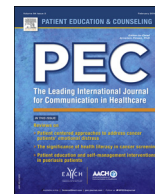




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Vision quality-of-life

Glaucoma patient-provider communication about vision quality-of-life

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ABSTRACT

Objective: The purpose of this study was to: (a) describe the extent to which ophthalmologists and glaucoma patients discuss vision quality-of-life during office visits, and (b) examine the association between patient and ophthalmologist characteristics and provider-patient communication about vision quality-of-life.

Methods: Patients with glaucoma who were newly prescribed or on glaucoma medications were recruited at six ophthalmology clinics. Patients' visits were video-tape recorded and quality-of-life communication variables were coded. Generalized estimating equations were used to analyze the data.

Results: Two hundred and seventy-nine patients participated. Specific glaucoma quality-of-life domains were discussed during only 13% of visits. Older patients were significantly more likely to discuss one or more vision quality-of-life domains than younger patients. African American patients were significantly less likely to make statements about their vision quality-of-life and providers were less likely to ask them one or more vision quality-of-life questions than non-African American patients.

Conclusion: Eye care providers and patients infrequently discussed the patient's vision quality-of-life during glaucoma visits. African American patients were less likely to communicate about vision quality-of-life than non-African American patients.

Practice implications: Eye care providers should make sure to discuss vision quality-of-life with glaucoma patients.

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1. Introduction

Glaucoma is one of the leading causes of blindness and visual disability. An estimated 1.5 million Americans suffer from glaucoma while approximately 120,000 of them have been blinded by the disease [1]. Between 9 and 12% of all blindness in the United

States is attributed to glaucoma [1]. One of the goals of Healthy People 2020 is to reduce glaucoma-related visual impairment [2].

The loss of visual abilities can profoundly impact a person's quality of life by limiting everyday tasks such as reading or walking [3]. Work in other disease areas has found that physicians tend to focus on symptoms and treatments rather than on patients' ability to participate in meaningful life activities [4,5]. This may be because it is difficult for patients to bring up meaningful life activities during medical visits naturally or some patients might prefer that their physicians start the quality-of-life discussion [6]. Nonetheless, empowering and involving patients in decisions made during medical visits can improve patient quality-of-life [7–12].

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It is important for ophthalmologists to discuss vision quality-of-life with glaucoma patients during visits to assess what aspects of the patient's vision are being negatively impacted by the disease. To our knowledge, prior research has not examined the extent to which ophthalmologists and glaucoma patients discuss specific aspects of a patient's vision quality of life such as seeing at night or adjusting to bright lights. The objectives of the study were to: (a) describe the extent to which ophthalmologists and glaucoma patients discuss vision quality-of-life during visits, and (b) examine the association between patient and ophthalmologist characteristics and provider-patient communication about vision quality-of-life.

2. Methods

2.1. Procedure

Enrollment for this study took place between 2009 and 2012. The study was conducted at six ophthalmology clinics located in four states in the United States. Four clinics were academic sites and two were private clinics. The academic sites were outpatient clinics that were affiliated the ophthalmology departments of universities. Providers completed a short demographic questionnaire after supplying written consent. English-speaking adults with glaucoma were referred by clinic staff to research assistants based at each clinic. Patient consent was then obtained. The eligibility criteria was that the patient had to: (1) speak English, (2) be at least 18 years old, (3) have a diagnosis of glaucoma or be considered a glaucoma suspect, (4) score at least 6 out of 10 on a mini mental status exam, and (5) be prescribed at least one glaucoma medication at the current medical visit. The medical visit was then video-tape recorded. Video-tapes were kept if they fit into one of two criteria: (a) the patient was diagnosed with glaucoma and glaucoma medications were prescribed for the first time or (b) patients had a glaucoma diagnosis and were already on glaucoma medications. Immediately after the visit, patients were interviewed.

The Institutional Review Boards at the University of North Carolina, Duke University, Emory University, and the University of Utah approved this study. The study was carried out in accordance with The Code of Ethics of the World Medical Association (Declaration of Helsinki) and was HIPAA compliant. The physicians and patients were blinded to the study's specific research questions.

2.2. Measurement

2.2.1. Socio-demographic and clinical measures

Self-reported patient age and years of education were recorded as self-reported continuous variables in years. Patient gender was recorded as a dichotomous variable (male, female). Self-reported race was recorded as a categorical variable (white, African American, Asian, Native American, and Hispanic). Self-reported race was then recoded into a dichotomous variable (African American and non-African American). Therefore, we wanted to be able to examine if there were differences between African American and non-African American patients because previous studies have found that African American glaucoma patients often have worse patient outcomes [1,2,13–24]. The number of glaucoma medications a patient was taking was recorded as a continuous variable and then recoded as a dichotomous variable because the majority of patients were on one or two medications (one medication versus two or more). Whether the patient was a new user of glaucoma medications was recorded as a dichotomous variable (yes/no). Glaucoma severity was extracted from the patients' medical records. The severity of glaucoma for each eye

was classified using the mean deviation of the eye from the last reliable visual field and recorded as mild, moderate, or severe [25]. The length of the visit was measured in minutes.

Self-reported provider age was measured in years as a continuous variable. Self-reported provider gender was measured as a dichotomous variable. Self-reported provider race was measured as a categorical variable (White, African American, Asian, Native American, and Hispanic).

Each subject received the Rapid Estimate of Adult Literacy in Medicine (REALM) so that we could control for patient reading level in our analyses [26]. This is a validated, rapid screening instrument designed to identify patients who have difficulty reading common medical and lay terms that are routinely used in patient education materials [26]. We chose the REALM because it has high face validity and high criterion validity and it only takes two to three minutes to administer and score [26]. Patient scores on the REALM correspond to reading levels (score of 0–60 = eighth grade and below, 61–66 = ninth grade and above).

The 12-item Duke Social Support Index was used to measure social support; it has an internal consistency of 0.81 [27,28]. Items are scored on a scale of 1 to 3, resulting in a total score range of 3 to 21, with higher scores indicating a higher level of perceived social support.

We used the 9-item validated Patient Health Questionnaire (PHQ) to measure depressive symptoms [29]. Scores on the PHQ range from 0 to 27 with higher scores indicating increased depressive symptoms [29].

2.2.2. Communication measures

All video-tapes were transcribed and identifiers were removed. A coding tool was developed using the 15-item Glaucoma Quality of Life-15 (GQL-15) scale as a guide [30]. The GQL-15 is a validated quality-of-life instrument [30]. We took the fifteen areas which are considered important quality of life areas for glaucoma patients and created a coding tool which research assistants used to code whether these fifteen important quality-of-life areas were discussed during patient visits [30]. The coders recorded whether a discussion occurred during the visit (yes/no) in the following fifteen domains: reading items up close, seeing at night, adjusting to bright lights, adjusting to dim lights, seeing objects from the other side, walking on uneven ground, bumping into objects, crossing the road, finding dropped objects, going from a light to dark room, or vice versa, judging distance of foot/step to curb, recognizing faces, tripping over objects, walking after dark, and walking on steps or stairs. Coders recorded whether the provider or patient initiated the discussion in each quality-of-life area. Coders also recorded if glaucoma-related vision loss was discussed and whether the provider or patient initiated the discussion. Since patients had more than one eye condition and it was difficult to ascertain which condition they were talking about when discussing vision quality-of-life, the coders recorded any discussions that occurred.

Using this tool, two research assistants with medical backgrounds coded the same 30 transcripts to establish inter-rater reliability using the intraclass correlation coefficient. Inter-rater reliability was 1.0 for whether one or more of the GQL-15 quality-of-life domains were discussed, 1.0 for whether glaucoma-related vision loss was discussed, 1.0 for whether the provider asked the patient one or more questions about their vision quality-of-life, 0.92 for whether the patient made one or more statements about their vision quality-of-life, and 0.79 for whether the patient asked one or more questions about their vision quality-of-life.

2.2.3. Analysis

We set the a priori level of statistical significance at $p < 0.05$. First, we ran descriptive statistics. Second, we examined the

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