

Do invitations to attend Well Man Checks result in increased male health screening in primary health care?

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ABSTRACT

BACKGROUND AND CONTEXT: Male health outcomes lag behind those of women in many areas. Male utilisation of primary health care and uptake of preventative health care is relatively lower. Our question was: will inviting males who have not received recent health screening nor attended the practice frequently result in a higher rate of male health checks?

ASSESSMENT OF PROBLEM: An auditable uniform classification 'Well Man Check' was established and education sessions on the importance of increasing male health care were held for all clinical staff. Recording of Well Man Check was audited for time periods prior to and after mailing out invitations to attend a Well Man Check. Thirty cases were reviewed to see if previously unrecognised health risks or symptomatic problems were detected.

RESULTS: Bottom line: inviting males to attend for a Well Man Check almost triples the number of recorded Well Man Checks, and does not reduce the number of opportunistic Well Man Checks carried out. A range of problems and health risks requiring intervention or follow-up were detected.

STRATEGIES FOR IMPROVEMENT: Further mail-outs to wider age ranges and ongoing discussion of results to stimulate ongoing interest amongst clinical staff is planned.

LESSONS: Mail-out invitations do increase recorded Well Man Checks both within the age group mailed to, and also for males outside that age group.

KEYWORDS: Male health; Well Man Check; primary health care

Background

Outline of problem

In recent years there has been increasing awareness of health disparities between female and male patients. Male outcomes are poorer within all socioeconomic deciles, but their outcomes also worsen with lower socioeconomic status.¹

Statistically males die younger than females, and they outnumber females in 14 of the top 15 causes of US mortality.² NZ statistics indicate a higher number of males with hyperlipidaemia and ischaemic heart disease and a slightly increased diagnosis rate for diabetes.³ Males are eight times more likely to be the victim of violence,² more likely to suicide,^{4,5} and are more likely to suffer

from chronic health conditions.^{2,6,7} Half of NZ males aged 18–24 drink alcohol at levels that are potentially hazardous.³

Males are less likely to seek primary or preventative health care,^{2,3,7} and several authors have suggested that provision of more 'male-friendly' health care is one approach to the multifactorial causes of poor male health outcomes.^{8,9} Given these facts we assume that there is a burden of detectable, modifiable disease or health risk factors in our non-presenting male population. Certainly US statistics state 70% of males aged over 20 are overweight, and 20% have hypertension.²

But will males respond to a simple intervention like a mail-out invitation to a Well Man Check?

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An intensive programme to invite candidates for cardiovascular risk screening found males had a significantly lower resultant screening rate than females, particularly for Maori males.¹⁰ Given several authors postulate a male culture that actively discourages health visits,^{1,7,10} and the pressure on time and resources most New Zealand GPs face, it is easy to put even simple measures like a mail-out invitation into the 'another day' basket.

We decided to look at several questions:

- Is an active programme of opportunistic testing by interested practitioners as effective as a formal invitation to attend a Well Man Check?
- Do we find a burden of undetected disease or modifiable risk factors when we look for them?
- Does establishing a formal Well Man Check and mailing invitations actually increase attendance in males with no known illness, and does doing so diminish the number of opportunistic checks practitioners would otherwise be doing?

Outline of local context

Muritai Health Centre is a small, multi-doctor GP practice servicing a high decile mainly Pakeha community. We have a single receptionist on duty and job-sharing practice nurses. On some days two nurses will be present for part of the day.

Assessment of problems

Approach taken

Initial staff education sessions for reception and clinical staff were held on the importance of male health. The author entered a simple tick-box screening template into the Medtech practice management system and the uniform classification 'Well Man Check' was set up. A guideline biopsychosocial screening process was also provided for individual staff to apply as they felt appropriate. The template and guideline covered family, social, occupational, and past medical history, hobbies, patient concerns, mood, risk-taking behaviour and cardiovascular risk.

When patients booked with reception for a Well Man Check they were offered a 15-minute nurse consultation where predominantly biometric data

(weight, height, abdominal girth, mid-stream urine, blood pressure and, when time permitted, smoking, drug and alcohol history) were taken, followed by a GP consultation. It was always recognised that completion of all the guideline assessment was unlikely to be practical in a limited time period and it was up to the individual practitioner to select the most appropriate assessment aspects for that individual.

Where patients presented directly to the GP in a 15-minute appointment space it was up to the practitioner to decide whether to rebook them or to apply the assessment they felt appropriate at the time. The tick-box template was to allow a simple recording of areas that may need to be addressed at a later time if not covered that day.

Workforce issues and the demands of meningococcal and influenza vaccination campaigns then delayed further steps from December 2006 until June 2008, and only opportunistic screening was undertaken in that time period. Regular staff reminders of Well Man Checks and the recording process were given during this time.

In June 2008 a 'Well Man Check' invitation letter was composed by the author, and registered males aged 40–50 years old were reviewed for suitability. Patients with known conditions requiring regular follow-up, or with recent health assessments, were excluded. One hundred and forty-four invitations were mailed out in batches from 17 June (86 in June and around 15/month for the next four months).

The age band 40–50 years was selected after discussion amongst clinical staff. Some patients where routine cardiovascular assessment would be of value were wanted (age 45+) as staff were considering doing this anyway. However, some younger males were also wanted partly to emphasise that a Well Man Check does not have to involve a cardiovascular risk assessment, and because it was felt by the author that engaging males earlier into the practice may improve their long-term utilisation of our service and hopefully health outcomes. It is beyond the scope of the current study to assess this outcome. The age range was a simple pragmatic means to limit the number of invitations sent out until we could assess the level of uptake and the

resource demands generated, and that it is open to change in future mail-outs.

Measurement of problem

Rates of recorded Well Man Checks were then compared for pre- and post-mail-out periods, and compared over individual months in case of seasonal variance. The month of June was included in the 'pre-mail-out' numbers as mail-out had not occurred until the 17th. There had been one Well Man Check prior to the 17th, and four afterwards.

While several males presented with a problem, commenting that the letter had swayed them to come in, they were only included if they had a Well Man Check done. The first 30 cases were reviewed to see if any morbidity or risk factors had been detected.

Approval from an ethics committee was not sought because this was an audit conducted by a health provider for the purposes of quality improvement.

Results of assessment

From December 2006 to June 2008, 62 Well Man Checks were recorded over 19 months—averaging 3.26 checks/month. Eighteen of those checks were within the 40–50 year age band later targeted by the mail-out (a rate of 0.94/month within targeted age range, 2.3/month outside it).

From July 2008 to December 2008, 57 Well Man Checks were recorded over six months, averaging 9.5 checks/month (a 291% increase in checks/month). See Figure 1. Of the 40–50 year age group invited, 20 attended by 31 December—a response rate of 13.8%. The remaining 37 checks were on males 'out of age range' for the mail-out, and presumably represent opportunistic screening. Thus the rate for the targeted age group was 3.3/month (up threefold) and for the out of range group six/month (again, an almost threefold increase).

New diagnoses of morbidity and risk factors

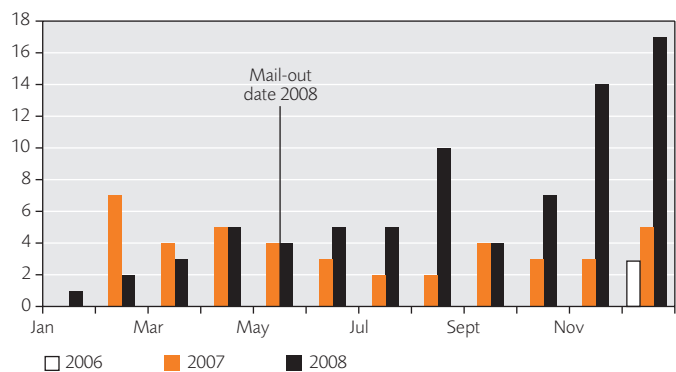
Of the first 30 Well Man Checks, seven males were considered well with no current problems or risk factors requiring further follow-up (23%).

WHAT GAP THIS FILLS

What is already known: Male health care outcomes lag behind those of females, in all socioeconomic deciles, and males are less likely to access primary health care. It is difficult to find any relevant evidence indicating males will respond to a simple mail-out invitation, or allowing practitioners to estimate the size of any such response.

What this study adds: This study demonstrates a manageable response to a mail-out invitation for a Well Man Check, with an increase in recorded checks, and newly-detected health risks and symptoms being identified. This enables practitioners in, and funders for, primary health care to better consider whether to undertake an intervention to improve male health care outcomes.

Figure 1. Number of Well Man Checks conducted per month



Three males did not do the requested bloods to assess risk factors fully (10%).

The following risk factors and conditions were detected:

- Two previously unrecorded smokers (6%);
- Six cases of confirmed hypertension (20%);
- Three cases of impaired fasting glucose (10%);
- Seven cases of lifestyle risk factors (stress/obesity/poor exercise) requiring follow-up;
- Two rheumatological cases (one palindromic arthritis, one chronic gout) (6%);
- One suspicious skin lesion (3%)—benign on excision;
- Two abnormal PSAs requiring follow-up. (Note only a minority of males elected prostate screening after discussing New Zealand guideline information); and
- One unrecorded significant family history of bowel cancer requiring surveillance.

Putting results into context

At first glance a response rate of 13.8% is not very impressive. It should be noted that Well Man Checks are continuing to increase and the full response from these mail-outs may not yet be known. However, it is clear that numbers of Well Man Checks increased markedly after the mail-out, including an increase in the targeted age band. It is interesting to see that initiating the mail-out process leads to increased health checks in other males also. This may be a combination of increased practitioner awareness or enthusiasm, and/or word of mouth in the community. It could be related to other factors promoting health checks such as the Movember campaign, or to local community factors (a widely-known early cardiac death in the community in June 2008, for example).

Strategies for quality improvement/change

Results and response rates have been fed back to the GP group on a monthly basis during regular staff meetings, and an overview of the results to date is planned with the combined clinical team, to decide whether to repeat the mail-out process and what group of males to target. It is intended to watch the results until after the influenza vaccine rush and see if a continued response is seen before finalising plans. Numbers of checks by individual practitioners have not been commented on nor used to compare performance.

Lessons and messages

No attempt was made to assess the satisfaction of males with the service provided or whether it has increased their likelihood of attending early if they develop another health problem. This is intended for another study. It has been argued that men may feel their health has been impaired by walking out with a list of new diagnoses and medications.¹¹ It is worth emphasising that a well man, with no morbidity detected, is not a negative result. The chance to encourage positive behaviour and establish a therapeutic relationship is at the core of what we are trying to achieve.

However, it is telling that 23 of the 30 supposedly well men cases reviewed had one or more

risks to their health that required some formal treatment or follow-up to be initiated. Again it would be interesting to investigate whether the men involved felt they had benefited or been harmed by the discovery of these health risks.

It is also worth noting that our practice services a high decile community, and the weight of morbidity in a lower decile community would be greater. The response rate to a mail-out programme in those communities may very well be lower, and other outreach schemes may work better in those communities.

The mail-out process does take resources, but the satisfaction of establishing relationships with those males on your books, whom you never usually meet until a crisis occurs, is part of what makes general practice worthwhile. A shortage of health practitioners may limit the feasibility of such a programme in some communities, and the value of screening 'presumed well' patients may be called into question.¹¹ However, it could be argued that identifying and working to modify risks early is a key to reducing our health demands in future and to better utilising our resources.

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COMPETING INTERESTS

None declared.