EFFECTIVE EDUCATION STRATEGIES FOR NONADHERENT PATIENTS

Sometimes the issue isn't convincing a patient to follow dry eye treatment, it's getting them to continue it for the long-term.

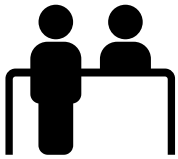
BY HARDEEP KATARIA, OD, FAAO, AND MAHNIA MADAN, OD, FAAO

Effective management of dry eye disease (DED) is largely dependent on patient adherence, much like it is with glaucoma, where patients must follow at-home treatments and attend frequent in-office follow-ups. Patient education and patient adherence are two major challenges that optometrists encounter in our daily management of patients with DED.

Nonadherence often reflects a patient's understanding, or lack thereof, of the severity of their disease and may be driven by symptomatology. Nonadherent patients bring a burden of treatment upon themselves as their disease process worsens, on their health care practitioners as we struggle to find treatments that are effective against worsening disease processes, and on the health care system as the financial cost to treat them increases.

If 60% of patients use artificial tears only when they have symptoms,[1] how do we fill the gap for asymptomatic patients? As health care practitioners, we must seek to understand how to overcome barriers to care, such as patients' lack of understanding of the disease, the complexity and cost of treatment, inadequate follow-up, treatment side effects, and poor patient/doctor connections.[1]

This article explores key strategies for improving patient education, even for those tough asymptomatic cases.

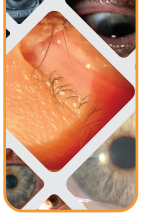


PATIENT EDUCATION: FROM CHECK-IN TO CHECK-OUT

Imagine this scenario: An established patient calls the clinic with concerns of increasing light sensitivity and fatigue while using the computer. The receptionist recommends that they try blue light-blocking glasses to help alleviate the symptoms. Not surprisingly, the patient tries the glasses for several months, but notes no improvement in symptoms. Assuming the recommendation came from the doctor, the patient decides to seek a second opinion from another clinic.

In this situation, an innocent recommendation made by an undertrained staff member resulted not only in the loss of the patient to the practice, but also in the undertreatment of DED. Because our staff are often the first point of contact for our patients, they should be well-trained to provide patient education.

Kambiz Silani, OD, explains that patient education can be in the form of pamphlets, videos, blog posts, and social media. "In fact, it is important to share analogies that may resonate with them. For example, 'You may not feel the cavity, but it's important to treat it so it doesn't lead to something worse' (signs precede symptoms) or



'Just as proper dental hygiene can help prevent cavities and gum disease, good eyelid hygiene or good ocular surface health can help with contact lens comfort, whiter eyes, clearer vision, less styes, better LASIK postop outcomes, and more.'"

David Kading, OD, agrees with a focus on patient education as a form of preventive care. "As a profession, we must educate people before they have the problem," he says.

Have your technicians initiate a discussion with patients about any symptoms they report on questionnaires and surveys and get them to assist you in interpreting imaging such as meibography. Creating a tailored treatment plan for each patient is imperative and demonstrates to them your investment in their treatment success. Opportunities to educate exist even after the patient leaves your office. Consider sending a personalized follow-up email with recommended educational materials, such as best eye makeup tips, or include a direct link to your favorite educational article.

A PICTURE IS WORTH 1,000 WORDS

We surveyed 35 primary care optometrists who treat DED and asked the question via social media, "What is your most valuable tool in educating asymptomatic dry eye patients?" An overwhelming majority reported photodocumentation to initially educate patients, to track progress of treatments, and to assist in quantifying improvements that patients can celebrate. Sharing videos of blink dynamics or meibomian gland expression after treatments can also be invaluable. We have found that when patients can visualize a tangible improvement from their investment in a dry eye treatment, it provides them with motivation to continue.

For Jaclyn Garlich, OD, FAAO, meibography is her favorite diagnostic tool for patient education. "I can explain meibomian gland atrophy all day long, but when patients see their glands versus what normal glands look like, they better understand my concern."

AT A GLANCE

- Effective management of dry eye disease (DED) is largely dependent on patient adherence, where patients must follow at-home treatments and attend frequent in-office follow-ups.
- Nonadherent patients are a burden on themselves as their disease process worsens, on their health care practitioners as we struggle to find treatments that are effective against worsening disease processes, and on the health care system as the financial cost to treat them increases.
- Untreated or ineffectively treated DED comes with indirect costs as well, such as missed time from work for additional doctor's appointments, lost wages due to missed work, and reduced productivity due to dry eye symptoms. These indirect costs sometimes outweigh the direct costs associated with DED.

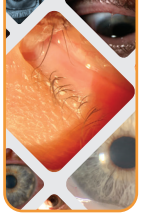
Jacob Lang, OD, FAAO, Dipl ABO, uses slit-lamp photos to establish patient-doctor trust. "Any time I can document a sometimes complicated and multifaceted disease state and actually show the patient what's broken (think x-ray on a broken bone), it's a win-win. The patient's engagement and understanding jumps forward light years, allowing a baseline to the 'why' with our treatment strategy and setting the stage for further conversations at follow-up appointments. Especially when a treatment 'pivot' occurs, it helps me point out *why*, while building the patient's trust and engaging the patient in the treatment strategies and therapies."

APPEAL TO YOUR PATIENT'S LEARNING STYLE

Analogies are an easy and relatable method of highlighting and enhancing patient understanding. Marc Bloomenstein, OD, FAAO, likes to use them to demonstrate for patients the consequences of lack of treatment or the benefits of a treatment. "For example, when educating about cataracts, I liken the lens to an M&M candy, with the coating being analogous to the capsule and the chocolate center the lens material. In the example of dry eye patients, it is the tear quality that induces a reduction of visual quality, creates fluctuation, and can create an inhospitable environment for all refractive options."

Tracy Doll, OD, FAAO, likes to set expectations using analogies. "The dental model is a good example." She explains, "If you don't brush and floss, then your dental cleaning exams and dental work are more costly. This is the same. I also discuss that dry eye is a chronic inflammatory condition that will never be cured, but rather needs to be managed consistently."

Encourage patients to bring family and friends who can assist in their care to dry eye consultations. If a member



MAKING IT STICK

What are some challenges patients face with staying compliant with their treatment regimens? Our panel of colleagues answer below.

Marc Bloomenstein, OD, FAAO: For patients who aren't consciously symptomatic, they notice their vision is not stable or have noticed something is not great. These patients need to be on a treatment that helps to reduce the inflammatory load and creates a more hospitable environment for good quality tear production. The challenge is getting these patients to believe that what they are doing is going to make a difference in the long run. Saying things such as, "this is a marathon not a sprint," or pointing out other proactive measures we take to maintain a healthy self is helpful; however, another challenge is the cost-benefit analysis that the patients will mentally pursue. Thus, finding what is important and how much a patient is willing to spend are some of the challenges we face with these patients.

One other challenge is getting patients to truly believe that without some intervention, the consequences will be worse than what they are experiencing at the moment.

Jacob Lang, OD, FAAO, Dipl ABO: Much of the challenge these days seems to lie with financial limitations, third-party payers dictating therapies (and their cost), physician assistants, tier exception paperwork, and the multitude of other misguided policies that are too numerous and complicated to comment on here. Lifestyle also plays a big role, as many busy people today have a hard time avoiding ocular surface disease stressors such as screen time, mask wear, and not having spare time for self-care in the morning or at night, because kids, jobs, spouses, and work are all vying for their limited 24 hours of time each day.

Tracy Doll, OD, FAAO: Honestly, the biggest challenge is that they feel better. Patients slack off on maintenance therapy when they look and feel better. There is always a treatment for everyone, so cost isn't as much of an issue as far as navigating adherence, as long as the patient is honest about what they can afford and any changes in insurance or life status.

Jaclyn Garlich, OD, FAAO: The biggest issue they have is forming a habit. If they are asymptomatic, then they have no symptoms to remind them to use their drops, warm compress, etc. I give them tips on easy ways to incorporate the treatment into their routine so that it can become more of a habit.

Kambiz Silani, OD: The real struggle is keeping patients on course for the long-term. Therefore, follow-up appointments to track their progress with vital dye staining, point-of-care testing, and imaging can be helpful to reinforce the treatment protocol. One of the easiest at-home options that patients forget about is warm compresses, because it is somewhat time-intensive and requires a microwave or heating source that isn't conveniently by their bedside, non-existent when traveling, or may be on a different level of their residence.

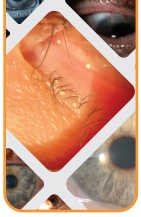
of their support system is unable to attend in person, having them call in can also be helpful.

PATIENT-CENTERED APPROACH

Dr. Lang expands, "There are a multitude of therapies and not every person or lifestyle allows for every therapy to be successful. I really don't feel this is the patient's fault but falls more on the provider typically, whether it was incomplete instructions or resources to remind them of the plan or an incomplete understanding of the patient and their world. I liken this to the adage about patients being a 'poor historian,' when really the patient isn't documenting the history, it's the provider's job. It's our job to understand our patients. An open ear and an interactive conversation are the keys here."

One approach involves a direct conversation with the nonadherent patient and addressing the barrier to treatment head-on. In one study, Wu and Yin identified barriers to adherence to glaucoma topical therapy, such as forgetting, drug side effects, and inconvenience in seeing the doctor.[3] Addressing these barriers directly can be helpful. For example, if the patient is having transportation difficulties, a telemedicine follow-up appointment might suffice.

Dr. Garlich directs patients on how to form habits. "Some example questions



HOW DO YOU APPROACH A NONADHERENT DRY EYE PATIENT?

We asked our esteemed colleagues to share with us some tips on how they handle patients who aren't compliant with the treatment plans they've been given. Below are their answers.

Jaclyn Garlich, OD, FAAO: Education on the disease process is key. I explain that it is much easier to be proactive rather than reactive in treating dry eye disease (DED). Preventive care seems to resonate with my patients.

Kambiz Silani, OD: We verbally review the customized treatment plan with each patient, but they also appreciate when we provide a written handout that lays out the dry eye products, how to use them, and how often to use them.

Because we gather baseline data with the Oculus Keratograph 5M corneal topographer (Oculus), we can objectively track our patients' treatment progress with at-home and office-based treatments. For patients who are not interested in an at-home regimen, we offer to perform in-office therapeutics more frequently.

David Kading, OD: I use images that are already available about the condition to compare to what the patient has and to show them the stages of progression.

Jacob Lang, OD, FAAO, Dipl ABO: Many of the treatments we have for DED require the patient to be an active participant in their therapy. If they aren't, I like to get back to basics and break down why they came to see me by mentioning how I want to help alleviate or improve their previous chief complaints, and then asking why the previous plan isn't working.

you might consider asking your patient include: How can I help you achieve _____? Are there any barriers you perceive that don't allow you to _____? An example of an instruction might be to use lid hygiene sprays in the shower, if that helps them remember better."

Dr. Silani then takes this information and "provide[s] guidance through various aspects of their daily habits including diet, cosmetics, contact lens wear, digital device use, etc. This way, we are not only their eye doctor but their trusted partner in the journey to optimal eye health."

COST OF TREATMENT AS A BARRIER

Treatment of a chronic disease such as dry eye is costly. In fact, Dr. Doll addresses the cost burden of nonadherence directly with her patients. "The more nonadherent with home therapy of lid hygiene, nutraceuticals, and any topical drop that is prescribed, the more frequently I will have to do in-office [treatment]," she explains. "Out-of-pocket treatments can be spaced-out longer if the patient will do home therapy."

There are several indirect costs of DED that patients may not be aware of, too, including time away from work for multiple appointments, loss of wages due to missed work, and reduced productivity due to dry eye symptoms. Often, these indirect costs end up costing the patient more than the direct costs. Greco et al reported that worsening Ocular Surface Disease Index scores were directly associated with increased impairment in work and non-work–related activities.[4] Research also supports that use of topical cyclosporine A reduced the cost burden of treating DED due to reduced frequency of follow-up office visits and reduced dependence on OTC eye drops. There is also less potential for additional intervention such as punctal plugs.[5]

Asymptomatic patients of a chronic disease process such as DED can create a significant burden for themselves and their health care providers through nonadherence. By implementing these patient education strategies, we hope to move the needle in the widespread understanding of DED and its visual consequences. ■

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