

SENSE OF COHERENCE

as a predictor of health-related quality of life among coronary heart disease patients

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BACKGROUND

Sense of coherence (SOC) could be of interest for decreasing the public health burden related to coronary heart disease (CHD). According to Antonovsky (1) SOC reflects a person's view of life and capacity to respond to stressful situations. Independent of the used measure, a strong SOC positively affects both mental and physical components of a patient's health-related quality of life (HRQoL) in different clinical populations (2-4). However, the studies on SOC among CHD patients are limited. Thus the aim of this study was to determine whether SOC at baseline predicts HRQoL at 12-28 months follow-up among patients with CHD when controlled for sociodemographic and medical variables.

METHODS

SAMPLE

179 pts (16.8% female; 58.28 ± 6.52) scheduled for CAG

MEASURES

- gender
- age (using median age divided into 39-58 and 59-73)
- socioeconomic status (measured by family income: low, middle, high)
- functional status (worst score of either NYHA or CCS)

SOC measured by:

- 13-item Orientation to Life Questionnaire (1) ($\alpha = 0.78$)

HRQoL measured by:

- Short Form Health Survey Questionnaire - SF-36 (5) (Physical Summary Component (PSC) and Mental Summary Component (MSC))

STATISTICAL ANALYSES

- 4 hierarchical linear regression models
- Independent variable: SOC measured at baseline (the day before CAG)
- Dependent variable: PSC and MSC measured at 12-28 months follow-up
- Controlled for: sociodemographic and medical data measured at 12-28 months follow-up

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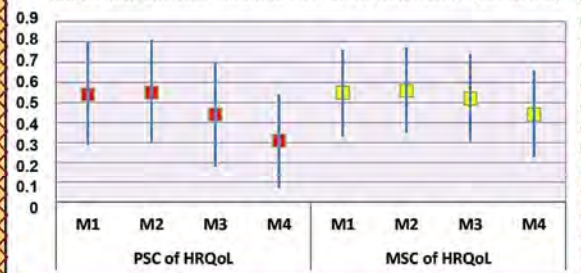
RESULTS

SOC proved to be a significant predictor of PSC-score ($B=0.54$; $95\%CI=0.29-0.80$) and MSC-score ($B=0.55$; $95\%CI=0.33-0.76$) (Fig. 2, Model 1). After adjustment for gender, age (Model 2), combined with sociodemographic (Model 3) and medical variables (Model 4), SOC remained a predictor of PSC-score ($B=0.31$; $95\%CI=0.07-0.54$) and MSC-score ($B=0.44$; $95\%CI=0.23-0.66$). Regarding PSC, adding in socioeconomic and functional status weakened its association with SOC, while with MSC, only adding in functional status weakened its association.

FIG.1 SOCIODEMOGRAPHIC AND MEDICAL CHARACTERISTICS FOR THE SAMPLE MEASURED AT 12-28 MONTHS FOLLOW-UP



FIG.2 ASSOCIATIONS BETWEEN SOC AND PSC- AN MSC- SCORE OF HRQoL RESPECTIVELY MEASURED BY LINEAR REGRESSION (OR, 95% CI)



- M1 the crude effect of SOC on PSC and MSC
- M2 gender and age were added to M1
- M3 socioeconomic status was added to M2
- M4 functional status was added to M3

CONCLUSIONS

SOC is a predictor of the mental and physical components of HRQoL at 12-28 months follow-up, crude and also after adjustment for sociodemographic and medical variables. Patients undergoing CAG with low SOC thus deserve particular attention in regard to the maintenance and improvement of their HRQoL.

PRACTICE IMPLICATIONS

Health care professionals might be able to use information on patients' SOC to improve their HRQoL by concentrating on changing one or more of the three components of the SOC: comprehension, manageability and meaningfulness not only during the hospitalisation but also during further recovery at home (3). Furthermore, preventing further cardiac recurrences through patient education, self-management and enhancement of personality resources could be a good alternative, as opposed to more costly solutions such as repeated hospital admissions.

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Finn Kamper-Jørgensen

Dineke Zeegers Paget



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EUROPEAN PUBLIC HEALTH ASSOCIATION

 **ASPHER**
The Association of Schools of Public Health
in the European Region



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ABSTRACT SUPPLEMENT

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to health promotion are less studied. Knowledge of work conditions and health in Lithuanian contexts is so far rare. The aim was to compare reports of salutogenic health indicators and work experiences between two large professional groups in Lithuania.

Methods

Nurses from one hospital (response rate 88%; $n=441$; 100% females) and teachers from 11 schools (response rate 83.5%; $n=180$; 87% females) completed a questionnaire on age, gender, other employment, health and work experience, using WEMS (Work Experiences Measurement Scale), and SHIS (Salutogenic Health Indicator Scale). WEMS and SHIS are two short validated instruments, which both give total indexes for work experiences and health indicators, respectively. WEMS also contains six subdomains of work factors. The WEMS and SHIS indexes were all standardised to range from 0 to 100% (from most negative to most positive work experiences and health indicators respectively). The analyses were made using t-test, chi-squared test and Pearson correlation.

Results

SHIS was higher among nurses compared to teachers (69% vs. 65%, $p<0.01$), although total WEMS scores showed the opposite relationship (66 vs. 71%, $p<0.001$). The teachers had higher values for all domains of WEMS, except Time experience (teachers 64 vs. nurses 68%; $p<0.01$). Both groups showed a positive correlation between WEMS and SHIS ($r=0.53$ and 0.56). Having more than one employment, which resulted in a lower SHIS, was more common among teachers (28% vs. 4%). Nurses were younger (43% < 40y) compared to the teachers (24% < 40y), which partly explains the difference in SHIS between the two professions.

Conclusion

Salutogenic health indicators were highly related to positive work experiences. Nurses reported less time stress compared to teachers, but scored less favourably on work conditions. They still showed a higher level on SHIS index. The differences may be explained by different work contexts, but also by the differences in age and gender. Further studies are necessary to increase the understanding of work health in relation to different professions and contexts.

Sense of coherence as a predictor of health-related quality of life among coronary heart disease patients

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Background

Sense of coherence (SOC) could be of interest for decreasing the public health burden related to coronary heart disease (CHD). One important clinical and research variable in patients with CHD is health-related quality of life (HRQoL). SOC affects mental and physical HRQoL in different clinical populations; the stronger the SOC, the better the HRQoL.

The aim of this study was to determine whether SOC at baseline predicts HRQoL at 12–28 months follow-up among patients with CHD when controlled for sociodemographic and medical variables.

Methods

179 consecutive patients (mean age 58.28 ± 6.52 , 16.8% female) scheduled for coronary angiography (CAG) were interviewed before CAG and then 12–28 months after. Both the baseline and the follow-up measurements were performed in the East Slovakian Institute for Cardiac and Vascular Diseases in Kosice, Slovakia. Medical and demographic data were obtained from medical records and a structured interview. SOC was measured using the 13-item Orientation to Life Questionnaire. HRQoL was measured using the Short Form Health Survey 36 (SF-36) from which the mental and physical summary components (MSC, PSC) were calculated. The relationship between a patient's SOC at baseline and HRQoL at 12–28 months follow-up was examined using regression analyses and adjusted for sociodemographic and medical variables.

Results

SOC proved to be a significant predictor of MSC ($B=0.55$; 95% CI=0.33–0.76) as well as PSC ($B=0.54$; 95% CI=0.29–0.80). After adjustment for gender, age, family income and functional status, SOC remained an independent predictor of both MSC ($B=0.44$; 95% CI=0.23–0.66) and PSC ($B=0.31$; 95% CI=0.07–0.54) components. Regarding PSC, adding family income and functional status to the models weakened the association between baseline SOC and PSC at follow-up.

Conclusions

SOC is a predictor of the mental and physical components of HRQoL at 12–28 months follow-up, crude and also after adjustment for sociodemographic and medical variables. Identifying predictors of HRQoL among CHD patients may help to tailor interventions for those at risk of recurrent CHD and mortality.

Process and outcome mental health indicators using administrative databases in Italy

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Background

In Italy and in other European countries, both at local and national level, the process of de-institutionalisation and implementation of a community-based model in mental health care has been characterized by a lack of evaluation. In particular, no activity is or has been in place to develop or maintain standards of quality of care. The aim of this study is to investigate the feasibility of the calculation of process and outcome indicators using administrative databases.

Methods

Process and outcome indicators of mental health care for 2 Local Health Authorities of Emilia-Romagna Region (Italy, 1.298.103 adult inhabitants) were obtained through linkage of hospital discharge records, the community mental health service database (year 2009) and the drug prescription database (years 2009 and 2010). The study cohorts include patients with a primary ICD-9-CM diagnosis code 290.xx-319 hospitalized or treated in the community mental health services in the year 2009. The set of indicators explore treated prevalence and incidence rates by disorder and setting, continuity between hospital and community care, retention in treatment, rehospitalizations, antidepressant drug and mood stabilizer prescriptions.