground. *Partnership* refers to how well a visiting service collaborates and integrates with the communities it services. The process of forming a healthy and robust partnership should occur prior to the organisation establishing itself in a new region with community consultation as a priority. *Scope* describes the capacity and specificity of services provided by the visiting service and their relation to the needs identified as a priority by, and for, the community. *Scheduling* refers to the frequency and duration of visits to a community. *Continuity* relates to the consistency and reliability of the visiting service. *Review* involves an iterative discussion of the effectiveness and appropriateness of clinical and non-clinical aspects of the client and community interaction. Review is likely to combine two components: a needs analysis of the community and an evaluation of the service provided.[5] The revised model provides visiting services a framework for evaluation; however, it is in need of critical appraisal by stakeholders in the field. The objective of the present study is to assess the clinical utility of the revised model and to determine how it can be conceptualised into a tool for evaluation used by visiting service organisations.

What is already known on this subject:

- There is limited literature describing different visiting service models and inconsistencies in the assessment and reporting of visiting primary care services
- A model of seven principles for effective visiting services has been proposed and revised to include Justification, Partnership, Scope, Scheduling, Continuity, Review and Feasibility

What this paper adds:

- This study confirms the clinical utility of the revised model of seven principles for effective visiting services through the case of Outback Futures
- The findings include the model conceptualised as a self-assessment protocol to be used by visiting primary care organisations
- The findings of this study emphasise the importance of the approach and posture adopted by visiting primary care services. To be effective, visiting service providers must prioritise their relationship with community members and invest in co-design to effectively adapt their service to local needs

Case study[6] was selected as the method to appraise the model and a visiting primary care organisation, Outback Futures (OF), was chosen as the case. Outback Futures is a not-for-profit allied health service based in a capital city, Brisbane, Australia. Its team of psychologists, counsellors, speech pathologists, occupational therapists and social workers travel to remote and very remote areas of Queensland to deliver face-to-face services. In between visits, clinicians meet with clients for regular sessions conducted by telehealth. Outback Futures work with clients across the lifespan in a range of formats including individual therapy, professional development, and community presentations.

The research questions guiding the case study were: What is the clinical utility of the revised model of seven principles for effective visiting services in the case of Outback Futures? And, can the model be conceptualised as a tool for evaluation used by visiting primary care services?

FIGURE 1 The revised model of seven principles for effective visiting services published in Volume 29, Issue 5 of the AJRH[5]

2 | STUDY DESIGN

2.1 | Research team and reflexivity

All authors are psychologists registered with the Australian Health Practitioners Registration Authority. The first author receives research funding from the case organisation, Outback Futures, and is interested in improving access to evidence-based health care services in rural and remote areas. The second and third authors have extensive experience in rural service delivery having worked as FIFO practitioners and have continued research and development in aspects of health and well-being in regional, rural and remote communities. The first author's pre-existing relationship with the organisation and potential for bias were managed through weekly supervision with the second and third authors.

2.2 | Theoretical framework, orientation and theory

The research deployed Merriam's[6] approach to case study design which is grounded in constructivism with its epistemology being that knowledge and meaning are constructed by people through interactions with one another using language and symbols. The method is designed to explore how people make sense of their experiences and the world around them.[7] Merriam's[6] approach describes a case as a single entity with boundaries defining both the features of the case, and features that are outside the boundaries of the case.[6] The first two steps of Merriam's approach are a review of relevant literature and construction of a theoretical framework to guide the enquiry.[7] A recent review of the literature pertaining to visiting primary care services was conducted, written up separately, and used to inform the approach of the present study.[3] The key findings from that review include concern for the quantity and standard of research pertaining to visiting primary care services. The review's conclusions implore researchers to increase the quality and transparency of studies conducted to enhance the literature and more accurately inform future research, clinical practice, sponsorship and health policy.[3] The theoretical framework adopted for the presented study was the revised model of seven principles for effective visiting services.[2,5] The research problem identified for the present study was the disconnection between theory and practice in the assessment and evaluation of visiting primary care services.

2.3 | Participant selection

Purposive sampling was used and involved a sample from which the most can be learned to understand and gain insight about the case.[6] Outback Futures is a small organisation with nine full-time equivalent (FTE) clinical staff and 15 FTE non-clinical staff, including administration and executive staff. Three staff members from the organisation's executive team were selected as appropriate participants to provide insights into both the clinical delivery of services and the current context in the areas they service. Due to the small size of the organisation, no further demographic details are provided to preserve participants' anonymity.

2.4 | Data collection

Group interviews are an accepted method in social science and health-related research to collect in-depth data and to inform the development of measures, surveys and questionnaires.[8] In the current study, data were collected in four 1-h group interviews with all three participants. The first interview was conducted in person and voice-recorded for transcription purposes. The remaining three interviews were conducted over videoconference (Zoom) due to COVID-19 lockdown, and the video was recorded. The number of group interviews was determined collaboratively with participants at the time of data collection. Following the fourth interview, sufficient data had been collected in response to each research question, for each of the seven principles of the framework in question (Table 1).

TABLE 1 Semi-structured interview questions

Group interview questions	Group interview number
Describe what each of the principles means in practice for Outback Futures	1 and 2
From Outback Futures' perspective and your experience as a visiting service, how important do you believe each principle to be? 1. Not at all important 2. Low importance 3. Slightly important 4. Neutral 5. Moderately important 6. Very important 7. Extremely important	1 and 2
How do you propose to apply each principle to Outback Futures?	3 and 4
Additional question added after session two: Identify key indicators for assessment of each principle	3 and 4

A semi-structured interview schedule was developed from the theoretical framework and research questions (Table 1).

Participants were asked to describe what each of the principles meant in practice for the case organisation, and asked to rate how *important* they believed each principle to be on a 7-point Likert scale from 1 = *not at all important* to 7 = *extremely important*.

The interview schedule was extended to include the concept of a self-assessment framework following data collected from the first interview. As such, participants were asked to identify relevant indicators for assessment of each principle in the third and fourth interviews.

A fifth meeting was scheduled to present provisional findings to the participants and allow them an opportunity to clarify or amend. The provisional findings were endorsed with minor amendments to wording of indicators suggested.

2.5 | Data coding

The six phases of thematic analysis were used to analyse the data collected.[9] The first author became familiar with the data through the process of transcribing each interview, as well as listening to the recordings to generate initial codes. Following this, seven preliminary themes were identified. The transcripts were again reviewed and quotations relating to any of the preliminary themes were extracted. The first author reviewed the preliminary themes in supervision with the second and third authors. The preliminary themes were further condensed into three potential themes. The potential themes were then reviewed and assessed for quality, boundaries, specificity, evidence in the dataset and relationship to other potential themes. Following review and further supervision, three themes were defined and named.

2.6 | Ethics approval

This project was approved by the University of Southern Queensland Human Research Ethics Committee (H20REA024).

3 | ANALYSIS

3.1 | Data analysis

Recordings of the group interviews were transcribed by the first author and analysed using Braun and Clarke's[9] six-phase approach to thematic analysis. The six phases include: 1. Familiarising yourself with the data, 2. Generating initial codes, 3. Searching for themes, 4. Reviewing potential themes, 5. Defining and naming themes, and 6. Producing the report.[9] The second and third authors provided regular supervision throughout the analysis. Data analysis began throughout the data collection process to inform further interviews, as recommended by Braun and Clarke.[9]

4 | FINDINGS

The findings are organised into subsections. The research questions are addressed first by summarising the participants' perspectives regarding the seven principles' clinical utility and potential for application and an evaluation tool. Then the findings of thematic analysis are reported as three themes of importance for the delivery of visiting primary care services to rural and remote regions.[9]

4.1 | Clinical utility

The participants were unanimous in their endorsement of the revised model of seven principles for effective visiting

services[5] (the model). The model's comprehensive approach fit with their organisation.

> I think all seven [principles] are really critical... We can be measuring clinical outputs and they can be good, but that doesn't mean that we're making any overall change in the whole of community. Our model is about whole of community transformation.
>
> (Participant #1)

Furthermore, the participants reported that each of the seven revised principles held clinical utility for the specific case of Outback Futures, rating them all as either *very* or *extremely important* (ratings 6 and 7). Two amendments were suggested to the definitions of principles Partnership and Review. Regarding Partnership, the participant's reported that it is important for visiting services to consult with community prior to establishing themselves, however, they indicated that the process of forming a healthy and robust partnership involves time and consistency. In the case of Outback Futures, the development of rapport with rural and remote communities occurs over a period of at least 2 years. The second suggested amendment was for the definition of Review where the participants requested the inclusion of a strengths analysis of the community, as well as the previously defined needs analysis, to reframe the approach where appropriate.

The participant's emphasised their perspective that OF is different from other visiting services.

> I think one of the challenging things is that if you're looking at general visiting services, it's actually quite different to Outback Futures... We're one of the few, organisations who offers service provision but is actually focussed on whole of community change... A standard visiting service isn't focussed on community engagement and community mapping, they don't have time for that, they don't have funds for that.
>
> (Participant #1)

The participants reported that they believed that OF is different from other visiting services because of their long-term commitment to community well-being. This commitment influences their funding decisions through the diversity of funders, and their workforce structure.

> The advantage of our workforce model...is the fact that we recruit to a region, so that even when we are not in a community physically, our headspace is in that community... It just means we're more accessible and... there's much greater consistency and reliability in that.
>
> (Participant #1)

Therefore, while the current study demonstrates clinical utility for the model with the case, the results cannot be completely generalised to all visiting services.

4.2 | Application to evaluation

During the second interview it was proposed for the model to be transformed into a self-assessment, accreditation tool. This suggestion was met with support from participants.

> I think it makes sense from the perspective that there's some consistency like across frameworks that are commonly used in Australia. To me it would be speaking the language of funders potentially as well, like Government bodies that would relate to that [the tool] and that can be helpful.
>
> (Participant #1)

> I agree with [Participant #2], I think at the moment there could be some real value in trying to get some consistency...whilst it looks daunting at one level, I think there could be some real value in it because I think ultimately, if it's evidence based and it's got some research behind it, it could actually um provide some validation for what we're doing and why we're doing it.
>
> (Participant #1)

The third and fourth interviews were structured to have participants brainstorm potential indicators for the accreditation tool. Each indicator was designed to capture an organisation's consideration of, and adherence to, each principle of the model. Preliminary indicators were proposed in the discussion of the group interviews. These were consolidated and refined by the research team and re-presented to the participants for review in a follow-up meeting. The participants expressed support for the preliminary indicators and suggested minor amendments in wording. The final indicators are presented in Table 2.

Throughout the data collection process, four of the seven principles were identified by the participants as mandatory indicating that they were of particular importance, and the remaining principles were classified instead as necessary. Upon review, the participants

requested the removal of the mandatory categories. "I feel like maybe you've ended up with seven categories that actually as wholes they're all pretty important" (Participant #2). "That was my feeling yesterday when I read through this, I was a bit concerned about only having four of them as mandatory, the others all felt really important" (Participant #1). The mandatory categories have since been removed.

As an outcome of the current study, the self-assessment tool has been established and produced into a document for use by visiting service organisations. A preview of the output is captured in Figure 2

TABLE 2 Indicators for self-assessment from the model of seven principles for effective visiting services

Principles	Indicators for self-assessment
Feasibility	The visiting service has: 1.1 Broad engagement with a variety of community stakeholders to ensure responsive and appropriate service delivery. 1.2 A long-term commitment to communities serviced. 1.3 Transparency of finances and justification of costs. 1.4 A diversity of funding sources for increased sustainability and flexibility of scope.
Justification	The visiting service has: 2.1 An active and ongoing invitation from communities. 2.2 Evidence of co-design and collaboration with community. 2.3 Produced a gap analysis of each community through the assessment of health needs and services available. 2.4 Evidence of regular monitoring for the purpose of updating the aforementioned gap analysis. 2.5 Met their identified service aims in each community.
Partnership	The visiting service has: 3.1 Support evident in community testimonials. 3.2 Support evident in the source of referrals. 3.3 Evidence of active engagement with health, community services and other organisations. 3.4 Evidence of active partnerships with health, community services and other organisations. 3.5 Evidence of liaison with multiple sectors (i.e., education, business, health, local council, etc.).
Scope	The visiting service: 4.1 Has a clearly defined scope of practice at all levels of the organisation. 4.2 Consistently applies the scope of practice with different practitioners. 4.3 Collects data to monitor how the organisation's scope is effectively fit to each community. 4.4 Has the capacity to absorb and manage limiting factors to preserve the scope of the organisation (e.g., funding limitations and reporting requirements). 4.5 Has flexibility and breadth embedded into the scope to respond appropriately to the specific needs of individual communities serviced.
Scheduling	The visiting service: 5.1 Has sufficient regular visits to each community to maintain authentic connection and trust. 5.2 Can provide evidence of co-design with the community in the development of schedule. 5.3 Prioritises multidisciplinary care through its schedule. 5.4 Incorporates both primary and secondary interventions in its schedule. 5.5 Plans their visits to a schedule that is responsive and appropriate to the needs of the community.
Continuity	The visiting service organisation: 6.1 Can demonstrate continuity in each community through data recorded (i.e., staff retention, length of time in a region and consistency of staff to each community). 6.2 Recruits to ensure consistency of specific personnel to each community. 6.3 Shows evidence of an adaptable workforce structure that prioritises continuity. 6.4 Has structures and systems established to maintain continuity with the community between face-to-face visits (i.e., telehealth, resourcing locals).
Review	The visiting service conducts: 7.1 Regular assessment of the effectiveness of clinical services through reliable, client-centred measures. 7.2 Regular assessment of the effectiveness of the organisation's community co-design and partnership with the community. 7.3 Annual review of community well-being at a whole of community level. 7.4 Assessments for evidence of change in the community following prolonged intervention from the visiting service.

Self-Assessment Tool for Effective Visiting Primary Care Services

Principle 1: Feasibility

Feasibility refers to the funding and expected sustainability of each visiting service. This might include an acknowledgement of funding bodies, any restrictions on service delivery that are built into funding contracts, the financial capacity of the organisation to deliver the intended service, and any external influences to clinical practice or model structure. Feasibility of visiting services has been identified as influential in determining the scope of each organisation. It is essential to consider the impact of the service on the community. If funding is short-term, it may be more effective to consider how to more effectively build local capacity to acknowledge and prepare for a time when the organisation is withdrawn from the community.

Self-Assessment Rating

0 = not meeting criteria
1 = have a plan to do this
2 = started this work
3 = established in a few areas
4 = established in most areas
5 = nothing to improve

Criteria for Assessment The visiting service has:	Rating	Evidence
1.1 Broad engagement with a variety of community stakeholders to ensure responsive and appropriate service delivery.		
1.2 A long-term commitment to communities serviced.		
1.3 Transparency of finances and justification of costs.		
1.4 A diversity of funding sources for increased sustainability and flexibility of scope.		
	Total	**Self-Assessment Score** 0-10= requires significant work 11-15= solid work with areas to improve 16+= strength, with some areas to improve

Page 6

FIGURE 2 Preview of the self-assessment protocol business-use document

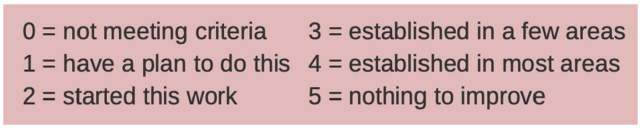

FIGURE 3 Scale used to rate performance on each indicator of the self-assessment protocol

with the full text available upon request. To use the self-assessment measure, visiting service organisations can use each indicator (four or five per principle) and rate their performance on a 6-point Likert scale presented in Figure 3. Totals can be calculated for each Principle to determine if the organisation *requires significant work* on a principle or has rated as *solid work with areas to improve*, or *strength with some areas to improve*. Organisations are required to provide evidence including specific examples to justify their decision. Graphic designers were used to construct the business-use document informing both cosmetic and functional features. Of note is the "Smart PDF" features that have been incorporated to allow users to fill the form out electronically. These features make regular review more achievable and allow organisations to capture changes over time.

4.3 | Notable themes

4.3.1 | Relationship is fundamental

The participants spoke frequently about the relationship between the visiting service and the community. The participants reported high frequency of staff turnover and inconsistency of services to the remote and very remote regions that OF visits. As a result of turnover and inconsistency, community members are sceptical of visiting services, their commitment and sustainability.

> I remember when [community member] sat down and said "oh no, not another one, we have had so many of you guys and I can never keep up." Then 2 years later he was saying "... you guys are the most consistent service providers we've got"... The reality is that when you've got schools with five principals in 1 year, and organisations where roles are vacant for 2 years at a time, then they are filled for 6-month and then they are vacant for another 2 years, if you are persistent, it doesn't take long to show people.
>
> (Participant #1)

The participants also spoke of rural and remote communities feeling invalidated by visiting services that make assumptions of their context and needs. The participants provided examples of how they develop and maintain a relationship with communities.

> One of the things that we try and drum into our team is that we're not the city experts... We don't come with all the answers. We are here to listen and learn and work with the local context and I think because there is that mindset very strong in the bush of "oh look here's someone else from Brisbane that's come out to show us the latest you-beaut thing and they'll be gone before we know it and nothing will change"... it's kind of the posture you go with and the way you carry as opposed to just turning up as the latest person with the silver bullet.
>
> (Participant #3)

As well as the approach of the visiting service, the participants reported the continuity of staff and continuity of brand, demonstration of consistency, and direct efforts to connect with local stakeholders as factors that influence the development of relationship. As an outcome of these strategies, the participants reported that once the relationship has been established and the organisation has demonstrated consistency and commitment to the community, the service is able to tailor the frequency of visits without impacting the strength of relationship. Further, the participants reported that a team approach with an existing relationship allows for the movement of staff when required (e.g., maternity leave, promotion to managerial role, or a reallocation to new region) without impact to client's access to services.

4.3.2 | Importance of co-design

In the case of Outback Futures, co-design is fundamental to their model of service. The participants explained that the organisation operated purely on an invitation-only basis.

> We won't go into a region unless there's been some level of invitation from the community, and that invitation then leads us to do a whole series of community engagement processes to ensure we are actually welcome and that we are doing what they want us to be doing.
>
> (Participant #1)

Once invited to work in a community, OF prioritises partnership through co-design.

> Hopefully we carry that posture of humility or partnership or working alongside and listening so that... we are designing stuff together. We use that word 'co-design' a lot. We genuinely try to collaborate and do all of that stuff that's good partnership work.
>
> (Participant #3)

> I think the coming together of our expertise with the community's expertise is what actually helped identify the priority because sometimes we go, "oh it's obviously going to be around..." whatever "mental health, education or working" they're going, "oh well it's obviously going to be this, because we know our community" but both of those groups actually have blind spots... it's really only as you put them together, and they wrestle together that you actually figure out what the priority is. It's actually a genuine co-creation of stuff and having the breadth of voices [from the community] is part of the important bit of that... you can get a bit of a biased view dependant on who you listen to.
>
> (Participant #3)

The participants indicated that to be effective in co-design requires flexibility from the visiting service. Specifically for the case, flexibility in funding sources, scope of practice, and in the structure of their workforce with non-clinical, community-focussed roles.

> I think the diversity of our funding comes back in again because, if you are just funded by Government, then it's only the procured services that are going to be funded and that's going to determine how much you've got to invest time, and money, and resources and into engagement, or into co-design, or into listening. The fact that we have diversity in our funding means that we have more flexibility to invest in the less service-orientated aspect of our model. Like the listening and the co-design.
>
> (Participant #1)

> They [rural communities] don't realise that, OT once a year is inadequate, until they experience OT once a week. I think it's evolving, and the scope needs to be flexible and needs to evolve.
>
> (Participant #1)

> Our regional leads and our regional coordinators are actually... they're thinking about the community, they're thinking about connection, they're thinking about our presence there... So, when you elevate it above just pure service delivery and you embed people in the team who constantly have an eye and an ear for what's going on in the community and our reputation there, and our presence there, and our impact there, then um that's important for continuity too because it sort of carries... an overarching understanding of the community that holds that team and its presence in the community together.
>
> (Participant #3)

Co-design between visiting services and rural and remote communities is essential but does not come without challenges.

4.3.3 | Being effective as a visiting service is challenging

The participants consistently indicated that being an effective visiting service is really challenging. This theme is the broadest of all three themes produces and is related to the previous two separately. Establishing an effective relationship is difficult due to the existing stigma in rural and remote communities and hesitancy to trust visiting services generally. Co-design is challenging due to mismatched expectations for what the service will provide, logistical challenges of partnership, and scheduling, as well as the difficulty sourcing a well-rounded, unbiased community opinion rather than an individual viewpoint. Further, both developing a reliable relationship and engaging in co-design require time and resources that are often not incorporated into funding grants. Outback Futures is a not-for-profit organisation and currently operates a no-fee for service to reduce barriers to engagement. A challenge for the organisation now, having worked in some communities for 5 years, is to introduce a fee to enhance the likelihood of long-term community engagement with healthcare, beyond visits from OF.

> Part of our challenge at the moment is looking at how do we build that in as part of the

> model? So that communities are actually valuing what they're getting, because if whoever- whether it's Government, or Outback Futures, or another agency give them [clients] free service for 5 years and later on they're forced to pay for it, if they don't value it enough, they won't be prepared to.
>
> (Participant #1)

The participants stated that OF is determined to make a long-term impact on community well-being which involves challenges particularly related to funding.

> ...You have never really got a long-term funding commitment, you've got a long-term service commitment. So, it does make feasibility really difficult but the organisation has committed to just keep trying to fill those buckets [of different funding].
>
> (Participant #2)

Another prominent challenge reported by the participants was the high rates of workforce turnover in rural and remote communities, and implications this has for the organisation's justification, partnership and scope.

> I think that one of the hard things is that because there's so much turnover... keeping on top of who's there, and also keeping on top of exactly what they're doing because part of the justification of what we're doing is because other services aren't doing it. But sometimes they are, sometimes they aren't, because sometimes they can get a speech [speech pathologist] and sometimes they can't, and that can really change with the wind. Sometimes we are doubling up [with other services] and sometimes there's gaping holes.
>
> (Participant #2)

> Other fly-in-fly-out services or even other services that are on the ground but are servicing 15 schools between Alpha and Birdsville or are servicing seven Central West Shires. The reality is, their head is only in the community that they're in, when they're there physically. Because they're in Winton this week, they're in Boolia next week, they're in Barcoo the next week, actually our capacity to collaborate with them, at any point, is very difficult.
>
> (Participant #1)

Within the organisation, the participants reported there are also logistical challenges related to scheduling clinics, coordinating with community and part-time staff. Finally, review and evaluation of visiting services is largely uncharted territory.

> I think any sort of impact stuff is really challenging. Even if at a clinical level it's very hard to get practitioners to use outcome measures well, to select outcome measures that are actually meaningful... it's just hard to get a good read of communities in general. What sort of tools can we use to help us to get to know the full breadth of the community better? Read it better and sort of have an ongoing iterative process around that evaluation so that we're being constantly informed by how that community's feeling and doing.
>
> (Participant #2)

5 | DISCUSSION

The current research provides evidence for the clinical utility of the revised model of seven principles for effective visiting services (the model).[2,5] A pragmatic outcome of the current research is a self-assessment tool for the case organisation to use as a tool for evaluation. This is an innovative contribution to the literature relating to visiting primary care services, also informing the area of clinical practice.

In the case of Outback Futures, the model received unanimous endorsement by the case study's participants. The participants reported that the comprehensive approach aligned well with their target of improving whole of community wellbeing.[10] The participants requested minor amendments to the existing published definitions of the principles Partnership and Review. Further, the participants reported that the case of Outback Futures is not representative of typical visiting services. This belief may have risen from the discrepancy between different community's expectations and OF's success with relationships and co-design. One of the many advantages of the OF's model is their availability to both community members and other service providers. By recruiting to a region, their staff are more available to meet with, and discuss matters relating to that region, even when not on the ground in person. Further, the multimodal approach with both face-to-face and telehealth interventions also contributes to the continuity of the service. Due to the perceived difference between OF and other visiting services, future research is required to determine the suitability of the model of seven principles to other visiting primary care organisations.

Currently, no guidelines, standard procedures or recommendations exist to direct the evidence-based evaluation of visiting primary care services. The product of the present study is the first known attempt to establish a tool for evaluation to be used by visiting services. Following the support collected for the model, the case of Outback Futures was used to inform the development of the self-assessment tool presented in Table 2. While currently this measure is specific to the case, it provides a prototype that could be replicated and modified by other services. Due to the variation in visiting primary care services, a framework centred on the model provides a consistent solution to be adaptably applied to different organisations.

Three themes were identified from the data collected, and illustrated different components of effective visiting service delivery from the perspective of the case.

5.1 | Relationship

The participants explained how the relationship between the visiting service and community is fundamental to the effectiveness of the organisation. They reported that the health workforce in the areas OF visit have high rates of staff turnover and difficulties in the attraction and retention of staff which aligns with evidence relating to workforce challenges in rural and remote areas.[4,11,12] These findings from the case organisation are further support for the revised model, particularly the principles of partnership and scheduling which emphasise collaboration with communities serviced.[5] In addition to existing literature, the present study implores visiting services to prioritise their relationship with community members by adopting a stance of humility to listen and learn the local context, and demonstrating reliability through continuity of staff and continuity of visits.

5.2 | Co-design

The development of a robust relationship can be further enhanced through collaborative co-design. This finding aligns with the conclusions of The Orange Declaration on Rural and Remote Mental Health.[10] The Orange Declaration is a publication that described ten problems related to current models of mental health and well-being in rural areas, and proposed ten solutions. In relation to the present research, the Orange Declaration outlined the problem of urban assumptions and their influence through top-down service models, as well as the discrepancy between service provision and population need in rural locations. Solutions proposed by the Orange Declaration include service models tailored to the context of individual communities, and co-designed, bottom-up processes to generate appropriate solutions.[10] The process of co-design encourages an increase in capacity, empowerment, resilience and connection as individuals are asked to provide their perspective as experts of their own community and culture.[10,13] For co-design to be effective, visiting services must have flexibility to tailor their service to the needs and plans discussed. For Outback Futures, this flexibility is found in the diversity of their funding sources that allows them to continue to prioritise community engagement and co-design beyond specific grants allocated only to the delivery of services. Co-design is a vital component of the effectiveness of Outback Futures as a visiting service.

5.3 | Challenge

From the perspective of the case, being effective as a visiting service organisation is challenging. It is challenging because of the stigma that has developed around visiting services and work required to build trust and rapport. It is challenging because being genuine and committed to co-design requires time, resources and flexibility. It is challenging because the literature related to visiting services is sparse and inconsistent and because OF feels different from the typical mould of visiting services. It is challenging because OF's commitment to communities extend beyond what they can grasp in funding, and because valued components of their service are not often included in funding grants (i.e., co-design). Further challenges include the turnover of workforce in rural and remote areas[4,11,12] and the impact this has on the organisation's justification, partnership and scope; internal team logistics scheduling clinics and responding to need. It is challenging to review the service in an evidence-based and meaningful way. The challenges reported have not been published in literature relating to visiting services, and could serve as an explanation for the state of the literature, being sparse and inconsistent. This clinical experience is a valuable contribution to the research literature.

5.4 | Conclusions and recommendations

This case study provides support for the clinical utility of the revised model of seven principles for effective visiting services, and includes a prototype self-assessment tool. The themes identified indicate that the posture adopted by visiting services in rural and remote communities is critical to their effectiveness. It is recommended that visiting services invest sincerely in their relationship with each community, prioritise co-design, and adapt their service to the unique needs of the individual communities. The case

acknowledges the challenges this involves but indicates the output is of great value to rural and remote residents. A limitation to the application of the prototype self-assessment tool is its development with reference to a single case. The case study represents a valuable contribution to the literature; however, further research is required to assess both the clinical utility of the revised model and the applicability of the prototype self-assessment tool to other visiting service organisations. The self-assessment tool should remain as a prototype until further assessment has been conducted.

AUTHOR CONTRIBUTIONS

LJH: conceptualization; data curation; formal analysis; methodology; project administration; visualization; writing – original draft; writing – review and editing. GB: conceptualization; methodology; supervision; writing – review and editing. PM: conceptualization; methodology; supervision; writing – review and editing.

ACKNOWLEDGEMENTS

The research team would like to formally acknowledge the generous contribution of each participant. Further, we would also like to thank the graphic design team that transformed the self-assessment protocol from a concept into a professional, user friendly tool. Finally, we greatly appreciate the financial assistance of the USQ Postgraduate Research Scholarship made possible by Outback Futures and the generosity of the Tim Fairfax Family Foundation. Open access publishing facilitated by University of Southern Queensland, as part of the Wiley-University of Southern Queensland agreement via the Council of Australian University Librarians.

FUNDING INFORMATION

This research has been supported by funding from Outback Futures and the University of Southern Queensland through the Postgraduate Research Scholarship.

CONFLICT OF INTEREST

LH has worked for Outback Futures since 2013 in varying roles. One of the three participants was an existing connection of LH. Regular supervision from GB and PM was maintained throughout the research to ensure that any biases from LH were identified and eliminated.

ETHICAL APPROVAL

This project was approved by the University of Southern Queensland Human Research Ethics Committee (H20REA024).

ORCID

Laura J. Healy https://orcid.org/0000-0002-5831-7815
Gavin Beccaria https://orcid.org/0000-0002-4341-804X
Peter McIlveen https://orcid.org/0000-0002-1864-9516

REFERENCES

1. de Roodenbeke E, Lucas S, Rouzaut A, Bana F. Outreach services as a strategy to increase access to health workers in remote and rural areas. Geneva: World Health Organization; 2011.
2. Carey TA, Sirett D, Wakerman J, Russell D, Humphreys JS. What principles should guide visiting primary health care services in rural and remote communities? Lessons from a systematic review. Aust J Rural Health. 2018;26(3):146–56.
3. Healy LJ, Beccaria G, Daken K, McIlveen P. Visiting primary care services: A systematic quantitative literature review. [submitted for publication]. In press 2022.
4. Carey TA, Sirett D, Russell D, Humphreys JS, Wakerman J. What is the overall impact or effectiveness of visiting primary health care services in rural and remote communities in high-income countries? A systematic review. BMC Health Serv Res. 2018;18(1):476.
5. Healy LJ, Beccaria G, McIlveen P. Revised model for evaluating visiting health care services in rural and remote settings. Aust J Rural Health. 2021;29(5):779–88.
6. Merriam SB. Qualitative research and case study applications in education. San Francisco, CA: Jossey-Bass; 1998.
7. Yazan B. Three approaches to case study methods in education: yin, Merriam, and stake. Qual Rep. 2015;20(2):134–52.
8. Barbour RS. Focus groups. In: Bourgeault I, Dingwall R, de Vries R, editors. The SAGE handbook of qualitative methods in Health Research. London: SAGE; 2010. p. 327–51.
9. Braun V, Clarke V. Thematic analysis. APA handbook of research methods in psychology, Vol 2: research designs: quantitative, qualitative, neuropsychological, and biological. Washington, DC: American Psychological Association; 2012. p. 57–71.
10. Perkins D, Farmer J, Salvador-Carulla L, Dalton H, Luscombe G. The Orange declaration on rural and remote mental health. Aust J Rural Health. 2019;27(5):374–9.
11. World Health Organization. Increasing access to heath workers in remote and rural areas through improved retention 2010. Available from: https://apps.who.int/iris/bitstream/handle/10665/44369/?sequence=1
12. Jackson Pulver L, Fitzpatrick S, Ritchie J, Norrie M. Filling the Gap: an evaluation of a voluntary dental program within an Aboriginal and Torres Strait Islander and Torres Strait islander community controlled primary health service. Aborig Isl Health Work J. 2010;34(4):3–7.
13. Steen M, Manschot M, De Koning N. Benefits of co-design in service design projects. Int J Des. 2011;5(2):53–60.

How to cite this article: Healy LJ, Beccaria G, McIlveen P. Indicators for effective visiting primary care services: A case study. Aust J Rural Health. 2022;30:760–771. doi: 10.1111/ajr.12946