Service Category Definition - DSHS State Services-R
September 1, 2019 - August 31, 2020

Local Service Category:	**Referral for Health Care: ADAP Enrollment Worker**
Amount Available**:**	**To be determined**
Unit Cost	
Budget Requirements or Restrictions **(TRG Only)**:	Maximum 10% of budget for Administrative Cost. No direct medical costs may be billed to this grant.
DSHS Service Category Definition:	Direct a client to a service in person or through telephone, written, or other types of communication, including management of such services where they are not provided as part of Ambulatory Outpatient Medical Care or Case Management Services.
Local Service Category Definition:	AIDS Drug Assistance Program (ADAP) Enrollment Workers (AEWs) are co-located at Ryan-White funded clinics to ensure the efficient and accurate submission of ADAP applications to the Texas HIV Medication Program (THMP). AEWs will meet with all potential new ADAP enrollees, explain ADAP program benefits and requirements, and assist clients with the submission of complete, accurate ADAP applications. AEWs will submit annual re-certifications by the last day of the client's birth month and semi-annual Attestations six months later to ensure there is no the lapse in ADAP eligibility and loss of benefits. Other responsibilities will include: • Track the status of all pending applications and promptly follow-up with applicants regarding missing documentation or other needed information to ensure completed applications are submitted as quickly as feasible; • Maintain communication with designated THMP staff to quickly resolve any missing or questioned application information or documentation to ensure any issues affecting pending applications are resolved as quickly as possible; AEWs must maintain relationships with the Ryan White ADAP Network (RWAN).
Target Population (age, gender, geographic, race, ethnicity, etc.):	People living with HIV in the Houston HDSA in need of medications through the Texas HIV Medication Program.
Services to be Provided:	Services include but are not limited to completion of ADAP applications/six-month attestations/recertifications, gathering of supporting documentation for ADAP applications/six-month attestations/recertifications, submission of ADAP applications/six-month attestations/recertifications, and interactions with clients as part of the ADAP application process.
Service Unit Definition(s) **(TRG Only)**:	One unit of service is defined as 15 minutes of direct client services or coordination of application process on behalf of client.
Financial Eligibility:	Income at or below 300% of Federal Poverty Guidelines
Client Eligibility:	People living with HIV in the Houston HDSA
Agency Requirements **(TRG Only)**:	Agency must be funded for Outpatient Ambulatory Medical Care bundled service category under Ryan White Part A/B/DSHS SS.
Staff Requirements:	Not Applicable.
Special Requirements **(TRG Only)**:	The agency must comply with **the DSHS Referral to Healthcare Standards of Care** and **the Houston HSDA Referral for Health Care and Support Services Standards of Care**. The agency must have policies and procedures in place that comply with the standards ***prior*** to delivery of the service.

FY 2021 RWPC "How to Best Meet the Need" Decision Process

Step in Process: **Council**		Date: **06/11/2020**
Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **Steering Committee**		Date: **06/04/2020**
Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **Quality Improvement Committee**		Date: **05/19/2020**
Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **HTBMTN Workgroup #1**	Date: **04/21/2020**
Recommendations:	Financial Eligibility:
1.	
2.	
3.	

RYAN WHITE PART B/DSHS STATE SERVICES
2021 HOUSTON HSDA SERVICE-SPECIFIC STANDARDS OF CARE
REFERRAL FOR HEALTH CARE AND SUPPORT SERVICES
ADAP ENROLLMENT WORKERS

Definition:
Referral for Health Care and Support Services directs a client to needed core medical or support services in person or through telephone, written, or other type of communication. This service may include referrals to assist eligible clients to obtain access to other public or private programs for which they may be eligible (e.g., Medicaid, Medicare Part D, State Pharmacy Assistance Programs, Pharmaceutical Manufacturer's Patient Assistance Programs, and other state or local health care and supportive services, or health insurance Marketplace plans).

#	STANDARD	MEASURE
9.0 Service-Specific Requirements		
9.1	Scope of Services Referral for Health Care and Support Services includes benefits/entitlement counseling and referral to health care services to assist eligible clients to obtain access to other public and private programs for which they may be eligible. *AEW Benefits Counseling*: Services should facilitate a client's access to public/private health and disability benefits and programs. This service category works to maximize public funding by assisting clients in identifying all available health and disability benefits supported by funding streams other than RWHAP Part B and/or State Services funds. Clients should be educated about and assisted with accessing and securing all available public and private benefits and entitlement programs. *Health Care Services:* Clients should be provided assistance in accessing health insurance or Marketplace plans to assist with engagement in the health care system and HIV Continuum of Care, including medication payment plans or programs. Services focus on assisting client's entry into and movement through the care service delivery network such that RWHAP and/or State Services funds are payer of last resort.	• Program's Policies and Procedures indicate compliance with expected Scope of Services. • Documentation of provision of services compliant with Scope of Services present in client files.

#	STANDARD	MEASURE
9.2	<u>Provision of Services</u> Staff will educate clients about available benefit programs, assess eligibility, assist with applications, provide advocacy with appeals and denials, assist with re-certifications and provide advocacy in other areas relevant to maintaining benefits/resources. ADAP Enrollment Workers (AEW) will meet with new potential and established ADAP enrollees to: 1. Explain ADAP program benefits and requirements 2. Assist clients and or staff with the submission of complete, accurate ADAP applications 3. Ensure there is no lapse in ADAP eligibility and loss of benefits, and 4. AEW will maintain relationships through the Ryan White ADAP Network (RWAN).	
9.3	<u>Staff Qualifications</u> All personnel providing care shall have (or receive training) in the following minimum qualifications: • Ability to work with diverse populations in a non-judgmental way • Working with Persons Living With HIV/AIDS or other chronic health conditions; • Ability to (demonstrate) or learn health care insurance literacy, (Third Party Insurance and Affordable Care Act (ACA) Marketplace plans). • Ability to perform intake/eligibility, referral/ linkage and/or basic assessments of client needs preferred. ➢ Data Entry Quickly establish rapport in respectable manner consistent with the health literacy, preferred language, and culture of prospective client.	• Personnel Qualification on file • Documentation of orientation of file
9.4	<u>Staff Education</u> • Education to be defined locally, but must have at minimum a high school degree or equivalency	• Documentation of education and/ or certification located in personnel file.

#	STANDARD	MEASURE
9.5	Staff Training Requirement: • THMP Training Modules within 30 days of hire • Complete the DSHS ADAP Enrollment Worker (AEW) Regional update at earliest published date after hire • DSHS ARIES Document Upload Training (to include TRG upload observation module), completed no later than (45) days after completing ARIES certificate process • Data Security and Confidentiality Training • Complete all training required of Agency new hires, including any training required by DSHS HIV Care	• Materials for staff training and continuing education are on file • Staff interviews indicate compliance
9.6	AEW Placement AIDS Drug Assistance Program (ADAP) Enrollment Workers will be co-located at Ryan-White Part A funded primary care providers to ensure the efficient and accurate submission of ADAP applications to the Texas HIV Medication Program (THMP).	
9.7	Initial Provision of Client Education The initial education to clients regarding the THMP process should include, but not limited to: • Discussion of confidentiality, specific to the THMP process including that THMP regards all information in the application as confidential and the information cannot be released, except as allowed by law or as specifically designated by the client. • Applicants should realize that their physician and pharmacist would also be aware of their diagnosis. • Discussion outlining that approved medication assistance through THMP may require a $5.00 co-payment fee per prescription to the participating pharmacy for each month's supply at the time the drug is dispensed and the availability of financial assistance for the dispensing fee. • Discussion outlining the recertification process, specific to THMP eligibility, including birth month recertification, half-birth month attestation and consequences of lapse.	• Documented evidence of education provided on other public and/or private benefit programs in the primary client record.

9.8	<u>Benefits Counseling</u> Activities should be client-centered facilitating access to and maintenance of health and disability benefits and services. It is the primary responsibility of staff to ensure clients are receiving all needed public and/or private benefits and/or resources for which they are eligible. Staff will explore the following as possible options for clients, as appropriate: • AIDS Drug Assistance Program (ADAP) • Health Insurance Plans/Payment Options (CARE/HIPP, COBRA, OBRA, Health Insurance Assistance (HIA), Medicaid, Medicare, Private, ACA/ Marketplace) • SNAP • Pharmaceutical Patient Assistance Programs (PAPS) • Social Security Programs (SSI, SSDI, SDI) • Temporary Aid to Needy Families (TANF) • Veteran's Administration Benefits (VA) • Women, Infants and Children (WIC) • Other public/private benefits programs • Other professional services Staff will assist eligible clients with completion of benefits application(s) as appropriate within (14) business days of the eligibility determination date. Conduct a follow-up within 90 days of completed application to determine if additional and/or ongoing needs are present.	• Documented evidence of other public and/or private benefit applications completed as appropriate within (14) business days of the eligibility determination date in the primary client record. • Eligible clients with documented evidence of the follow-up and result(s) to a completed benefit application in the primary client record. • Percentage of clients with documented evidence of education provided on other public and/or private benefit programs in the primary client record.

9.9	<u>Health Care Services</u> Clients should be provided assistance in accessing health insurance or Marketplace plans to assist with engagement in the health care system and HIV Continuum of Care, including medication payment plans or programs. • Eligible clients will be referred to Health Insurance Premium and Cost-Sharing Assistance (HIA) to assist clients in accessing health insurance or Marketplace plans within one (1) week of the referral for health care and support services intake. Eligible clients should be referred to other core services (outside of a medical, MCM, or NMCM appointment), as applicable to the client's needs, with education provided to the client on how to access these services. • Eligible clients are referred to additional support services (outside of a medical, MCM, NMCM appointment), as applicable to the client's needs, with education provided to the client on how to access these services. Staff will follow-up within (10) business days of an applicable referral provided to HIA, any core or support service to ensure the client accessed the service(s).	• Documented evidence of assistance provided to access health insurance or Marketplace plans in the primary client record. • Clients who received a referral for other core services who have documented evidence of the education provided to the client on how to access these services in the primary client record. • Clients who received a referral for other support services who have documented evidence of the education provided to the client on how to access these services in the primary client record. • Clients with documented evidence of referrals provided for HIA assistance that had follow-up documentation within 10 business days of the referral in the primary client record. • Clients with documented evidence of referrals provided to any core services that had follow-up documentation within 10 business days of the referral in the primary client record. • Clients with documented evidence of referrals provided to any support services that had follow-up documentation within 10 business days of the referral in the primary client record.
	<u>THMP Intake Process</u> Staff are expected to meet with new/potential clients to complete a comprehensive THMP intake including explanation of program benefits and requirements. The intake will also include the determination of client eligibility for the ADAP program in accordance with the THMP eligibility policies including Modified Adjusted Gross Income (MAGI). Staff should identify and screen clients for third party payer and potential abuse Staff should obtain, maintain, and submit the required documentation for client application including residency, income, and the THMP Medical Certification Form (MCF).	• Documented evidence of THMP education provided to new/potential clients in the primary client record. • Documentation of acquisition of all required THMP application documentation (including proof of residency, income and MCF)

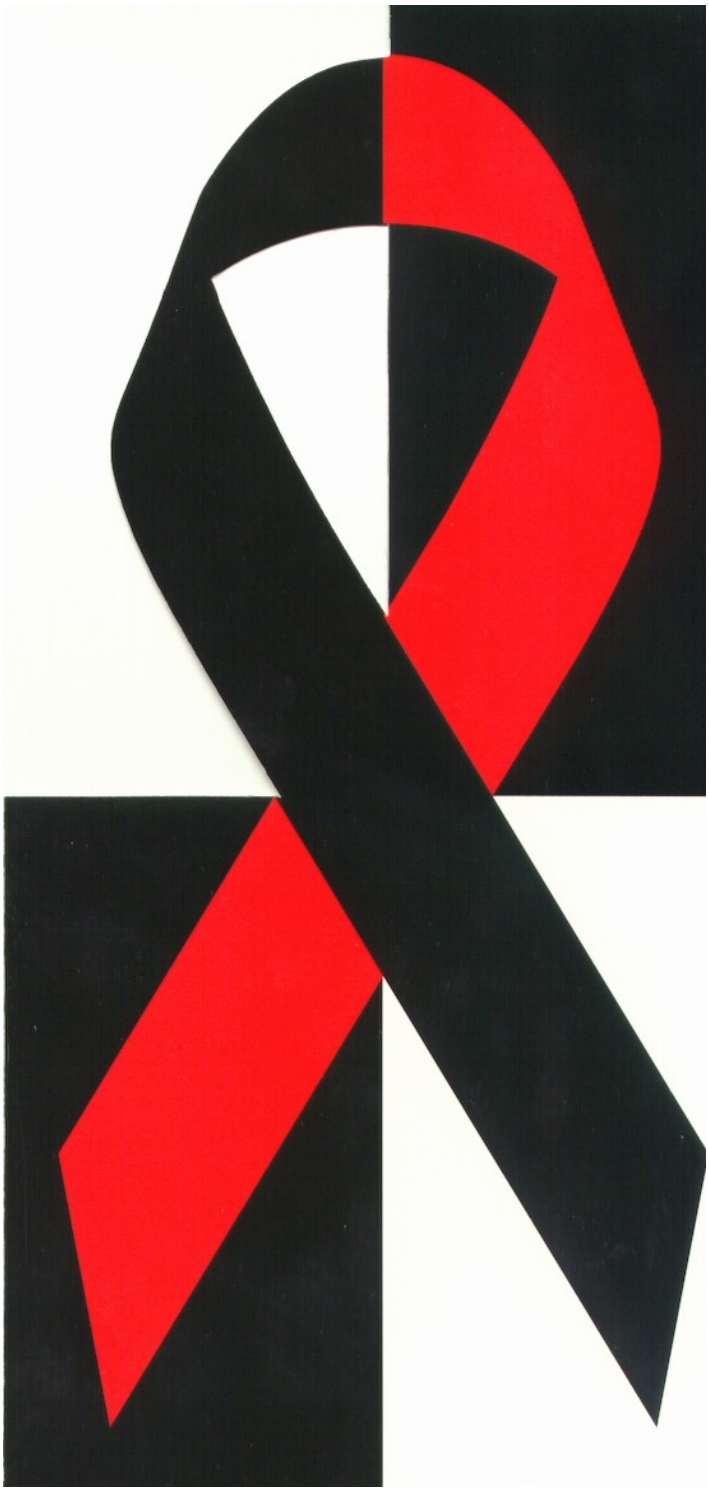
9.10	<u>Benefits Continuation Process (ADAP)</u> ADAP Enrollment Workers are expected to meet with new/potential and established ADAP enrollees; explain ADAP program benefits and requirements; and assist clients and or staff with the submission of complete, accurate ADAP applications. Birth Month/Recertification • Staff should conduct annual recertifications for enrolled clients in accordance with THMP policies. Recertification should include completion of the ADAP application, obtaining and verifying all eligibility documentation and timely submission to THMP for approval. • Recertification process should include screening clients for third party payer to avoid potential abuse. • Complete ADAP application includes proof of residency, proof of income, and the THMP Medical Certification Form (MCF). • Staff must ensure Birth Month/Recertifications are submitted by the last day of client's birth month to ensure no lapse in program benefits. • Proactively contact ADAP enrollees 60-90 days prior to the enrollee's recertification deadline to ensure all necessary documentation is collected and accurate to complete the recertification process on or before the deadline. Half-Birth Month/ 6-month Self Attestation • Staff should conduct a 6-month half-birth month/self-attestation for all enrolled clients in accordance with THMP policies. Staff will obtain and submit the client's self-attestation with any applicable updated eligibility documentation. • Proactively contact ADAP enrollees 60-90 days prior to the enrollee's attestation deadline to ensure all necessary documentation is collected and accurate to complete the attestation on or before the deadline. • Half-birth/6-month self-attestations must be submitted by the last day of the client's half-birth month to ensure no lapse in program benefits.	• Documentation of lapse benefits due to non-completion of timely recertification/attestation in the client's record.

#	STANDARD	MEASURE
9.11	<u>ARIES Document Upload Process</u> ARIES Document Upload is the uniform practice for submission and approval of ADAP applications (with supportive documentation). This process ensures accurate submission and timely approvals, thereby expediting the ADAP application process. • Completed ADAP Applications (with supportive documentation) must be uploaded into ARIES for THMP consideration. All uploaded applications must be reviewed and certified as "complete" prior to upload. • ADAP applications should be uploaded according to the THMP established guidelines and applicable guidelines as given by AA. • To ensure timely access to medications, all completed ADAP applications must be uploaded into ARIES within one (1) business day of completion • To ensure receipt of the completed ADAP application by THMP, notification must be sent according to THMP guidelines within three (3) business days of the completed upload to ARIES. • Upload option is only available for ADAP applications; other benefits applications should be maintained separately and submitted according to instruction. Houston Only: Medication Certification forms for changes to medication should be faxed to THMP for approval.	• Documentation of upload receipt by THMP within (3) business days of application completion.
9.12	<u>Tracking ADAP Applications</u> Track the status of all pending applications and promptly follow-up with applicants regarding missing documentation or other needed information to ensure completed applications are submitted as quickly as feasible Maintain communication with designated THMP staff to quickly resolve any missing or questioned application information or documentation to ensure any issues affecting pending applications are resolved as quickly as possible	
9.13	<u>Case Closure Summary</u> Clients who are no longer in need of assistance through Referral for Health Care and Support Services must have their cases closed with a case closure summary narrative documented in the client primary record. The case closure summary must include a brief synapsis of all services provided and the result of those services documented as 'completed' and/or 'not completed.' A supervisor must sign the case closure summary.	• Clients who are no longer in need of assistance through Referral for Health Care and Support Services that have a documented case closure summary in the primary client record.

References

HRSA/HAB Division of Metropolitan HIV/AIDS Programs Program Monitoring Standards – Part A April 2013. p. 43-44.

HRSA/HAB Division of State HIV/AIDS Programs National Monitoring Standards – Program Part B April 2013. p. 42-43.
Virginia Department of Health, Division of Disease Prevention, HIV Care Services Referral for Health Care/Supportive Services (PDF)
HRSA/HAB Ryan White & Global HIV/AIDS Programs, Program & Grants Management, Policy Notices and Program Letters, Policy Clarification Notice 16-02
DSHS Policy 591.000, Section 5.3 regarding Transitional Social Service linkage.



REFERRAL FOR HEALTH CARE SERVICES- ADAP
2019 CHART REVIEW

PREFACE

DSHS Monitoring Requirements

The Texas Department of State Health Services (DSHS) contracts with The Houston Regional HIV/AIDS Resource Group, Inc. (TRG) to ensure that Ryan White Part B and State of Texas HIV Services funding is utilized to provide in accordance to negotiated Priorities and Allocations for the designated Health Service Delivery Area (HSDA). In Houston, the HDSA is a ten-county area including the following counties: Austin, Chambers, Colorado, Fort Bend, Harris, Liberty, Montgomery, Walker, Waller, and Wharton. As part of its General Provisions for Grant Agreements, DSHS also requires that TRG ensures that all Subgrantee's comply with statutes and rules, perform client financial assessments, and delivery service in a manner consistent with established protocols and standards.

As part of those requirements, TRG is required to perform annual quality compliance reviews on all Subgrantee's. Quality Compliance Reviews focus on issues of administrative, clinical, data management, fiscal, programmatic and quality management nature. Administrative review examines Subgrantee operating systems including, but not limited to, non-discrimination, personnel management and Board of Directors. Clinical review includes review of clinical service provision in the framework of established protocols, procedures, standards and guidelines. Data management review examines the Subgrantee's collection of required data elements, service encounter data, and supporting documentation. Fiscal review examines the documentation to support billed units as well as the Subgrantee's fiscal management and control systems. Programmatic review examines non-clinical service provision in the framework of established protocols, procedures, standards and guidelines. Quality management review ensures that each Subgrantee has systems in place to address the mandate for a continuous quality management program.

QM Component of Monitoring

As a result of quality compliance reviews, the Subgrantee receives a list of findings that must be address. The Subgrantee is required to submit an improvement plan to bring the area of the finding into compliance. This plan is monitored as part of the Subgrantee's overall quality management monitoring. Additional follow-up reviews may occur (depending on the nature of the finding) to ensure that the improvement plan is being effectively implemented.

Scope of Funding

TRG contracts with five Subgrantees to provide referral for health care services in the Houston HSDA.

INTRODUCTION

Description of Service

Referral for Health Care and Support Services directs a client to needed core medical or support services in person or through telephone, written, or other type of communication. This service may include referrals to assist eligible clients to obtain access to other public or private programs for which they may be eligible (e.g., Medicaid, Medicare Part D, State Pharmacy Assistance Programs, Pharmaceutical Manufacturer's Patient Assistance Programs, and other state or local health care and supportive services, or health insurance Marketplace plans).

Benefits Counseling: Services should facilitate a client's access to public/private health and disability benefits and programs. This service category works to maximize public funding by assisting clients in identifying all available health and disability benefits supported by funding streams other than RWHAP Part B and/or State Services funds.

Health Care Services: Clients should be provided assistance in accessing health insurance or Marketplace plans to assist with engagement in the health care system and HIV Continuum of Care, including medication payment plans or programs. Services focus on assisting client's entry into and movement through the care service delivery network such that RWHAP and/or State Services funds are payer of last resort.

Tool Development

The DSHS Referral for Healthcare Review tool is based upon the established local and DSHS standards of care.

Chart Review Process

All charts were reviewed by Masters-level Social Worker experienced in programmatic requirements and guidelines for the THMP program. The collected data for each site was recorded directly into a preformatted computerized spreadsheet. The data collected during this process is to be used for service improvement.

File Sample Selection Process

File sample was selected from a provider population of 6,098 clients who accessed oral healthcare services in the measurement year. The records of 200 clients were reviewed, representing 3.3% of the unduplicated population. The demographic makeup of the provider was used as a key to file sample pull.

Demographics- Referral for Healthcare Services-ADAP

2019 Annual		
Total UDC: 6098		
Age	**Number of Clients**	**% of Total**
Client's age as of the end of the reporting period		
Less than 2 years		0.00%
02 - 12 years		0.00%
13 - 24 years	319	5.23%
25 - 44 years	3355	55.02%
45 - 64 years	2260	37.06%
65 years or older	164	2.69%
Unknown	0	0.00%
	6098	100%
Gender	**Number of Clients**	**% of Total**
"Other" and "Refused" are counted as "Unknown"		
Female	1433	23.50%
Male	4577	75.06%
Transgender FTM	1	0.02%
Transgender MTF	86	1.41%
Unknown	1	0.02%
	6098	100%
Race/Ethnicity	**Number of Clients**	**% of Total**
Includes Multi-Racial Clients		
White	741	12.15%
Black	2758	45.23%
Hispanic	2468	40.47%
Asian	90	1.48%
Hawaiian/Pacific Islander	3	0.05%
Indian/Alaskan Native	10	0.16%
Unknown	28	0.46%
	6098	100%

From 01/01/19 - 12/31/19

2020 Annual		
Total UDC:		
Age	**Number of Clients**	**% of Total**
Client's age as of the end of the reporting period		
Less than 2 years		
02 - 12 years		
13 - 24 years		
25 - 44 years		
45 - 64 years		
65 years or older		
Unknown		
		100%
Gender	**Number of Clients**	**% of Total**
"Other" and "Refused" are counted as "Unknown"		
Female		
Male		
Transgender FTM		
Transgender MTF		
Unknown		
		100%
Race/Ethnicity	**Number of Clients**	**% of Total**
Includes Multi-Racial Clients		
White		
Black		
Hispanic		
Asian		
Hawaiian/Pacific Islander		
Indian/Alaskan Native		
Multi/Unknown		
		100%

From 01/01/20 - 12/31/20

RESULTS OF REVIEW- BASELINE YEAR

Benefits Counseling

Documented evidence of education provided on public and/or private benefit programs in the primary client record.

	Yes	No	N/A
Number of client records that showed evidence of the measure	108	92	-
Number of client records that were reviewed.	200	200	-
Rate	**54%**	**46%**	**-**

Documented evidence of public and/or private benefit applications completed as appropriate within (14) business days of the eligibility determination date in the primary client record.

	Yes	No	N/A
Number of client records that showed evidence of the measure	117	83	-
Number of client records that were reviewed.	200	200	-
Rate	**58.5%**	**41.5%**	**-**

Health Care Services

Documented evidence of assistance provided to access health insurance or Marketplace plans in the primary client record.

	Yes	No	N/A
Number of client records that showed evidence of the measure	118	82	-
Number of client records that were reviewed.	200	200	-
Rate	**59%**	**41%**	**-**

Documented evidence of a referral for other core or support services who have documented evidence of the education provided to the client on how to access these services in the primary client record.

	Yes	No	N/A
Number of client records that showed evidence of the measure	9	83	108
Number of client records that were reviewed.	92	92	200
Rate	**10%**	**90%**	**54%**

Documented evidence of referrals provided to any core or support services that had follow-up documentation within (10) business days of the referral in the primary client record.

	Yes	No	N/A
Number of client records that showed evidence of the measure	9	83	108
Number of client records that were reviewed.	92	92	200
Rate	**10%**	**90%**	**54%**

ARIES Documentation

Documented evidence of ADAP application being uploaded onto ARIES within one (1) business day of completion.

	Yes	No	N/A
Number of client records that showed evidence of the measure	95	62	43
Number of client records that were reviewed.	157	157	200
Rate	**60.5%**	**39.5%**	**21.5%**

Documented evidence of THMP being notified within three (3) business days of completed ADAP application upload into ARIES.

	Yes	No	N/A
Number of client records that showed evidence of the measure	104	53	43
Number of client records that were reviewed.	157	157	200
Rate	**66.2%**	**33.8%**	**21.5%**

Documented evidence of completed secondary review of ADAP application indicated before application submission to THMP.

	Yes	No	N/A
Number of client records that showed evidence of the measure	115	42	43
Number of client records that were reviewed.	157	157	200
Rate	**73.2%**	**26.8%**	**21.5%**

Case Closure Summary

Documentation of case closure summary in client primary client record.

	Yes	No	N/A
Number of client records that showed evidence of the measure	0	84	116
Number of client records that were reviewed.	84	84	200
Rate	**0%**	**100%**	**58%**

CONCLUSIONS

The ADAP Enrollment Worker (AEW) program funded under the Referral for Healthcare service category is a new program. In 2019, there were 6098 unduplicated clients served, with 848 new clients. AEW workers provided assistance with 4035 applications, 1797 attestations, and 2446 recertifications during the calendar year. They also entered 18,928 service encounters! Review year 2019 was a baseline year to assess all Houston HSDA programs with a revised review tool. Six (6) of the ten (10) indicators reviewed were above the established threshold of 50%, however follow-up needs to occur with four (4) indicators below the threshold. Due to this program(s) being newly established, documentation of activities was inconsistent. Technical assistance was provided and outcomes for 2020 review should reflect training on documenting service activities.

Non-adherence to HIV treatment for cost-saving reasons reported by 8% in American study

Roger Pebody
Published: 27 March 2019

Much of the excessive cost of prescription drugs in the United States falls on patients, and national surveillance data has now found that this has a real impact on HIV treatment outcomes. A study presented at the Conference on Retroviruses and Opportunistic Infections (CROI 2019) earlier this month found that 13% of people with diagnosed HIV reported at least one cost-saving strategy, including 8% who did not always adhere to their treatment to cut costs. Rates of viral suppression and engagement in care were lower in those reporting non-adherence for economic reasons.

Dr Linda Beer of the Centers of Disease Control and Prevention (CDC) presented the study. Data came from the Medical Monitoring Project, which collects clinical and behavioural information from individuals carefully sampled to be representative of the range of people diagnosed with HIV in the United States. Interview data and medical records were available for 3650 people taking prescription drugs in 2015-2016.

Based on self-report:

- 8% had asked their doctor for a lower-cost medication to save money
- 1% had bought prescription drugs from another country to save money
- 2% had used alternative therapies to save money
- 4% had skipped medication doses to save money
- 4% had taken less medicine to save money
- 6% had delayed filling a prescription to save money

Looking specifically at the last three of those strategies, they were more common in individuals with private insurance (prevalence ratio 1.76, p <0.01), reflecting the problem of incomplete coverage and co-payments associated with private insurance. As might be expected, they were more common in individuals who had sought, but not received, help from the Ryan White AIDS Drug Assistance Program (prevalence ratio 3.88, p <0.01). They were also more common in individuals who had a disability (prevalence ratio 1.91, p <0.01).

Individuals reporting these cost-saving non-adherence strategies were significantly less likely to be virally suppressed (prevalence ratio 0.83, p <0.01) or engaged in care (prevalence ratio 0.88, p <0.01).

They were also more likely to have visited an emergency room or been hospitalised more than once.

Reference

Beer L et al. *Nonadherence due to prescription drug costs among U.S. adults with HIV, 2015-2016.* Conference on Retroviruses and Opportunistic Infections, Seattle, abstract 1078, 2019.

View the abstract and poster on the conference website.