Table D4. Intervention’s disease focus, goal, and theoretical model

| Author, YearTrial Name | Name of Disease or Condition | Specify Other Dx or Combinations of Dx | Goal of Intervention | What was the Target of the Intervention  | Theoretical Model |
| --- | --- | --- | --- | --- | --- |
| Bender et al., 20101NA | Asthma | NA | to improve adherence to controller medications among adults with asthma | Patient | Other  |
| Berg et al., 19972NA | asthma | NA | use a nurse-administered asthma self-management program to improve compliance, asthma symptoms, and airway obstruction among patients in a rural setting | Patient | Self-efficacy theory |
| Berger et al., 20053NA | Multiple sclerosis |   | Decrease discontinuation of Avonex | Patient | Transtheoretical Model of Change (stages of change) |
| Bogner et al., 20084NA | Depression | Hypertension | (1) fewer depressive symptoms, (2) lower systolic BP and diastolic BP, (3) a greater proportion with 80% or greater adherence to an antidepressant medication, and (4) a greater proportion with 80% or greater adherence to an antihypertensive medication | Patient | Other  |
| Bogner et al., 20105NA | Multiple chronic conditions | Diabetes and depression | Adherence Goals: To increase the proportions of participants with >80% adherence to an oral hypoglycemic agent and >80% adherence to an antidepressant at 6 weeks, compared to usual careClinical Goals: To increase the proportion of participants with lower amounts of glycosylated hemoglobin in their blood and fewer depressive symptoms, compared to usual care | Patient | Other  |
| Bosworth et al., 20056V-STITCH | Hypertension | NA | To promote adherence with medication and improve health behaviors | patient | Prospect Theory |
| Bosworth et al., 20087TCYBBosworth et al., 20078TCYB Methods paper | Hypertension | NR | To promote medication adherence and improve hypertension-related health behaviors | patient | Transtheoretical Model of Change (stages of change) |
| Capoccia et al., 20049na | Depression | NA | Improving quality of care and out-comes to patients diagnosed with anew episode of depression. | patient | Other  |
| Carter et al., 200910NA | Hypertension | NA | To achieve better guideline adherence, lower mean BP, higher rates of BP control, and higher rates of medication adherence to antihypertensives | Patient, pharmacists, MDs |   |
| Chernew et al., 200811NA | Multiple chronic conditions | Diabetes, hyperlipidemia, *hypertension* | Improve medication adherence | Patient | Other  |
| Choudhry et al., 201012NA | Multiple chronic conditions | Diabetes, hypercholesterolemia, coronary artery disease, congestive heart failure, hypertension  | To improve medication adherence to statins & clopidogrel among company employees & beneficiaries with diabetes or vascular disease by eliminating copayments for statins and lowering copayments for all employees & beneficiaries prescribed clopidogrel | Patient & policy | Other  |
| Choudhry et al., 201113MI FREEE | Myocardial Infarction |  NA | Increase adherence to medications and improve outcomes after myocardial infarction | Policy | None |
| Friedman et al., 199614NA | Hypertension | heart disease, stroke, diabetes, and other (see baseline characteristics) | monitoring BP and treatment and counseling patients to be adherent | patient | Other  |
| Fulmer et al., 199915NA | Congestive Heart Failure |   | Increase the proportion of prescribed cardiac medications taken by these patients | patient | Other  |
| Grant et al., 200316NA | Diabetes | NS | 1. Increase medication adherence rates by identifying and reducing barriers; 2. identify and reduce discrepancies between patient-reported and physician-documented medication regimens | patient and physician | Other  |
| Guthrie et al., 200117First Myocardial Infarction (MI) Risk Reduction Program | Elevated cholesterol | at increased risk for first MI | To examine adherence to medication regimens and to recommendations to modify lifestyle risk factors in patients at risk for a first MI | patient | Other  |
| Hoffman et al., 200318NA | Depression | NA | To increase antidepressant medication adherence | Patient | Other  |
| Hunt et al., 200819NA | Hypertension | See baseline characteristics | Goal of the study: assess the impact of physician-pharmacist team-base care on BP control, quality of life, and patient satisfaction in patients cared for by all physicians practicing in multiple community-based clinics. | Patient | Other  |
| Janson et al., 200921NA | Asthma | NA | self-management educationto improve long-term adherence to inhaled corticosteroid (ICS) therapyand markers of asthma control | patient | Other  |
| Janson et al., 200320NA | asthma | NA | use individual self-management education= to improve adherence to anti-inﬂammatory medication, biological markers of airway inﬂammation, and clinical outcomes | patient | Other  |
| Johnson et al., 200622NR | Elevated cholesterol | NR | To provide individualized guidance to improve medication adherence, moderate exercise, and low fat diet | patient | Transtheoretical Model of Change (stages of change) |
| Johnson et al., 200623NR | Hypertension | NA | To overcome limitations to medication adherence by delivering individualized, theoretically derived interventions for entire populations of individuals, including those who may not be motivated to change | patient | Transtheoretical Model of Change (stages of change) |
| Katon et al., 199524NA | Depression | NA | improve treatment of depression to the level recommended by practice guidelines | patient, provider, and structure of delivery of care | Other  |
| Katon et al., 199625NA | Depression | NR | To improve the management of depression in primary care | patient, provider, and system | Other  |
| Katon et al., 199926NAKaton et al., 200227NA | Depression | NA | To improve antidepressant medication adherence; severity of depressive symptoms and functional impairment.  | Patient & provider | Other  |
| Katon et al., 200128 NALudman et al., 200329NAVan Korff et al., 200330NA | Depression | NA | to prevent depression relapse; improve adherence to antidepressant medication; determine whether increased adherence is associated with less depressive symptoms and relapse/recurrence of major depressive episodes; and to increase self-efficacy and behavioral skills for self-management of depression | patient, provider | Social Cognitive Theory (self-efficacy) |
| Lee et al., 200631FAME | Not Specified | NR | To improve medication adherence, BP, and LDL cholesterol for a population at increased risk for medication non-adherence | Patient | Other  |
| Lin et al., 200632NA | Diabetes | Depression | To improve diabetes self-care behaviors, including adherence to diabetes medications, by improving depression treatment | Patient | Other  |
| Maciejewski et al., 2010 33NA | Multiple chronic conditions | Diabetes, HTN, hyperlipidemia, congestive heart failure | To improve medication refill adherence over a one-year period | Policy | NA |
| Mann et al., 201034The Statin Choice | Diabetes | NS | To improve perceived risk of heart attack and medication adherence to statins of patients with diabetes. | Patient | Other  |
| Montori et al., 201135NA | Osteoporosis | NA | Improve adherence to osteoporosis treatment | Patient | None |
| Murray et al., 200736NA | Congestive Heart Failure | NA | To determine whether a pharmacist intervention improves medication adherence and health outcomes compared with usual care for low-income patients with HF. | Patient | NR |
| Nietert et al., 200937NA | Multiple chronic conditions | Diabetes, hypertension, hyperlipidemia, heart failure, depression, psychosis | To improve pharmacy medication refill rates for 1 of 6 chronic diseases among patients identified as being overdue for their prescriptions | Patient | Other  |
| Okeke et al., 200938NA | Glaucoma | Could also be glaucoma suspect or have ocular hypertension (rather than having glaucoma diagnosis) | Improve adherence with topical, once daily glaucoma medication | Patient |   |
| Pearce et al., 200839Cardiovascular Risk Education and Social Support (CaRESS) Trial | Diabetes | NA | To educate, motivate, and facilitate patients and their support persons to work together to improve the patients' cardiovascular risk, health-related quality of life, and satisfaction with health care | Patient | Health Belief Model |
| Powell et al., 199540NA | Multiple chronic conditions | Hypertension, hyperlipidemia | To improve medication adherence by enhancing patients' knowledge about their disease/condition and their prescribed treatment for it | Patient | Other  |
| Powers et al., 201168NA | Hypertension | Cardiovascular heart disease | Evaluate the impact of personalized CHD and stroke risk communication on patients' knowledge, beliefs, decision making, and health behaviors | Patient | NA |
| Pyne et al., 201141HIV Translating Initiatives for Depression Into Effective Solutions (HITIDES) | Depression | HIV | Apply collaborative care of depression model to HIV settings for: improved depression severity, health-related QOL, health status, HIV symptom severity, and medication regimen adherence | intervention targeted at patients and providers: educated patients, made treatment recommendations for providers  | Other  |
| Rich et al., 199642NA | Congestive Heart Failure | NA | To use a multidisciplinary approach to improve medication compliance rates among the elderly with congestive heart failure | patient | Other  |
| Rickles et al., 200543NA | Depression | NA |  (1) Greater frequency of patient feedback to pharmacist, (2) fewer missed antidepressant (AD) doses, (3) greater AD knowledge, (4) more positive AD beliefs, (5) a more positive orientation toward treatment progress, and (6) greater improvement in depression symptoms. | patient | Other  |
| Ross et al., 200444NR | Congestive Heart Failure | NA | To improve self-efficacy, adherence, satisfaction, and possibly health status | combination [patient, system] | Other  |
| Rudd et al., 200946NA | Inflammatory Arthritis | Also included patients with rheumatoid arthritis and psoriatic arthritis | To test how effective educational interventions are in reducing barriers to literacy and improve outcomes including medication adherence in patients with inflammatory arthritis | Patient |   |
| Rudd et al., 200445NA | Hypertension | NA | To increase patient education and frequent home BP monitoring | Combination [patient, system of care] | Social Cognitive Theory (self-efficacy) |
| Schaffer et al., 200447NA | asthma | NA | The study primarily compared the effects of a theoreticallyfocused audiotape or a standard educational booklet, or both of these, on adherence to asthma preventive medication.  | Patient | Protection Motivation Theory |
| Schectman et al., 199448NA | Elevated cholesterol | NA | To improve patient adherence and tolerance to niacin and BAS therapy | Patient | Other  |
| Schneider et al., 200849NA | Hypertension | N-A | Improve adherence and clinical outcomes | Patient |   |
| Schnipper et al., 200650NA | Other  |   | Reduce the rate of preventable adverse drug events | System, patient |   |
| Simon et al., 200651na | Depression | NA | NR; however, implicitly it is to use low intensity phone care management system to diminish depressive symptoms and functional impairment with low insensitivity are  | Patient and provider | Other  |
| Sledge et al., 200652NA | Other  | N-A | Decrease inpatient readmission rates, reduce use of emergency services, reduce total costs, improve health outcomes (including adherence) | Patient, provider |   |
| Smith et al., 200853NR | Myocardial Infarction | NR | To promote adherence to Beta-blocker therapy following MI | Patient and providers | Other  |
| Solomon et al., 199854naGourley et al., 199855NA | Chronic Obstructive Pulmonary Disease | Hypertension | To improve compliance to medication regimen, satisfaction with care, knowledge about disease and management, and quality of life in the intervention group compared to the control group. | Patient  | Other  |
| Stacy et al., 200956NA | Elevated cholesterol | NA | To increase statin Adherence/persistence by enhancing both intrinsic motivations for medication persistence and self-management. | patient | Transtheoretical Model of Change (stages of change) |
| Taylor et al., 200357NA | Other  | Multiple Conditions | Improve the prevention, detection, and resolution of drug-related problems. | Patient, provider | Other  |
| Vivian et al., 200258NA | Hypertension | NA | To determine whether a pharmacist-managed hypertension clinic improves treatment outcomes (medication compliance, BP control, diabetes control, patient satisfaction, quality of life) in patients with hypertension | patient | Other  |
| Waalen et al., 200959NA | Osteoporosis | N-A | improve use of medication 1 year after prescription | Patient |   |
| Wakefield et al., 201160 | Diabetes | Hypertension | To improve outcomes in veterans with comorbid DM and HTN | Patient | NA |
| Weinberger et al., 200261NA | Other  | asthma and COPD | not stated, but implicitly to use a pharm care to improve patients’ peak expiratory flow rate (PEFR), health-related quality of life (HRQOL), medication compliance, and to decrease breathing-related emergency department (ED) or hospital visits; also to increase patient satisfaction with care and with their pharmacist | provider (i.e. pharmacist), but outcomes measured at patient level | Other  |
| Weymiller et al., 200762Statin Choice Randomized TrialJones et al., 200963Statin Choice Randomized Trial | Diabetes | NA | To estimate the extent to which the Statin Choice decision aid compared with usual care plus a standard pamphlet was acceptable to patients, could improve patient knowledge, and reduced decisional conflict in choosing whether or not to use a statinTo test the hypothesis that improvements in the conversations between patients and their clinicians about therapy can enhance adherence. | Patient | Other  |
| Williams et al., 201064NA | asthma | NA | Implicit - to improve patient adherence to ICS by facilitating the provision of adherence feedback from physicians | Providers were targeted but outcomes measured among patients | Other  |
| Wilson et al., 201065Better Outcomes of Asthma Treatment (BOAT) | Asthma | NA | SDM approach would exhibitgreater adherence to controller medications, better asthma-related quality of life, and lower health care utilization for acutesymptoms than patients who received usual care (no asthmacare management); | Patient | Shared Decision Making |
| Wolever et al., 201066NA | Diabetes | NA | To improvelifestyle behaviors, psychosocial functioning, and A1C | Patients | Other  |
| Zhang et al., 201067NA | Multiple chronic conditions | NA | Medicare Part D was intended to reduce the burden of high drug costs on the elderly and to reduce the underuse of medication due to cost. | Patient | Other  |