



Communication Study

The content of diet and physical activity consultations with older adults in primary care

Shoshana H. Bardach^{a,*}, Nancy E. Schoenberg^b^a Lexington Veterans Affairs Medical Center, Lexington, USA^b Department of Behavioral Science, University of Kentucky, Lexington, USA

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ABSTRACT

Objective: Despite numerous benefits of consuming a healthy diet and receiving regular physical activity, engagement in these behaviors is suboptimal. Since primary care visits are influential in promoting healthy behaviors, we sought to describe whether and how diet and physical activity are discussed during older adults' primary care visits.

Methods: 115 adults aged 65 and older consented to have their routine primary care visits recorded. Audio-recorded visits were transcribed and diet and physical activity content was coded and analyzed.

Results: Diet and physical activity were discussed in the majority of visits. When these discussions occurred, they lasted an average of a minute and a half. Encouragement and broad discussion of benefits of improved diet and physical activity levels were the common type of exchange. Discussions rarely involved patient behavioral self-assessments, patient questions, or providers' recommendations.

Conclusions: The majority of patient visits include discussion of diet and physical activity, but these discussions are often brief and rarely include recommendations.

Practice implications: Providers may want to consider ways to expand their lifestyle behavior discussions to increase patient involvement and provide more detailed, actionable recommendations for behavior change. Additionally, given time constraints, a wider array of approaches to lifestyle counseling may be necessary.

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1. Introduction

Healthy diet and sufficient physical activity have significant health and quality of life benefits across ages [1,2] and generally result in lower healthcare utilization and associated costs [3]. While the benefits are greater if positive health behavior changes take place earlier in life, advantages still exist if changes begin in later years [4,5]. Even small behavior improvements may result in significant health benefits [6].

As individuals reach age 65, women have an average of 20.3 and men an average of 17.6 years of life remaining, allowing for sufficient time for changes in dietary intake and physical activity levels to have an effect on functional status and quality of life [7]. Unfortunately, despite well documented benefits of engaging in healthy lifestyles, poor diet and physical inactivity are pervasive

across ages, particularly among older adults. In the US, only 30.0% of adults ages 65 and older consume five or more fruits/vegetables a day [8] and 32.7% of adults ages 65 and over report no leisure time physical activity within the past 30 days [9]. Among older adults age 65 and over in the United States, self-reported rates of moderate physical activity participation range from 39.3% to 51.2%, depending on the criteria used [10,11], and only 10% of adults over the age of 65 engage in any vigorous physical activity [12].

One potential venue for addressing these suboptimal health behaviors is through primary care providers. Primary care providers are particularly well situated to counsel older adults because older Americans are the largest consumers of health care services [7]. Adults between the ages of 65–74 average 6.5 physician office visits per person per year; adults ages 75 and over make 7.7 visits per person per year [13]. In 2008, 44% of visits for adults ages 65 and over were to primary care providers [14]. While fewer than 8% of these visits are dedicated preventive care visits, this frequent contact creates opportunities for lifestyle counseling [13].

Prior research indicates that provider counseling has the potential to help patients with dietary and physical activity changes [15,16]. Currently however, there is very little research

* Corresponding author at: Lexington Veterans Affairs Medical Center, 1101 Veterans Drive, C203B Lexington, KY 40502-2236, USA.
Tel.: +1 859 233 4511x5255; fax: +1 859 233 4804.

E-mail address: shoshana.bardach@va.gov (S.H. Bardach).

that documents how often these discussions occur with older patients or the nature of the counseling that occurs. The scant existing research indicates that diet and physical activity discussions occur in less than a quarter of primary care visits [17], though these estimates pertain to a general adult population rather than to older adults. Stange et al. (2002) found that the average duration of diet and physical activity discussions was 1.35 min, reduced to only .7 min when also taking into account visits during which prevention counseling did not occur [18]. Eaton, Goodwin, and Stange (2002) found that the average duration of dietary counseling was 55 s, ranging from less than 20 s to over 6 min [19]. Preventive service delivery is often associated with related signs or symptoms, suggesting that illnesses care may present opportunities for prevention [20]. Flocke, Kelly, and Highland (2009) found that most prevention discussions occurred in the context of structured routines (e.g., checklists) or opportunistic triggers (symptoms or conditions) [21]. Anis and colleagues (2004) determined that most (61%) lifestyle counseling was physician-initiated [22].

Surprisingly little research has examined the actual content of lifestyle counseling. Sciamanna and colleagues (2004) conducted a study where all participating physicians were instructed to counsel their patients on physical activity, but the content of that counseling was left up to them [23]. The most common topics physicians counseled on were type of activity recommended, reasons to become active, and past experiences with activity. Action items – such as written plans or making plans for future discussion – were very uncommon. To rectify this sparse knowledge base regarding provider lifestyle counseling, we seek to describe whether and how diet and physical activity are discussed during older adults' primary care visits.

2. Methods

2.1. Eligibility and recruitment

Providers and patients from the departments of Internal Medicine and Family and Community Medicine in an academic medical center were recruited and consented to have their visits audio-taped. The consent form indicated that the research study was focused on lifestyle behaviors, but did not specify diet and physical activity. Providers included attending physicians, nurse practitioners, physician assistants, resident physicians, and medical students. Patients over the age of 65 were identified using the daily patient list from consenting providers. Patients were recruited from the clinic waiting areas immediately prior to their visit. Patients were informed that the study involved recording their visit and an interview immediately following about their health behaviors and relationship with their provider. Patients who agreed to participate signed both a general informed consent document and a Health Insurance Portability and Accountability Act consent form. Exclusionary criteria included: too hard of hearing to participate in an interview, not English speaking, unable or unwilling to speak at length, and cognitive impairment (either as evidenced by difficulty comprehending the consent form, from patient or companion self-report, or by provider notification).

2.2. Procedures

Tape recording began once the intake nurse left the patient's exam room. Following the visit, patients completed the socio-demographic questionnaire and behavioral assessment which included the six-item Behavioral Risk Factor and Surveillance System (BRFSS) questions about fruit and vegetable consumption and the three-item Godin Leisure Time Exercise Questionnaire (GLTEQ) Assessment of Physical activity [27]. The BRFSS fruit and

vegetable questions are considered to be of moderate reliability and moderate validity among adults ages 18 and older [28]. The GLTEQ has moderate test-retest reliability for light to moderate physical activity and high test-retest reliability for strenuous activity; while not specifically designed for older adults, the GLTEQ also has demonstrated validity among older adult populations with chair stands and walking speed [27,29]. To describe the visit characteristics, we recorded when providers entered and exited the room (to calculate the duration of the visit), noted whether anyone accompanied the patient to his/her visit, and asked patients questions about their relationship and history with their provider and the care they received. Similar to the approach used by Zhang and colleagues, quality of care was assessed with a single-item scale from 1 to 10 with 1 being completely awful and 10 being completely wonderful [30]. To preempt literacy concerns all questions were completed orally. Participants were not compensated for their participation. All protocols were approved by the University of XXX's Institutional Research Board and appropriate reviewing bodies within the clinics themselves. Data collection took place between September, 2011 and March, 2012.

2.3. Sample

One hundred fifteen patients participated to insure a broad array of diet and physical activity discussions for analysis. In order to recruit these 115 patient participants and record their visits, 84 providers consented to participate (consisting of 16 attending physicians, 3 nurse practitioners, 1 physician assistant, 44 resident physicians, and 20 medical students).

2.4. Data analysis

We conducted descriptive analyses for all patient sociodemographics and health behavior questionnaire data. Using the height and weight information provided by patients, body mass index (BMI) was calculated using the National Heart Lung and Blood Institute calculator [31] and the resulting BMIs were categorized into underweight (BMI < 18.5), normal weight (BMI = 18.5–24.9), overweight (BMI = 25–29.9), and obese (BMI of 30 or greater) according to the National Heart Lung and Blood Institute criteria. The BRFSS fruit and vegetable questionnaire enables computation of total daily fruit consumption and total daily vegetable consumption. The GLTEQ indicated how many times a week individuals participated in mild, moderate, and vigorous physical activity for periods of at least 15 min [27].

Upon completion of the interview, the tapes were transcribed. Time stamps, the time to the second that had elapsed from the beginning of the audio-recording, were included anytime a provider exited or entered the exam room and at the initiation and conclusion of all instances of diet and physical activity discussions. These stamps enabled calculations of the time spent with providers and of the duration of diet and physical activity discussions. The Microsoft Word's word count feature was used to assess the relative contribution of the patient versus the provider to the discussions.

In addition to documenting the duration of the discussion, qualitative description allowed us to explore the nature and structure in which providers discuss diet and physical activity with their older patients [32]. Qualitative description is "a rich, straight description of an experience or an event" [33], where this description is itself the goal [34]. Our qualitative description included content analysis and quasi-statistical analysis [33]. Qualitative content analysis involves codes that are generated from the data and are modified as needed to fit the data rather than pre-existing codes [34,35]. Content analysis refers to methods of

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