What role health care systems in engagement in care?

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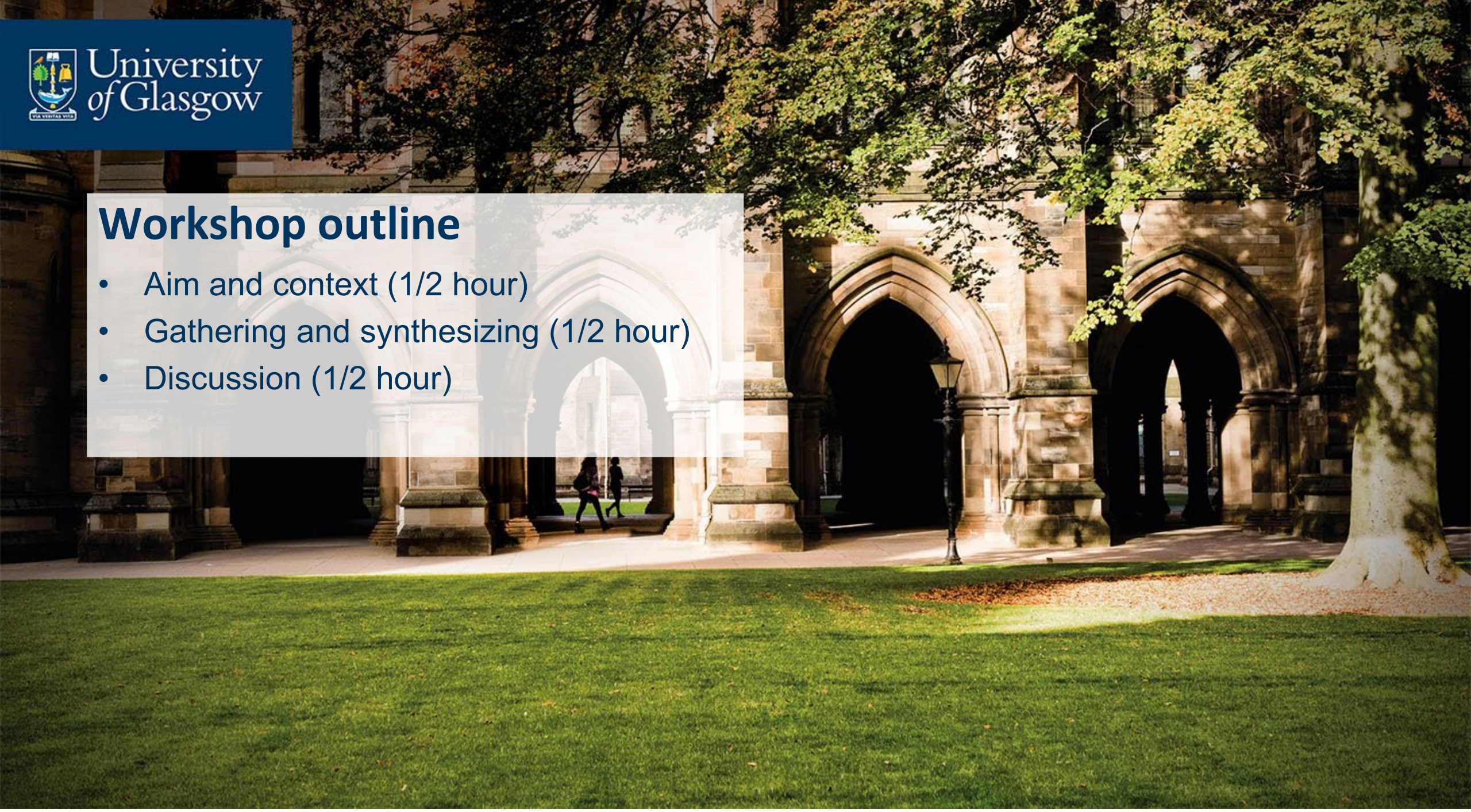

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Workshop outline

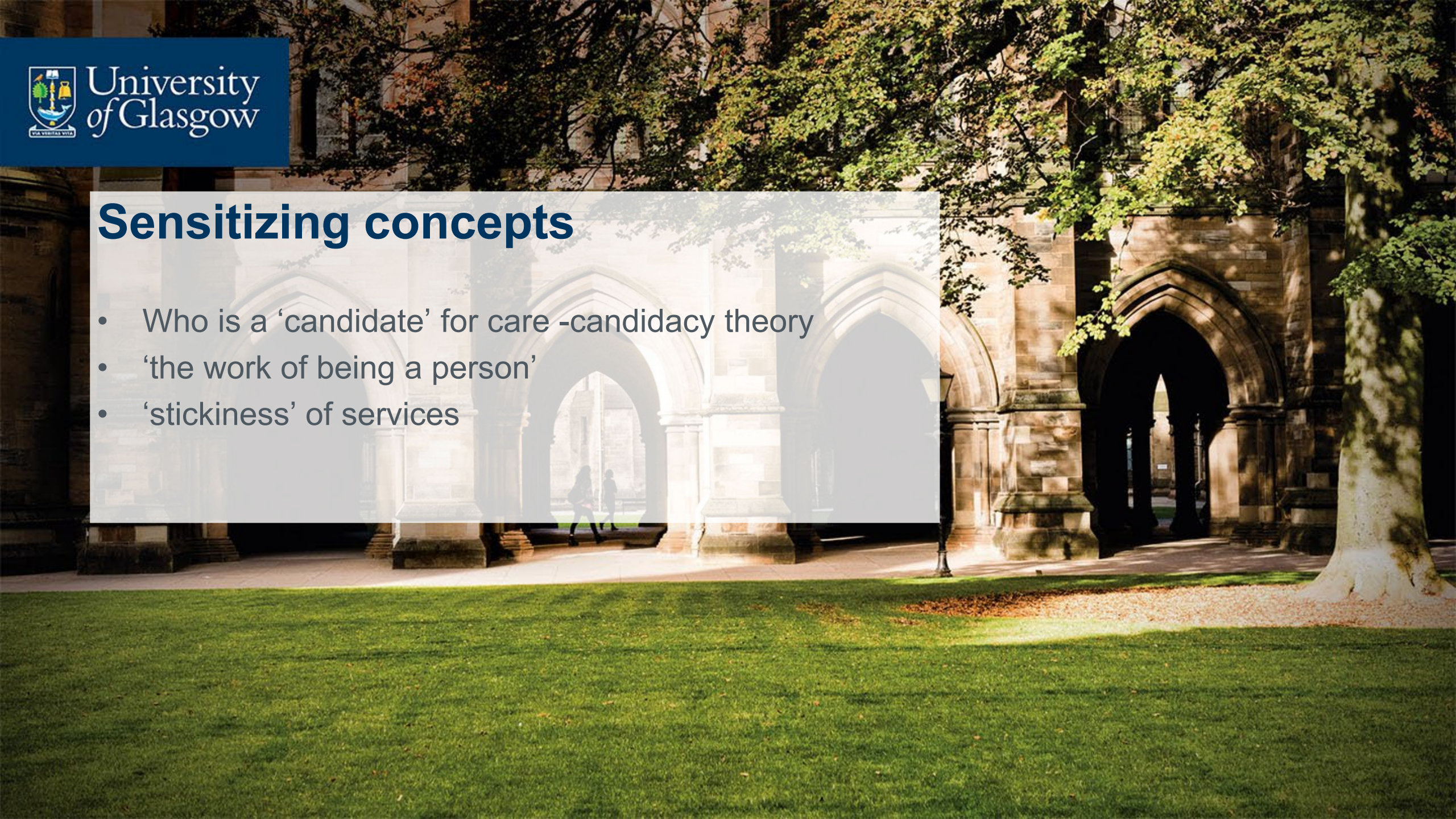
- Aim and context (1/2 hour)
- Gathering and synthesizing (1/2 hour)
- Discussion (1/2 hour)

Aims

- Gather & reflect on the influences that impact on patients' ability to engage in health care- lower and higher engagement
- What are the implications for the primary care research agenda?
  - generally?
  - specifically for your context?

Context

- Health & health care as a human right (HRBA)
- Low engagement in care as **MISSINGNESS**
- Who is missing from our services/care and why?
- Flipping this- examples of explicit **INCLUSION**?



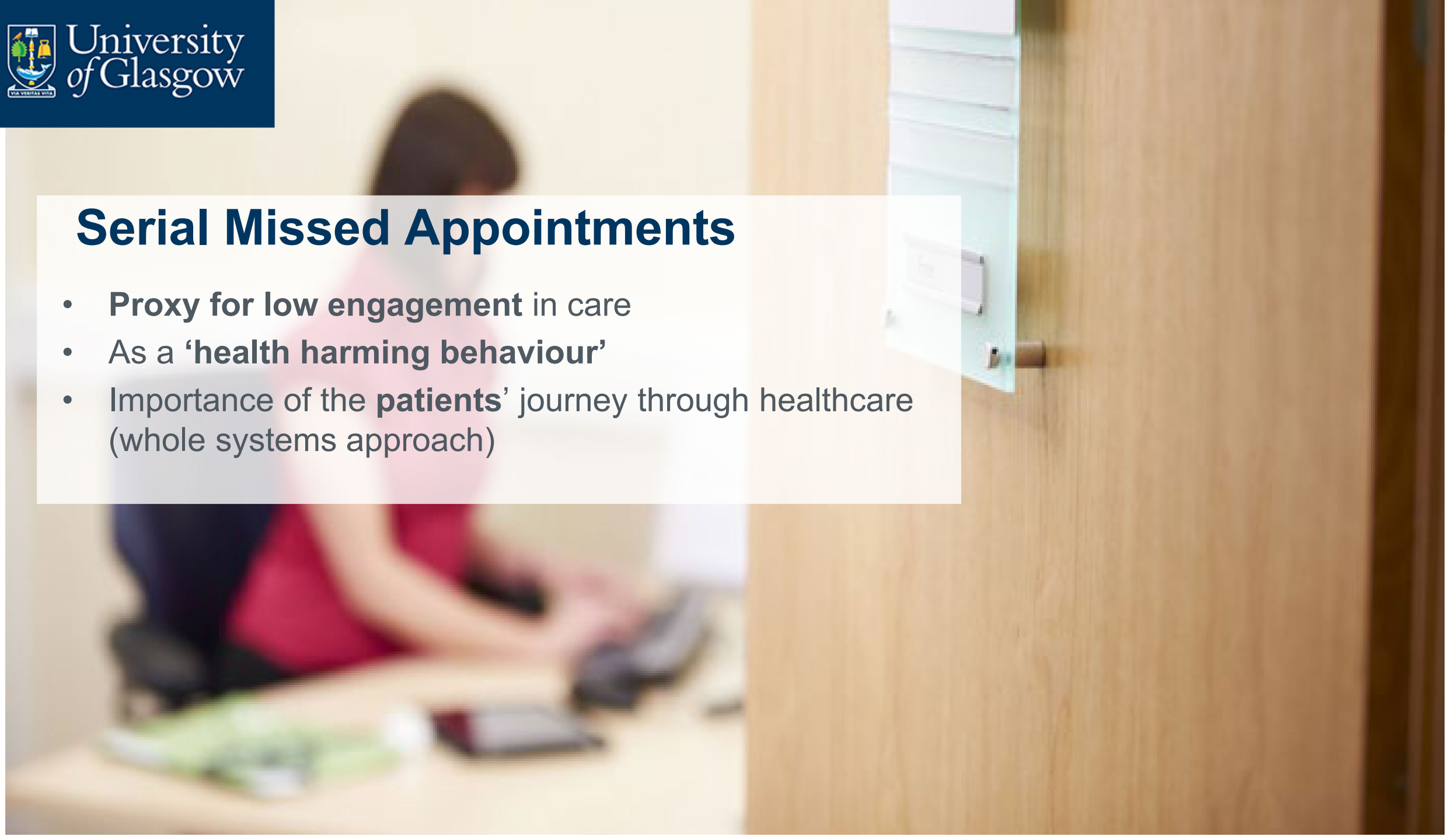
Sensitizing concepts

- Who is a ‘candidate’ for care -candidacy theory
- ‘the work of being a person’
- ‘stickiness’ of services

Candidacy theory

Aspect	example
Identification of candidacy	Individuals view themselves as legitimate candidates for particular health services
Navigation of services	Knowing how to make contact with a service & mobilising practical resources
Permeability of services	Service organisation demands specific qualifications of candidacy & mobilisation of resources for initial access
Asserting candidacy	Individuals presenting their claim to candidacy for medical attention
Adjudication by health service	Individuals' claim to candidacy is validated or otherwise, which influences previous stages of subsequent candidacy journeys
Offers of, resistance to, services	Follow-up services may be appropriately or inappropriately offered & these may or may not be acted upon by service users
Operating condition & local production of candidacy	The contingent & locally specific influences on interactions between health services & service users, which develop over time

(Acknowledgement- Jamie Stewart; summary from McKenzie et al Social Policy and Adminstration 2012)



Serial Missed Appointments

- **Proxy for low engagement** in care
- As a **'health harming behaviour'**
- Importance of the **patients**' journey through healthcare (whole systems approach)

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Scottish General Practice

- (almost all) **population coverage**
- **Universal access** & **free** at point of care
- Unique **patient record from birth to death**
- Major advances in electronic records recording & retrieval

Definition & analysis

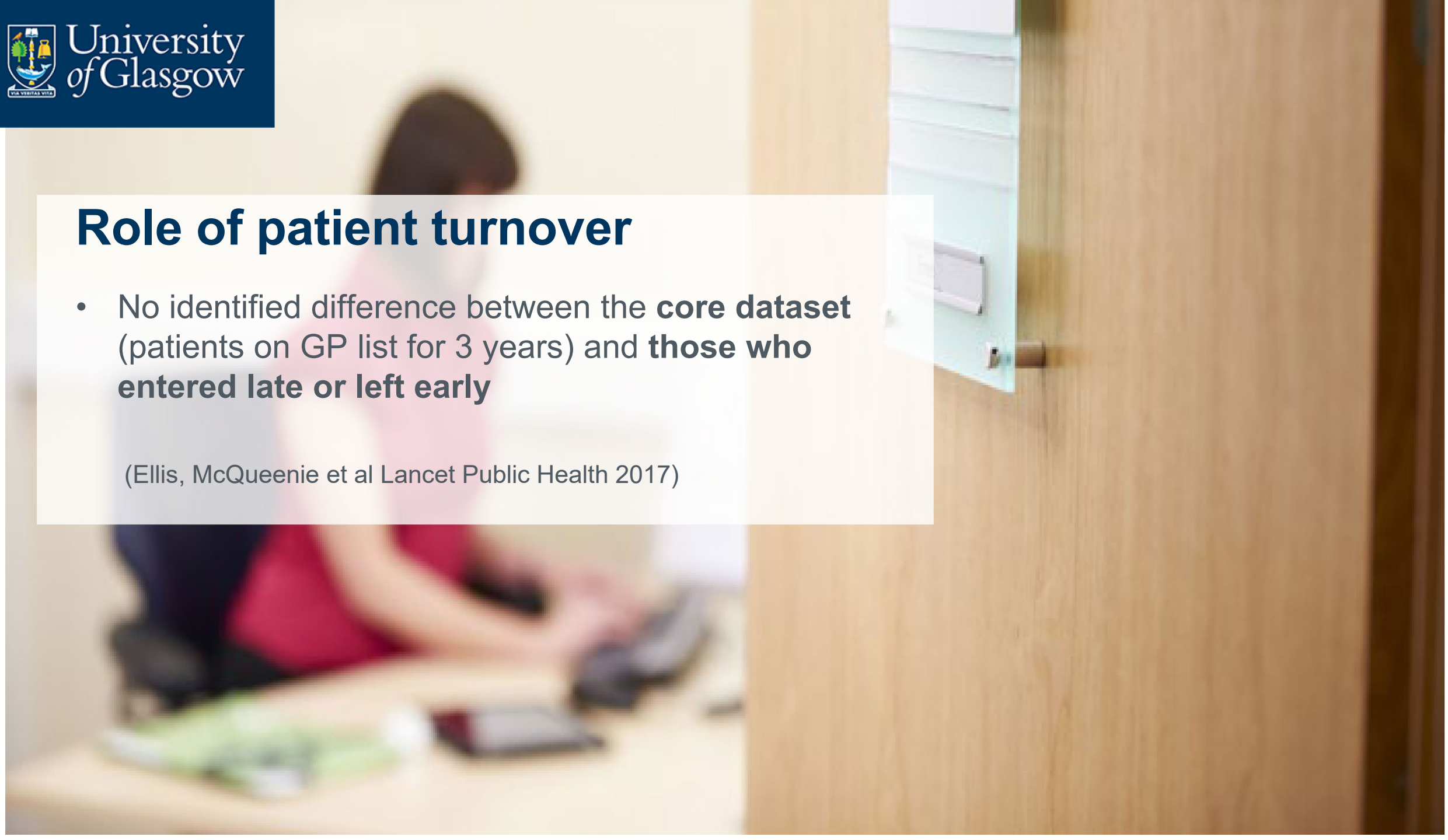
Average of primary care face to face appointments over previous **three years**

- **Never missed appointments per year, 0**
- **Low missed appointments per year, <1**
- **Medium missed appointments per year, 1-2**
- **High missed appointments per year, 2 or more**

Frequency counts

Negative Binomial Regression Modelling across 4 appointment groups

(Williamson et al BMJ Open 2017)



Role of patient turnover

- No identified difference between the **core dataset** (patients on GP list for 3 years) and **those who entered late or left early**

(Ellis, McQueenie et al Lancet Public Health 2017)

Missed appointments results

136 Scottish representative GP practices

550 083 patient records

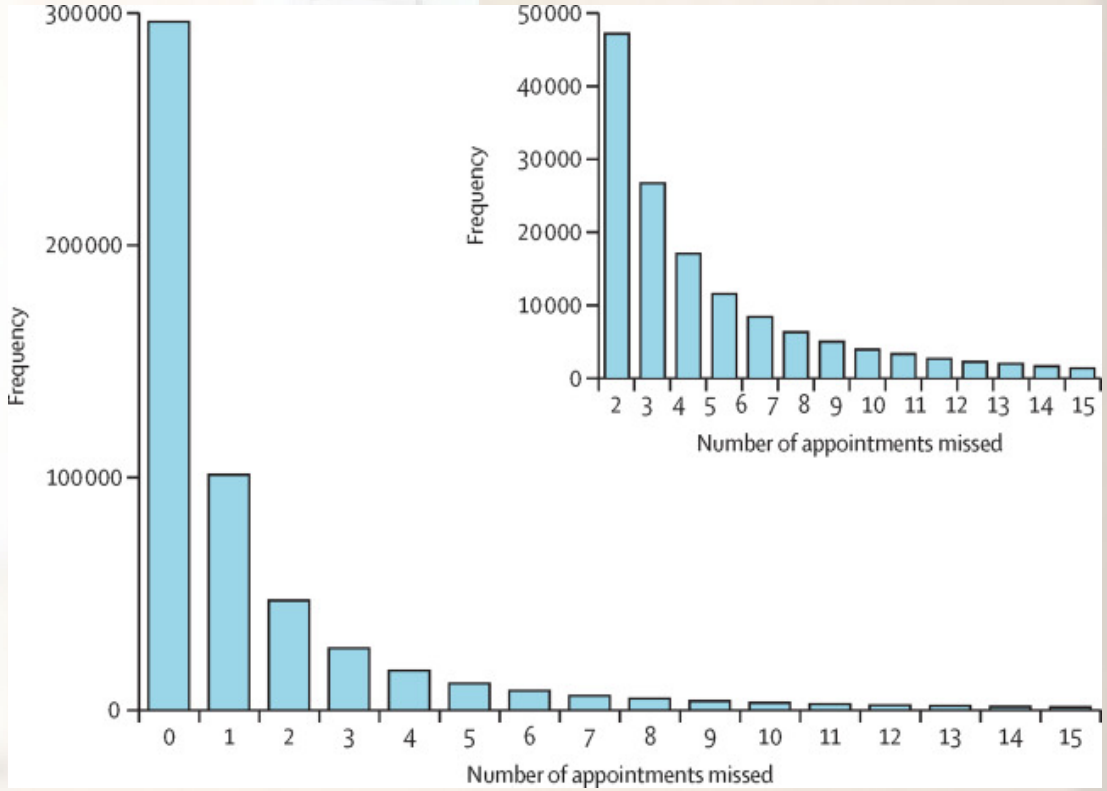
9 177 054 consultations

54·0% (297,002) missed no appointments

46·0% (212,155) missed one or more appointments

19·0% (40,926) missed more than two appointments

(Ellis, McQueenie et al Lancet Public Health 2017)



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Patient demographic factors

- Most socio-economically deprived **(SIMD 1)** patients most likely to miss appointments (RRR 2·27, 95% CI 2·22–2·31)
- Most remotely located patients least likely to miss appointments (RR 0.37, 0.36–0.38)
- Patients aged **16–30 years** (1·21, 1·19–1·23) & **older than 90 years** (2·20, 2·09–2·29) more likely to miss appointments
- Effect of gender small
- Ethnicity poorly recorded (2.69% all records)

(Ellis, McQueenie et al Lancet Public Health 2017)

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GP practice demographic factors

- **Appointment delay 2–3 days** (RRR 2·54, 95% CI 2·46–2·62) most strongly associated with non-attendance
- **Urban GP practices** more strongly associated with missed appointments
- **More deprived patients registered with GP practices in more affluent settings have the highest risk of missing appointments**

(Ellis, McQueenie et al Lancet Public Health 2017)

Patient and practice demographics

- **Practice factors have a larger effect** than patient factors but a model combining both patient and practice factors gave a higher Cox-Snell pseudo R^2 value (0·66) than models using either group of factors separately (patients only R^2=0·54;practice only R^2=0·63)

(Ellis, McQueenie et al Lancet Public Health 2017)

Morbidity and mortality (1)

- Patients with **more long-term conditions** have increased risk of missing GP appointments (controlling for number of apts made)
- Patients missing appointments were at much greater risk of **all-cause mortality, the risk increasing with number of missed appointments** (independent of morbidities)

(McQueenie et al BMC Medicine, 2019)

Morbidity and mortality (2)

- Patients with **long-term mental-health conditions missing >2 appointments per year had >8x** risk of all-cause mortality compared with those who missed no appointments
- These patients died at a **younger age**, and commonly from **non-natural external factors**
- **Missing appointments repeatedly seems to be a powerful marker for greatly increased risk of mortality, particularly among those without physical long-term conditions** (after adjustment for all other mortality risks)

(McQueenie et al BMC Medicine, 2019)

Gathering

Low engagement in care= high risk of missingness

Person……Family medicine……..hospital care

- What factors **influence low** engagement in care?
- What factors **influence higher** engagement in care?
- **Add** ✓ if you agree with another's statement

Synthesizing

- Lower engagement in care - organize within person, family medicine, hospital care
- Higher engagement in care- organize within person, family medicine, hospital care
- Frequently agreed first

Discussion

- What have we discovered?
- What are the implications for the primary care research agenda?
  - generally?
  - Specifically for your context?

- Leave your email contact to be sent our synthesis of today's workshop

Further SMA papers

- ACEs and recording rates
- Health care utilization
- Educational attainment and exclusions
- ADHD cohort
- Modelling unmet need

Further SMA work

- Current evidence base:
  - Complete the patient journey through health care-outcomes & utilisation
    - **diagnosis codes for A&E, OP and admissions**
    - **GP OOH, NHS24 and ambulance data**
- Current practice developments:
  - Develop an SMA predictive model
    - **practices target existing SMA patients for care**
- Future interventions development:
  - GP practice whole system predictive template
  - Systematic review of whole system interventions
  - Qualitative study work with stakeholders and SMA experts by experience

Acknowledgements

- Participating GP practices
- Dave Kelly, Albasoft (TTP)
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- DLDS Scot Gov
- EDRIS team – Dionysis Vragkos

Further information

http://www.gla.ac.uk/serialmissedappointments

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