PEER REVIEW HISTORY

ARTICLE DETAILS

TITLE (PROVISIONAL)	Does risk and urgency of requested out-of-hours general practitioners care differ for people with intellectual disabilities in residential settings compared to the general population in the Netherlands? A cross-sectional routine data-based study
AUTHORS	Heutmekers, Marloes; Naaldenberg, Jenneken; Verheggen, Sabine; Assendelft, Willem; Van SchrojensteinLantman- de Valk, Henny; Tobi, Hilde; Leusink, Geraline

VERSION 1 – REVIEW

REVIEWER	Rory Sheehan University College London
REVIEW RETURNED	29-Aug-2017

GENERAL COMMENTS	This is an interesting, if brief, paper that interrogates routinely-collected health data to explore the differences in rates of utilisation of out-of-hours general practice care between people with and without intellectual disability and differences in urgency with which these requests were rated in a triage system. The paper is a timely addition to the literature and framed in the context of the health inequalities that people with intellectual disability experience. The discussion includes consideration of some of the ways forward in terms of further research and practical changes to healthcare that might benefit people with intellectual disability. The findings are that people with intellectual disability were more likely than those without to request out-of-hours general practice care. This could be due to difficulties experienced in accessing primary care which would accord with the finding that many of their requests for out-of-hours care were triaged as less urgent or routine. The authors could expand on this point with a discussion about how to make primary care more accessible and consultations more meaningful, including the concept of ‘reasonable adjustments’ and preventative healthcare (e.g. screening programmes and annual health checks). I feel there is room in the manuscript for more information to be given about the settings people with intellectual disability live in in the Netherlands and in this sample – this would better serve the international readership of BMJ Open. It would also be important to know who is requesting the out-of-hours general practice care (family members, carers, people with intellectual disability) and the level of intellectual disability of the sample (if these data are available).

	The relatively low ascertainment rate of intellectual disability (0.33%) should be highlighted as a limitation of the study, as many with intellectual disability are likely to have been misclassified as being members of the non-intellectually disabled population. I would question the emphasis in the discussion on the appropriateness of the triage system – having fewer ‘urgent’ requests in the intellectually disabled group does not necessarily mean that there was systematic “under-estimation” of the seriousness of their complaints but does suggest that they utilise health services differently. The STROBE statement is included but not completed (i.e. statements are not appended with page in text).

REVIEWER	Helene Ouellette-Kuntz Queen's University, Canada I have recently served on a committee with one of the authors (J. Naaldenberg).
REVIEW RETURNED	31-Aug-2017

GENERAL COMMENTS	The paper reports on an important and as of yet under examined aspect of health disparities in the field of intellectual disability (ID); namely out-of-hours GP services. The paper is generally well written with a few sentences requiring clarification (see p. 4 lines 34-35, p. 5 lines 36-38, p.6 lines 45-47, p.7 line 42 change on the direction to in the direction, p.8 lines 16-19). Reference #25 should be replaced by the reference to the original study by Wullink et al. 2007. Addressing the following two issues would improve the quality of the study. A concern common to similar studies relying on routinely collected data to examine access to care by persons with ID is the very low representation (0.33% prevalence). The authors need to be more explicit in their title and manuscript that they are comparing individuals with ID receiving (residential?) services from agencies for ID and health care from two GP cooperatives to the other residents in the area receiving health care from the two GP cooperatives. In essence, it is a study of the patients of two GP cooperatives where those with ID are identified by ID service providers. While this is mentioned in the Abstract and in the Discussion, it needs to be clarified from the outset. A table describing the two groups being compared (ID vs non-ID) would be useful in this regard. It would allow the reader to better understand the potential for misclassification (why is the prevalence of ID so low) and it would allow the identification of potential confounders (wouldn't use of after hours care by/for children be expected to have a different pattern to that of adults?). Depending on the differences observed between the groups along characteristics that may be associated with use of out-of-hours care (such as age, sex), regression or stratified analyses may be warranted. The authors should also discuss how they treated individuals who were hospitalized for all or part of the observation period as these individuals would not have had the opportunity to access out of hours care. If no information is available, the authors should consider whether a resulting bias may be differential.

VERSION 1 – AUTHOR RESPONSE

Reviewer: 1

Comments aand Responses:
Comment 1: The findings are that people with intellectual disability were more likely than those without to request out-of-hours general practice care. This could be due to difficulties experienced in accessing primary care which would accord with the finding that many of their requests for out-of-hours care were triaged as less urgent or routine. The authors could expand on this point with a discussion about how to make primary care more accessible and consultations more meaningful, including the concept of 'reasonable adjustments' and preventative healthcare (e.g. screening programmes and annual health checks).

Response: We would like to thank this reviewer for the positive feedback regarding the timeliness of our study. We agree with comment 1 that access to primary care is an important issue and we have extended our discussion (fourth paragraph on page 8-9) to better incorporate this point.

Comment 2: I feel there is room in the manuscript for more information to be given about the settings people with intellectual disability live in in the Netherlands and in this sample – this would better serve the international readership of BMJ Open. It would also be important to know who is requesting the out-of-hours general practice care (family members, carers, people with intellectual disability) and the level of intellectual disability of the sample (if these data are available). The relatively low ascertainment rate of intellectual disability (0.33%) should be highlighted as a limitation of the study, as many with intellectual disability are likely to have been misclassified as being members of the non-intellectually disabled population. I would question the emphasis in the discussion on the appropriateness of the triage system – having fewer 'urgent' requests in the intellectually disabled group does not necessarily mean that there was systematic "under-estimation" of the seriousness of their complaints but does suggest that they utilise health services differently.

Response: We are aware that the setting for people with ID in the Netherlands might differ from other countries and thank the reviewer for pointing out that more information is required for an international readership. A paragraph 'study population' is now added to the methods section on page 5. Information on who requested care or level of ID are not available in our dataset. While the ID group has been selected from residential care provider services, their carers were most likely the ones making the requests
We have emphasised the ascertainment rate more clearly as a limitation to our study in the second paragraph of the discussion (page 8). In addition, the emphasis on the appropriateness of the triage system is amended. We moved the information from the fifth paragraph on page 8 to the fourth paragraph on page 8. The appropriateness of the triage system has been put more in context as a factor contributing to primary care access.

Comment 3: The STROBE statement is included but not completed (i.e. statements are not appended with page in text).

Response: We have amended the STROBE checklist.

Reviewer: 2
Reviewer Name: Helene Ouellette-Kuntz

Comments and Responses:
Comment 1: The paper reports on an important and as of yet under examined aspect of health disparities in the field of intellectual disability (ID); namely out-of-hours GP services. The paper is generally well written with a few sentences requiring clarification (see p. 4 lines 34-35, p. 5 lines 36-38, p.6 lines 45-47, p.7 line 42 change on the direction to in the direction, p.8 lines 16-19). Reference #25 should be replaced by the reference to the original study by Wullink et al. 2007.

Response:
We thank the reviewer for acknowledging the importance of examining health disparities for people with ID and the contribution of our work to this topic. Clarifications were made in the following way:
- Page 4 line 34-35 (current page 4, second paragraph): "Furthermore, out-of-hours primary care is the gatekeeper to out-of-hours hospital care, which in addition is internationally of growing research interest with high found overall hospitalization rates and associated costs."
- Page 5 line 36-38 (current page 5, third paragraph): "The degree of urgency of every request was rated on a 5-point scale (Table 1) by telephone nurses conform the validated classification method: National Triage System of the Dutch College of General Practitioners."
- Page 6 line 45-47 (current page 7, first paragraph): "The different distribution of urgency level entailed more than 60% of requests made by people with ID categorized as counseling and advice, and did not reflect on life threatening requests (Table 3).
- Page 7 line 42 (current page 8, second paragraph): "Because of the size of the general population, this misclassification may have had a minor impact in the direction of overestimation of the out-of-hours care for the general population compared to people with ID. Results are generalisable to people with ID living at care provider services for people with ID."
- Page 8 line 16-19 (current page 9, first full paragraph): "These uncertainties may be adding to difficulties in the exchange of health information between carers and GPs and GP practices not being fit to the consultation and communication needs of people with ID."
- Reference #25 (current page 8, second paragraph): "On the basis of an estimated prevalence of 0.6-0.7%,16,25 only 0.3% (1,448/431,134) of the expected 2,595-3,028 persons with ID were identified in this study." With reference 25 being: "Wullink M, van Schrojenstein Lantman-de Valk HM, Dinant GJ, Metsemakers JF. Prevalence of people with intellectual disability in the Netherlands. J Intellect Disabil Res 2007; 51(Pt 7): 511-9."

Comment 2: A concern common to similar studies relying on routinely collected data to examine access to care by persons with ID is the very low representation (0.33% prevalence). The authors need to be more explicit in their title and manuscript that they are comparing individuals with ID receiving (residential?) services from agencies for ID and health care from two GP cooperatives to the other residents in the area receiving health care from the two GP cooperatives. In essence, it is a study of the patients of two GP cooperatives where those with ID are identified by ID service providers. While this is mentioned in the Abstract and in the Discussion, it needs to be clarified from the outset. A table describing the two groups being compared (ID vs non-ID) would be useful in this regard. It would allow the reader to better understand the potential for misclassification (why is the prevalence of ID so low) and it would allow the identification of potential confounders (wouldn't use of after hours care by/for children be expected to have a different pattern to that of adults?). Depending on the differences observed between the groups along characteristics that may be associated with use of out-of-hours care (such as age, sex), regression or stratified analyses may be warranted.

Response:
In line with the comments by reviewer 1, we have emphasised the ascertainment rate more clearly as a limitation to our study in the second paragraph of the discussion (page 8). We amended the title and abstract, and provided a paragraph ‘study population’ in the methods section (page 5) to include more information about the setting. The final paragraph of our discussion (page 9) was revised accordingly to address the specific residential setting of the study population.
Privacy regulations regarding medical studies in the Netherlands limit the availability of descriptive information on the level of the whole study population. Available information (sex and age distributions) of the people who contact the GP cooperative is now added in table 2 on page 7. Descriptive information was only available for the people who requested GP cooperative care, this thus not permit the suggested stratified analyses.

Comment 3: The authors should also discuss how they treated individuals who were hospitalized for all or part of the observation period as these individuals would not have had the opportunity to access out of hours care. If no information is available, the authors should consider whether a resulting bias may be differential.

Response: Information on hospitalisation is not reliably recorded in GP cooperatives' and GP databases. In contrast to other countries, in the Netherlands long-stay hospitalisation of people with ID for reasons such as psychiatric crises or somatic disease is not common practice. Instead, care provider services intensify their support. This implies that it is not likely that hospitalised individuals that would not access out-of hours primary care are a large part of our sample and the risk of bias is therefore small. We have not further addressed this issue in the revised manuscript.

VERSION 2 – REVIEW

REVIEWER	Rory Sheehan University College London, UK
REVIEW RETURNED	26-Sep-2017

GENERAL COMMENTS	The authors have amended the manuscript in line with reviewer comments and I believe the paper is now suitable for publication. There are some minor errors in language throughout that should be improved on copy editing.