

HAVES VS HAVE-NOTS IN HEALTHCARE COMMUNICATION: EXAMINING THE PARADOX WHERE PLHIV WHO NEED QUALITY DISCUSSIONS WITH THEIR PROVIDERS THE MOST, ACCESS IT THE LEAST

Patricia de los Rios,¹ Benjamin Young,² Marvelous Muchenje,¹ Nicolas Van de Velde,³ Chinyere Okoli³

¹ViiV Healthcare, Quebec, Canada; ²ViiV Healthcare, Research Triangle Park, NC, USA; ³ViiV Healthcare, Brentford, Middlesex, UK

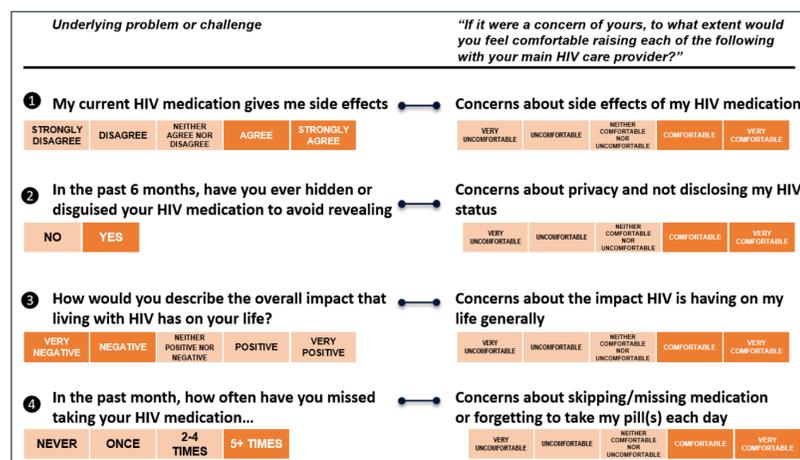
Introduction

- Quality communication with patients can allow healthcare providers (HCPs) to identify/address gaps in knowledge and care
- The importance of good 2-way patient-HCP communication cannot be overemphasized as it encourages joint decision-making that may empower PLHIV to own their care, and perhaps, overcome emotional and psychosocial barriers of living with HIV and taking treatment
- As the modes of communication broaden, and with the move toward telehealth, it is important to understand which aspects of communication need improving
- We investigated communication barriers among those uncomfortable discussing with their HCP and the relationship between high HCP engagement and aspects of quality of life (QOL) among PLHIV in North America

Methods

- We analyzed self-reported data for 520 PLHIV from the 2019 Positive Perspectives study from Canada (N=120) and the United States (N=400)
- Survey was over the web; participants recruited using snowball and convenience sampling
- Patient engagement in care (low, moderate, high) was measured based on a modified version of the Observing Patient Involvement scale¹
- The survey assessed for presence of specific treatment challenges or problems as well as perceived comfort discussing those problems with HCP. Responses of "Comfortable"/"Very comfortable" were classified as perceived comfort discussing with their HCP²

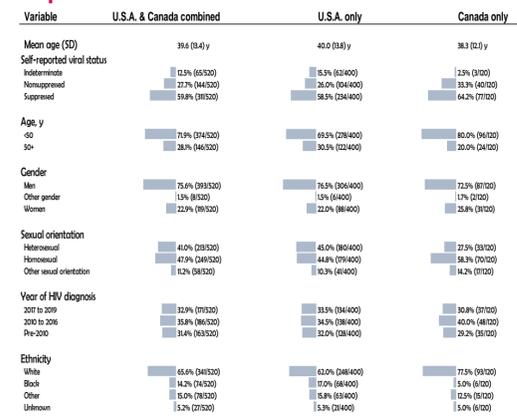
Figure 1. Survey Constructs Assessing Perceived Comfort Discussing Treatment Concerns as Well as Reported Presence or Absence of Specific Treatment Challenges



- Outcome variables: Optimal overall, sexual, physical, or mental health ("Good" or "Very good"); self-reported viral suppression (report of "Undetectable" or "Suppressed"); treatment satisfaction ("Satisfied" or "Very satisfied" with current medication); and suboptimal adherence (missed antiretrovirals ≥5 times in past month for ≥1 reasons)
- Analyses: prevalence estimates computed and compared with χ^2 tests at $P < 0.05$

Results

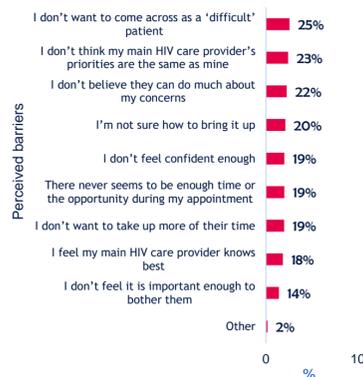
Figure 2. Characteristics of the Study Population



- Most participants reported being virally suppressed (59.8%), younger (<50 y, 71.9%), and men (75.6%)
- The two countries had similar distributions and mean ages

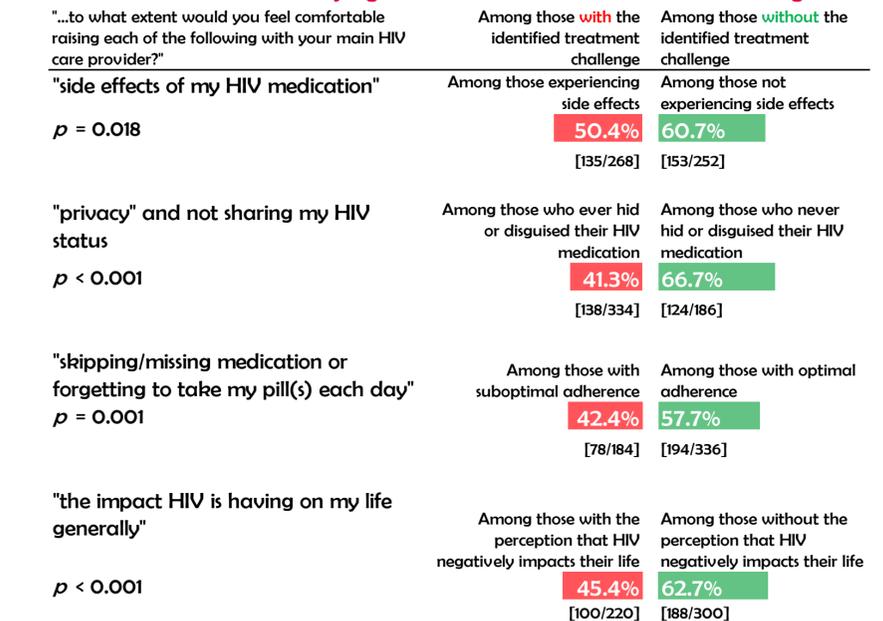
Figure 3. Perceived Barriers to Discussing With HCPs (N=520)

Why, if at all, would you feel uncomfortable raising concerns with your main HIV care provider?



Among all participants, the top perceived barrier to discussing with HCPs was the fear of coming "across as a difficult patient" (25% [129/520])

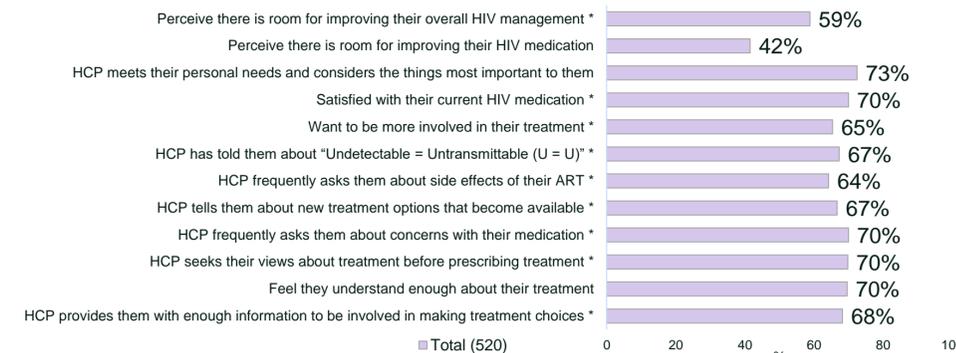
Figure 4. Perceived Comfort Discussing Treatment Challenges With HCPs Among Those With or Without Underlying Treatment-Related Problem or Challenge



Perceived comfort discussing salient issues with HCPs was significantly lower among PLHIV with vs without the specified challenges, including side effects and privacy concerns

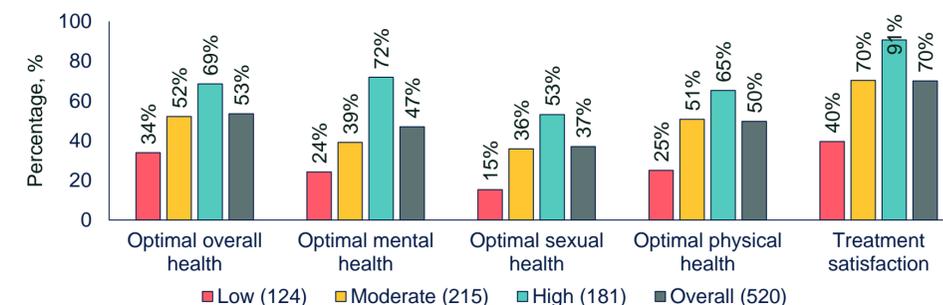
Figure 5. Indicators of Communication Between HCPs and PLHIV in Canada and the United States Combined

(Asterisks (*) indicate $P < 0.05$ for the difference between the United States and Canada)



- Overall, 58.8% [306/520] believed there was room for improving their HIV management (US = 62.2% [249/400] vs Canada = 47.5% [57/120]; $P = 0.004$)
- 33.3% [173/520] indicated their HCP did not discuss new treatment options with them (US = 29.0% [116/400] vs Canada = 47.5% [57/120]; $P < 0.001$)
- Furthermore, 30.2% [157/520] reported their viewpoint was not sought regarding treatment (US = 25.8% [103/400] vs Canada = 45.0% [54/120]; $P < 0.001$)

Figure 6. Pooled Analysis of the Relationship Between Extent of Patient Engagement in Care and Aspects of QOL (N=520)



Note: All P -trend < 0.05 (χ^2 tests)

Strengths and Limitations

- This study's strength is use of a standardized protocol to collect information from PLHIV with verified diagnosis
- Limitations include non-probabilistic sampling and use of online questionnaires, which may limit generalizability; only associations can be inferred from the cross-sectional design

Conclusions

- A high proportion of participants in North America with identified HIV-related issues were not comfortable discussing this with their HCP
- Those participants with low HCP engagement were significantly more likely to report poorer aspects of QOL
- HCP should proactively seek to improve 2-way communication with all their patients as this may improve overall QOL in PLHIV

Acknowledgments: We deeply thank survey participants and community groups that helped with enrolment. Statistical analyses and medical writing were supported by Zatum LLC.

References: 1. Elwyn et al. *Qual Saf Health Care*. 2003;12:93-99. 2. Okoli et al. *AIDS Behav*. 2020;1-12. [Epub ahead of print].