A Qualitative Study of Underutilization of the AIDS Drug Assistance Program

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In our previous work, we demonstrated underutilization of the AIDS Drug Assistance Program (ADAP) at an HIV clinic in Alabama. In order to understand barriers and facilitators to utilization of ADAP, we conducted focus groups of ADAP enrollees. Focus groups were stratified by sex, race, and historical medication possession ratio as a measure of program utilization. We grouped factors according to the social-ecological model. We found that multiple levels of influence, including patient and clinic-related factors, influenced utilization of antiretroviral medications. Patients introduced issues that illustrated high-priority needs for ADAP policy and implementation, suggesting that in order to improve ADAP utilization, the following issues must be addressed: patient transportation, ADAP medication refill schedules and procedures, mailing of medications, and the ADAP recertification process. These findings can inform a strategy of approaches to improve ADAP utilization, which may have widespread implications for ADAP programs across the United States.

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Sub-optimal adherence to antiretroviral therapy (ART) is an all-too-familiar challenge for HIV care providers and patients. One of the many ways in which this challenge is manifest is in the underutilization of programs such as the AIDS Drug Assistance Program (ADAP), which we have demonstrated in our previous work (Godwin et al., 2011). The discovery that many program enrollees do not take full advantage of life-saving medications is in contrast to the standard of care of a lifetime of uninterrupted ART (Panel on Antiretroviral Guidelines for Adults

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and Adolescents, 2008). While overcoming the challenges of strict adherence can be daunting for patients, care providers, and the health care system, the ultimate outcomes of optimal personal health, increased longevity, potential for productivity, and decreased transmission risk to others justifies individual and collective efforts to promote uninterrupted ART receipt and high adherence. Lack of treatment can be fatal, and nonadherence can lead to increased hospital stays (Sansom et al., 2008), an increased viral load, development of resistant strains of the virus, and an increase in morbidity and mortality rates (Panel on Antiretroviral Guidelines for Adults and Adolescents, 2012). Moreover, findings from the HIV Prevention Trials Network 052 study demonstrated the prevention benefits of early ART initiation, bolstering enthusiasm for HIV treatment as a prevention approach, which is dependent upon uninterrupted ART to optimize sustained viral suppression (Cohen et al., 2011).

Recognizing the individual and public health importance of HIV treatment programs, federal legislation created the Ryan White Care Act, which included the ADAP as a prominent component, as a payer of last resort. The program supplies lifesaving ART and, in some states, other essential HIV-related medications free of charge to low-income people living with HIV who qualify for the program. All 50 states, the District of Columbia, and U.S. territories (American Samoa, Federated States of Micronesia, Guam, Northern Mariana Islands, the Republic of Marshall Islands, Republic of Palau, Puerto Rico, and the U.S. Virgin Islands) are eligible for federal funding for ADAP. Some ADAPs may be known by different names (e.g., HDAP [HIV Drug Assistance Program]). Each state or territory is responsible for administering its program; covering each class of HIV drug on its formulary; determining the type, amount, duration, and scope of services; developing a list of covered drugs in its formulary; and establishing ADAP eligibility. These responsibilities were mandated in Title XXVI of the Public Health Service Act as amended by the Ryan White HIV/AIDS Treatment Extension Act (2009). However, state laws and administrative policies, as well as overall fiscal solvency of the state or territory, determine the rules and policies associated with these responsibilities.

One quarter of all persons engaged in HIV care in the United States are enrolled in ADAP (Bassett, Farel, Szmuilowicz, & Walensky, 2008). In 2012, the federal Ryan White budget was $2.392 billion, of which $933.3 million (38%) was allocated for ADAP (AIDS Budget and Appropriations Coalition, 2012). Despite this substantial allocation of resources, a qualitative evaluation of ADAP has not been performed to identify the factors contributing to program underutilization. There is a wealth of literature examining factors related to ART adherence, but few studies have investigated factors related to utilization of ART-supplying programs, such as ADAP. A recent article provided further information on the history and current status of ADAP in the United States and highlighted the need for qualitative evaluation of ADAP and sharing of findings across state programs (Martin, Meehan, & Schackman, 2013). Because Congress scheduled the Ryan White Act for possible reauthorization in 2013, this kind of programmatic evaluation of ADAP is needed to inform health policy and practical implementation.

A retrospective cohort study (Godwin et al., 2011) of 245 patients at the University of Alabama at Birmingham 1917 Clinic evaluated ADAP utilization measured by medication possession ratios (MPR). MPR is a calculated measure based on pharmacy refill data, calculated by dividing the total number of days of medications in a patient's possession by the number of days in the measurement period. That study found that two of every three patients did not achieve an MPR of at least 90%, and that younger patients, non-White males, those with a past or current history of alcohol abuse, and those with poor baseline HIV surrogate markers (low CD4+ T cell count and high plasma HIV viral load) were at higher risk for underutilization. These trends were consistent with those found in other studies of non-ADAP-specific HIV-infected populations in the United States and abroad (Oh et al., 2009; Simoni et al., 2012). The risk for underutilization was shown to be higher in non-White men because they disproportionately contributed to the number of new cases (Centers for Disease Control and Prevention, 2007).

In order to better understand contributing factors and to inform theory- and evidence-based approaches to improve ADAP utilization, we conducted focus groups, informed by the previous quantitative