Providers Need Additional Training to Improve Patient HIV Treatment Adherence

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Providing clinicians with more data on their patients' antiretroviral (ARV) adherence doesn't ultimately translate to better adherence practices, according to a study published online ahead of print by the Journal of Acquired Immune Deficiency Syndromes. In other words, it's not what health care providers know about their patients' difficulties taking ARV treatment as prescribed that translates into better adherence practices, but rather how health care providers act on the information once it's made available to them.

The pitfalls of poor adherence have been written about repeatedly. Not only is poor adherence associated with HIV disease progression and worsening health, but it also contributes to drug resistance—often to multiple classes of ARVs. In turn, improving ARV adherence is of vital importance.

According to study author Ira Wilson, MD, of Tufts Medical Center in Boston and his colleagues, most programs designed to improve adherence have focused on overcoming the obstacles faced by patients. Less is done to address the shortcomings of health care providers, who must determine if their patients are struggling with adherence, understand the reasons for patients inability to take their medications and prescribed and, lastly, to offer effective counseling.

Wilson's team hypothesized that if health care providers had accurate information about their patients' treatment adherence, they would ultimately have more dialog with their patients to overcome challenges. To test this, the researchers provided the participating doctors with comprehensive adherence data for participating patients at the time of routine outpatient visits. This report included electronic data from the Medication Event Monitoring System (MEMS)—pill bottle caps that record open rates—along with patient self-reported data on ARV adherence, patients' beliefs about ARV therapy, reasons for missed doses, alcohol and drug use and depression.

To test the effectiveness of this approach, Wilson's team randomized 156 HIV-positive individuals to either have their adherence data reported to their physicians or to serve as controls, whereby data was collected but not provided to their clinicians.

The difference between the two groups was marginal at best. Adherence improved by 2 percent among those whose health care providers received comprehensive adherence data, compared

with those whose clinicians did not. “There was a trend toward an intervention effect, but the average effect…was quite small, and we do not believe that an effect of this magnitude is clinically important,” the authors write.

Wilson and his colleagues offer a possible reason for the lackluster results, notably after listening to audio recordings of several doctor-patient pairs participating in the study. “As hypothesized, the intervention did indeed increase certain aspects of ARV-related dialogue—specifically utterances related to adherence with the current regimen and ARV problem solving—but adherence did not improve,” the researchers found. One possible explanation offered by the researchers: “that providers’ approach to improving adherence was ineffective.”

In their conclusion, the authors stressed that adherence is a serious problem for all chronic medications and that improved physician skills in this area are fundamental not just to HIV care, but to the modern day practice of medicine. “However,” they write, “we know relatively little about how such training should be conducted, and the development and testing of creative approaches to this problem are needed.”
