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Infrequent older adult-primary care provider discussion and documentation of dietary supplements

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CONCLUSION

A significant negative correlation was found between leucocyte telomere length and cancer survival in older adults, and this is novel. Telomere length may be a prognostic indicator in older adults with cancer. Larger studies are required for confirmation.

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INFREQUENT OLDER ADULT–PRIMARY CARE PROVIDER DISCUSSION AND DOCUMENTATION OF DIETARY SUPPLEMENTS

To the Editor: Almost half of older adults take dietary supplements,¹ with 19.5% taking nonvitamin, nonmineral (NVNM) supplements.² Despite the potential for drug–supplement interactions,³ individuals report disclosing <40% of their dietary supplements to a physician.⁴ Few studies have examined physician–patient interactions to measure how often supplement-related conversations occur, nor have studies investigated the concordance between physician–older adult dietary supplement discussions during office visits, patient reports of supplement use, and medical record documentation. This study compares older adults' self-reported dietary supplement use with observed disclosure of supplement use in a primary care setting and physician documentation of supplement use.

METHODS

This study analyzes data collected from academically affiliated physician offices in southern California between February 2009 and February 2010 for a study on physician–patient communication about prescription medications.⁵ Study subjects included six family physicians, seven general internists, 14 internal medicine residents, and 256 of their patients. Eligible patients were aged 50 and older; spoke English; had a new, worsening, or uncontrolled problem; and were available for a follow-up assessment. The response rate among eligible patients was 57.9%, consistent with other studies using similar data collection methods.⁶

Physician–patient encounters were audio-recorded, transcribed verbatim, and analyzed to determine the dietary supplements discussed during the visit. Patients were surveyed about the supplements that they were currently taking, and their medical records were abstracted for any

documentation about supplement use in the 12 months before the audio-recorded office visit. For every patient who reported dietary supplement use and for every dietary supplement that patients reported taking, mention of supplement discussions during office visits was compared with medical record documentation.

RESULTS

Patients who reported taking dietary supplements were mostly white (60%) and had a mean age of 64.6 ± 10.1 , and 52.1% reported completing at least some college education. Sixty-six percent of women and 50% of men were taking supplements ($P = .01$).

Fifty-six percent (142/256) of the patients in the study reported taking at least one supplement and had their visit audio-recorded and their medical records abstracted. These patients reported taking a total of 448 supplements (mean 3.1 ± 2.4 , range 1–18), of which 303 (67.6%) were vitamins and minerals and 145 (32.4%) were NVNM dietary supplements. Patients most frequently reported taking calcium with or without vitamin D (25.7%), fish oil or omega-3 (13.4%), and glucosamine or chondroitin (3.6%).

Fifty-nine (42%) of the 142 patients discussed at least one of their supplements during their office visit, and 58 (41%) had at least one supplement documented in their medical record, but only 7% discussed all of their supplements and only 13% had all of their supplements documented. Only 5% of patients mentioned all of their supplements during their office visit and had all of them documented. There was no association between the number of supplements patients were taking and supplement discussions or documentation.

Of the 448 dietary supplements that patients were taking, 16% (19% of vitamins and minerals and 10% of NVNM supplements; $P = .02$) were discussed during patients' visits and documented in their medical records (Figure 1). Thirteen percent of patients' supplements were discussed during office visits but were not noted in the medical record.

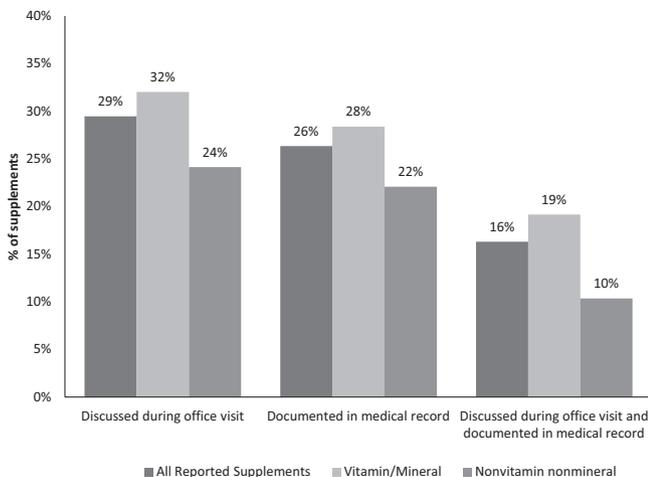


Figure 1. Reported supplements discussed and documented (N = 448).

DISCUSSION

These results reveal incomplete discussion and documentation of dietary supplements during primary care office visits with older adults. Although it may be unrealistic to expect dietary supplement discussions to occur during every office visit, it is surprising that there was such incomplete documentation of supplement use. Poor documentation of supplements discussed during office visits may reflect provider ambivalence about the importance of documenting supplement use.

The importance of full disclosure of an individual's dietary supplements is debatable because many may be unlikely to cause adverse events or supplement–drug interactions.⁷ More vigilance might be expected with dietary supplements that have potential drug–supplement interactions, but the current study did not find significant differences in supplement discussion or documentation based on whether supplements were NVNM supplements (more likely to have potential interactions or adverse events)^{3,8} or supplements considered to be more benign, such as vitamins and minerals.^{7,9} The study examined medical records over a 12-month period, so it was not possible to assess documentation of supplement use on the day of audio-recorded visits.

Given the lack of awareness about potential adverse effects of dietary supplements and about drug–supplement interactions, physicians may need to ask patients proactively about supplement use. Greater physician education about the potential risks of dietary supplements may be needed to enhance awareness of the importance of assessing and documenting supplement use¹⁰ and to ensure patient safety.

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RECRUITMENT OF OLDER DRIVERS FROM PRIMARY CARE CLINICS FOR ON-ROAD FITNESS-TO-DRIVE TESTING: RESULTS OF A PILOT STUDY

To the Editor: Older driver fitness-to-drive screening in primary care clinics (as part of a tiered assessment system with further testing of screen-positive individuals) may help balance older driver mobility and safety. Ideally, participants should be recruited from the site where an intervention will be implemented, but most prior studies of older driver screening or assessment have used convenience sampling from unique populations (e.g., specialist clinics¹ or behind-the-wheel (BTW) evaluation programs^{2–5}) or from the general community^{6,7} and have not reported participation rates. The goal of this pilot study was to examine the feasibility of recruiting older drivers from outpatient primary care clinics for an off-site BTW evaluation and estimate eligibility and completion rates. It is planned to recruit people from primary care settings in a larger study to validate a screening tool⁸ for use in these settings.

METHODS

Older (≥ 65) adults were recruited from a general internal medicine and a geriatric clinic at a university hospital (April–June 2012). Eligible individuals spoke English, lacked significant acute illness or dementia (Six-Item Screener⁹ score ≥ 4), and reported driving during the past 30 days.

Participation required completing a brief questionnaire; a free, confidential BTW evaluation at a site 10 miles from the clinics; and telephone follow-up. During recruitment sessions (≥ 3 consecutive hours each), a research assistant (RA) used the clinic schedule to identify

and approach all older adults. Encounters occurred in clinic waiting areas, and eligible individuals who declined were asked why. The institutional review board approved this project.

For this feasibility analysis, primary outcomes were enrollment and completion of the off-site BTW evaluation.

RESULTS

During 97 hours of RA presence, 310 older adults presented for medical care. The RA missed 20% of potentially eligible participants while interacting with other patients (Figure 1). Of the 248 remaining, 53% were ineligible, most commonly because of being a nondriver. Ineligible individuals were more often female (77% vs 22%, $P < .001$) and older (median 83 vs 77, $P < .001$). Overall enrollment was 24% (0.29 participants per hour of RA presence).

Fourteen (50%) enrolled participants completed the BTW evaluation. These participants rated highly the ease of making an appointment and the utility of the on-road session and recommendations. When asked how much money they would have been willing to pay for the BTW evaluation (priced at \$99), the median response was \$10 (mean \$21, range \$0–75).

DISCUSSION

Given the goal of developing a tiered assessment program for primary care settings, the current study sought to recruit older drivers from these settings. These pilot results demonstrate the feasibility of this approach, at least when the BTW evaluation is free. Recruitment challenges, including concern over the location of BTW evaluation site, were also identified.

In this pilot sample, 24% of eligible individuals enrolled. Comparison with other older driver studies is difficult, because many have used convenience samples without reporting full recruitment or participation data.^{1,5–7} In the current study, the most common primary reason given for declining participating was the off-site BTW evaluation location. A monetary incentive could mitigate transportation costs but would not address concern over driving in an unfamiliar neighborhood, so a closer BTW evaluation site (or multiple sites) may be preferable, if feasible. Concern over possible license revocation may have been another barrier to participation, especially in the individuals who declined participation because of lack of interest or without a given reason.

The findings have implications for the introduction of tiered older driver assessment into outpatient clinical settings, because there will be obstacles in gaining acceptance of all drivers and in finding ways to ensure that drivers are able and willing to complete a BTW evaluation. Strategies could include physician involvement (e.g., counseling about testing) and integration into a larger program that includes advance planning for future changes in driving.¹⁰ In addition to BTW program location, another important barrier to real-world functioning of a tiered assessment program will be cost and insurance reimbursement.

Limitations include the small sample and minimal data on nonparticipants and ineligible or missed individuals, so conclusions cannot be drawn about participation biases or generalizability to other clinic populations.