



Barriers to Rapid Enrollment and ART Initiation Among US HIV Care Facilities

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Abstract

Background: Rapid linkage to HIV care and antiretroviral therapy (ART) initiation is now the standard of care for treating people with HIV. Understanding and intervening on barriers to rapid enrollment and ART initiation are needed to meet the goals of the Ending the HIV Epidemic in the US initiative.

Methods: We analyzed 2021 data from the Medical Monitoring Project on characteristics of 455 facilities providing care to a national probability sample of US People with HIV.

Results: Overall, only 19.9% (95% CI: 16.0% to 23.9%) of HIV facilities could routinely offer a first appointment in <1 business day (rapid enrollment). The most commonly reported barriers to rapid enrollment were insufficient provider capacity (56%), patient preference (50%), and patients lacking required documents (19%). The most commonly reported documents required for enrollment were positive HIV antibody or detectable viral load (52%), government-issued identification (36%), proof of residence (24%), and proof of income (22%). RWHAP-funded facilities more frequently required these documents than non-RWHAP-funded facilities. Most facilities (73%) were routinely able to obtain a 30-day supply of ART during the first HIV care provider visit (rapid ART initiation). The most commonly reported barriers to rapid ART included unavailable test results (56%), delays in getting medication paid for (49%), unavailable starter packs (36%), inability to afford copayment (31%), and patient preference (29%).

Conclusion: Structural, provider-related, or patient-level barriers may delay rapid clinic enrollment or ART initiation. HIV care programs can benefit from removing barriers to care, easing requirements for clinical enrollment and ART prescriptions, and improving patient readiness.

Keywords

rapid start; clinic enrollment; HIV; antiretroviral therapy

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The findings and conclusions in this report are those of the authors and do not necessarily represent the official position of the Centers for Disease Control and Prevention.

BACKGROUND

To achieve the Ending the HIV Epidemic in the US (EHE) initiative goal of reducing new HIV infections in the United States by 90% by 2030, people with HIV (PWH) need to have a diagnosis as early as possible and be treated with antiretroviral therapy (ART) rapidly and effectively to have sustained viral suppression.^{1,2} Rapid initiation of ART, ideally on the same day as HIV diagnosis or return to care, offers immediate access to HIV medical care.^{3–6} Rapid ART reduces the time to viral suppression and improves morbidity and mortality in PWH.^{3–5} Delays in initiating ART are associated with subsequent lower rates of viral suppression and retention in care, and with earlier development of first AIDS event.⁵

The Ryan White HIV/AIDS Program (RWHAP) is a federally funded program providing a comprehensive system of HIV primary medical care, essential support services, and medications for low-income PWH who are uninsured and underserved.⁷ For the past 30 years, the RWHAP has had an important role in the national public health response to HIV—more than half of adults with diagnosed HIV rely on the program.^{8,9} However, RWHAP may have specific eligibility requirements and considerations that can affect clinic enrollment and ART initiation processes.

Rapid linkage to HIV care and ART initiation is now the standard of care for treating PWH and is a key strategy of EHE.^{1–6} Structural, provider-related, and patient-level barriers may impede rapid clinic enrollment and initiation of ART. Understanding and addressing these barriers is essential to meet the goals of EHE. In this study, we examined the availability of, and barriers to, rapid enrollment and ART initiation among HIV care facilities attended by a representative sample of PWH in the United States, overall and by RWHAP funding status of facilities.

METHODS

The Medical Monitoring Project (MMP) is a two-stage complex sample survey that produces nationally representative estimates of US adults with diagnosed HIV.¹⁰ We analyzed MMP Facility Survey data collected 07/2021–11/2021 on characteristics of 455 facilities providing care to MMP 2019 cycle respondents (response rate, 45%).¹¹ Participating facility characteristics and survey administration methods have been described elsewhere.¹¹ Data were weighted based on weighting classes informed by a nonresponse analysis to reduce nonresponse bias in facility-level estimates. Facility data on the number of business days needed to offer an appointment to patients who are new to the facility, availability of and barriers to rapid enrollment and ART initiation, and facility characteristics, including RWHAP funding, were collected. Time to enrollment was defined as the number of business days from an initial request by patients who are new to the facility until an appointment with an HIV care provider is routinely offered. Rapid enrollment was defined as ≤ 1 business day. Rapid ART initiation was defined as routinely being able to provide a 30-day supply of ART at the first HIV care provider visit. The term provider refers to a health care professional with prescribing privileges authorized by the state. See Appendix 1 for relevant survey questions, Supplemental Digital Content, <http://links.lww.com/QAI/C508>. We generated weighted percentages with 95% confidence

intervals (CI) of facility characteristics. We assessed significant ($P < 0.05$) differences in characteristics of facilities by RWHAP funding status using Rao–Scott χ^2 tests.

RESULTS

Rapid Enrollment and ART Initiation

Overall, 19.9% (95% CI: 16.0% to 23.9%) of HIV facilities could routinely offer a first appointment in ≤ 1 business day (rapid enrollment; data not displayed in tables). However, a larger proportion of HIV facilities could routinely offer a first appointment in 2–9 business days (48.4%; 95% CI: 43.4% to 53.4%). Nearly a third of facilities (31.6%; 95% CI: 27.0% to 36.3%) routinely offered new patients an appointment in ≥ 10 business days. The median business days to offer a first appointment was 4.8 (95% CI: 4.0% to 5.6%) days. Most facilities (73%) reported that all patients were routinely able to obtain a 30-day supply of ART on the day of the first HIV care provider visit (rapid ART initiation).

Barriers to Rapid Enrollment

The most commonly reported barriers to rapid enrollment were insufficient provider capacity (56%), patient preference (50%), and patients lacking required documents (19%) (Table 1). For facilities that routinely offered an appointment within ≤ 1 business day (rapid enrollment), the most common barriers cited were patient preference (65%), insufficient provider capacity (24%), and patients lacking documents for facility enrollment (17%). For facilities offering appointments within 2–9 business days, the most common barriers cited were patient preference (56%), insufficient provider capacity (52%), and patients lacking documents for facility enrollment (20%). For facilities offering appointments in 10 or more business days, the most common barriers cited were insufficient provider capacity (77%), patient preference (37%), and patients lacking documents for facility enrollment (18%).

Facilities reported requiring the following documents for scheduling the first appointment: positive HIV antibody or detectable viral load (52%), government-issued identification (36%), proof of residence (24%), proof of income (22%), a CD4 lymphocyte count result (19%), and the result of a test for tuberculosis (6%) (Table 1). Overall, 32% of facilities did not require any of these documents, including 44%, 33%, and 23% of facilities routinely offering a first appointment within ≤ 1 , 2–9, and ≥ 10 business days, respectively.

Barriers to Rapid ART Initiation

Overall, the most commonly reported barriers to obtaining a 30-day supply of ART at the first HIV care provider visit included unavailable test results (56%), delays in getting medication paid for (49%), unavailable starter packs (36%), patient cannot afford copayment (31%), and patient preference (29%) (Table 2).

Other administrative barriers to obtaining a 30-day supply of ART at the first HIV care provider visit included provider not committed to rapid ART (12%), lack of standardized protocol for clinicians to follow (10%), lack of trained staff to submit patient assistance program applications (9%), and facility administration is not committed to rapid ART (4%). Approximately 77.8% (95% CI: 71.5%–84.2%) of facilities with an on-site pharmacy were

able to offer a 30-day supply of ART to all patients at the first visit, compared with 68.8% (95% CI: 61.9%–75.7%) without an on-site pharmacy (data not displayed in tables).

Differences by RWHAP Funding Status

In this analysis, 43% of facilities reported receiving RWHAP funding (Table 1). There were no significant differences in the prevalence of being able to provide rapid enrollment and ART initiation between RWHAP-funded and nonfunded facilities (data not displayed in tables). However, the prevalence of barriers to rapid enrollment differed by RWHAP funding status. Higher percentages of RWHAP-funded facilities reported patient preference (59% vs. 44%, $P = 0.003$), and lower percentages reported insufficient provider capacity (48% vs. 62%, $P = 0.005$) as barriers to rapid enrollment. A higher percentage of RWHAP-funded facilities required proof of income (42% vs. 6%), proof of residence (43% vs. 9%), and government-issued ID (42% vs 31%) for the first appointment (all P -values < 0.05). A higher percentage of non-RWHAP-funded clinics did not require any of these documents (41% vs. 21%, $P < 0.0001$). A higher percentage of non-RWHAP-funded facilities reported patients unable to afford copayments (38% vs. 17%; $P < 0.05$) as a barrier to providing 30 days of ART at the first visit.

DISCUSSION

Among HIV care facilities providing care to a nationally representative sample of US PWH, we documented the availability of and barriers to rapid enrollment and ART initiation, which are key strategies of Ending the HIV Epidemic in the United States. Only 1 in 5 facilities could routinely enroll patients with a first appointment in ≤ 1 day. However, 73% of facilities reported all patients were routinely able to obtain a 30-day supply of ART on the day of their first HIV care provider visit. Structural, provider-related, or patient-level barriers may delay rapid enrollment or ART initiation. HIV care programs can benefit from removing barriers to care, easing requirements for clinical enrollment and ART prescriptions, and improving patient readiness.

Although rapid clinic enrollment is a crucial component of efforts to reduce the time from HIV diagnosis to viral suppression, only 20% of HIV facilities were able to provide rapid enrollment. Insufficient provider capacity was a major barrier to rapid enrollment. Studies have highlighted gaps between the current HIV workforce and the demand for HIV services, along with high dissatisfaction among HIV care providers regarding remuneration and administrative tasks.^{11–13} To address this HIV workforce shortage, strategies such as establishing a broad base of clinicians serving fewer patients and recruiting/training non-HIV primary care providers have been proposed.¹⁴ In addition, task shifting and care models that prioritize patients with higher medical needs and newly diagnosed individuals are also potential solutions.^{15–17} Likewise, improved care coordination in Federally Qualified Health Centers has shown promise in addressing provider capacity issues.^{11,18}

Many facilities require certain documents, generally related to establishing benefits in order for services to be covered (such as proof of income or residence), before scheduling or offering an appointment for clinic enrollment. Notably, RWHAP-funded facilities mandate more documents for scheduling the first appointment, which may hinder rapid enrollment

and ART initiation. We also found that requiring diagnostic or confirmatory HIV test results could be a barrier to both rapid clinic enrollment and ART initiation. These concerns or policies may stem from past experiences when ART had higher toxicity and testing methods were less precise.^{19,20} To expedite care, successful interventions have involved easing document requirements and expanding eligibility (eg, presumptive RWHAP eligibility) for rapid enrollment.¹⁶ Other streamlining efforts include dedicated open scheduling slots specifically for patients starting ART and not mandating baseline laboratory tests before an appointment or ART initiation.^{6,21}

Our findings show that patient—and, to a lesser extent, provider—concerns about rapid enrollment and ART initiation are prevalent. Patient preference was a frequently reported barrier to both rapid clinic enrollment and ART initiation. Concerns about side effects, mistrust of medications/providers, impact on quality of life, HIV stigma, discrimination, and preference for alternative medicine/self-care are linked to lower ART acceptance in patients already receiving HIV care.^{22–24} Patient–provider communication that reinforces respect, trust, and HIV treatment literacy, along with convenient multipurpose HIV care facilities and personalized treatment plans addressing possible diagnosis denial, are essential for optimizing engagement.^{25,26}

Provider knowledge, attitudes, and beliefs about rapid ART initiation vary. Many providers adhere to “traditional” views of readiness (eg, insufficient time to adjust to an HIV diagnosis), which in turn influences perceived patient willingness to start treatment.^{19,27} Furthermore, provider views on readiness differ based on patient characteristics, potentially leading to disparities if certain groups are not considered ready for treatment.¹⁹ Our data reveal that a minority of facilities report providers (12%) or facility administration (4%) not being fully committed to immediate ART initiation. Other surveys also support this by indicating provider apprehension toward rapid ART initiation because of ART resistance and effectiveness concerns.^{16,28}

To improve perceived readiness among both patients and providers, exploring shared decision-making and providing education for both parties are crucial areas of focus. Patients may not be fully prepared for ART initiation before their first visit date. Since Rapid ART initiation is now the standard of care, clinics, programs, and providers should have personnel available to offer ART promptly while also being attentive to patients’ preferences and needs. Training initiatives, such as those provided by AIDS Education Training Centers and Centers for Disease Control and Prevention’s Capacity Building Assistance programs, have demonstrated some success in increasing the quality of care provided to PWH.^{16,29–31} Enhancing and expanding patient-centered initiatives focused on the benefits of rapid ART initiation, along with increasing provider participation in these efforts, may help improve rapid ART knowledge and beliefs.

Some limitations of this analysis include low facility survey response rate, although we minimized potential bias by weighting the data based on information known for all facilities. Because patients did not complete facility surveys, barriers such as patient readiness were measured from the facility perspective, and some terms that were not defined were subject to interpretation from the facility. Patient-level information, including diagnosis date, was

unavailable for this study, preventing the calculation of key metrics such as the time from diagnosis to the first appointment and ART initiation. In addition, individual outcomes and sociodemographic factors associated with ART receipt and care were not reported here but have been published by the MMP.³² Facilities adapt varying ancillary services to overcome barriers to care. The survey did not measure the implementation of reported practices, nor was the quality of implemented practices assessed. Facility patients' perspectives on the availability of services and their quality may differ from those of facility staff.^{33,34} Finally, social desirability bias in reporting on facility practices might have affected our estimates.

The barriers reported in this analysis are similar to those in prior studies.^{16,19} Future analyses should consider individual-level variables such as housing instability, stigma, and medical mistrust to better understand their impact on rapid enrollment and ART initiation. Structural, provider-related, or patient-level barriers may delay rapid clinic enrollment or ART initiation. To ensure the success of rapid ART programs, health systems must streamline bureaucratic processes, reduce structural barriers, increase the HIV workforce, and improve patient/provider readiness to initiate ART rapidly.

Supplementary Material

Refer to Web version on PubMed Central for supplementary material.

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Barriers to Rapid Enrollment and Documents Required for Scheduling First Appointment at HIV Care Facilities Attended by People With Diagnosed HIV, Overall and by RWHPAP Facility Funding Status and by Number of Business Days to Offering First Appointments—Medical Monitoring Project, United States, 2021

Facilities	Facilities at Which New Patients are Routinely Offered an Appointment With an HIV Care Provider in																		
	All Facilities								RWHAP Funded				RWHAP Nonfunded				Rao Scott χ^2 P		
	N	Weighted Col%	95%CI	N	Weighted Col%	95%CI	N	Weighted Col%	95%CI	N	Weighted Col%	95%CI	N	Weighted Col%	95%CI				
Total (row)	455	-	-	257	43.1	38.4 to 47.7	198	56.9	52.3 to 61.6	-	89	19.9	16.0 to 23.9	217	48.4	43.4 to 53.4	128	31.6	27.0 to 36.3
Barrier Patient preference	217	50.4	45.3 to 55.5	139	58.8	52.1 to 65.4	78	43.8	36.5 to 51.1	0.003	52	64.9	53.5 to 76.4	115	55.9	48.6 to 63.1	49	37.1	28.4 to 45.9
Insufficient provider capacity to see rapid entry patients	223	55.5	50.5 to 60.5	113	47.5	40.8 to 54.2	110	61.8	54.6 to 69.0	0.005	17	24	13.6 to 34.5	105	52	44.8 to 59.3	96	77	69.4 to 84.6
Patients lack documents required for facility enrollment	83	18.6	14.7 to 22.5	52	20	14.8 to 25.3	31	17.4	11.8 to 23.0	0.505	13	17.3	8.2 to 26.4	42	19.5	13.8 to 25.2	26	17.7	10.9 to 24.4
Patients lack documents required for HIV/AIDS program enrollment	69	12.1	9.1 to 15.0	65	24.6	18.9 to 30.2	4	2.2*	0.1 to 4.4*	<0.0001*	8	6.9*,†	(1.8 to 11.9)*,†	39	13.7	9.3 to 18.1	21	12.8	7.2 to 18.4
Facility administration is not committed to rapid enrollment	10	2.6*	1.0 to 4.3*	5	2.4*	0.3 to 4.5*	5	2.8*	0.4 to 5.2*	0.799*	1	1.8*,†	(0.0 to 5.3)*,†	4	2.3*	0.0 to 4.5*	4	2.8*,†	(0.0 to 5.6)*,†
Other staff are not committed to	8	1.6*	0.4 to 2.7*	7	2.9*	0.7 to 5.1	1	0.6*	0.0 to 1.7*	0.087*	1	1.8*,†	0.0 to 5.3)*,†	5	1.8*	0.1 to 3.5*	2	1.2*	0.0 to 2.9)*

		Facilities at Which New Patients are Routinely Offered an Appointment With an HIV Care Provider in																	
		All Facilities				RWHAP Funded				RWHAP Nonfunded				Rao Scott χ^2 P					
		Weighted Col%		95%CI		Weighted Col%		95%CI		Weighted Col%		95%CI							
N	Weighted Col%	95%CI	N	Weighted Col%	95%CI	N	Weighted Col%	95%CI	N	Weighted Col%	95%CI	N	Weighted Col%	95%CI	N	Weighted Col%	95%CI		
rapid enrollment																			
Documents required for scheduling the first appointment with an HIV care provider																			
Proof of income	122	21.8	17.9 to 25.6	110	41.9	35.4 to 48.3	12	6.3	2.8 to 9.7	<0.0001	20	15.8	8.5 to 23.2	69	26.8	20.7 to 32.8	32	19.6	12.9 to 26.3
Proof of residence	129	24.1	20.1 to 28.1	111	43.2	36.6 to 49.7	18	9.4	5.3 to 13.6	<0.0001	22	19.5	11.2 to 27.8	71	28	21.9 to 34.2	34	22.1	14.9 to 29.2
Government-issued identification	164	35.9	31.1 to 40.6	105	42.3	35.8 to 48.8	59	30.9	24.3 to 37.5	0.017	32	33.6	23.2 to 43.9	77	35.6	28.7 to 42.4	51	38.2	29.4 to 47.0
Result of a test for tuberculosis (PPD or IGRA)	28	5.6	3.4 to 7.8	19	6.8	3.5 to 10.0	9	4.7*	1.7 to 7.7*	0.371*	5	4.0*,†	(0.1 to 7.9)*,†	11	5.4*	2.1 to 8.7*	11	7.0*	2.6 to 11.4*
Positive HIV antibody or detectable viral load	247	51.5	46.6 to 56.4	172	67.4	61.2 to 73.6	75	39.3	32.3 to 46.2	<0.0001	40	37.3	26.9 to 47.7	118	49.8	42.6 to 56.9	81	61.8	52.9 to 70.7
CD4 lymphocyte count result	90	19.2	15.3 to 23.0	53	18.9	13.9 to 23.9	37	19.4	13.7 to 25.0	0.902	12	9.9*	4.0 to 15.9*	37	15.9	10.8 to 21.0	36	27.7	19.6 to 35.8
None of the above	134	32.3	27.7 to 37.0	56	21.3	16.0 to 26.6	78	40.8	33.8 to 47.8	<0.0001	36	43.9	32.8 to 55.0	65	33.1	26.3 to 40.0	29	23.4	15.7 to 31.1

Numbers are unweighted, and percentages are weighted.

* Estimates with a coefficient of variation ≥ 0.30 were considered to be unstable and, therefore, should be interpreted with caution; associated statistical testing based on 1 or more unstable estimates should also be interpreted with caution.

† Estimates with an absolute CI width ≥ 30 , estimates with an absolute CI width between 5 and 30, and a relative CI width $>130\%$ should be interpreted with caution.

TABLE 2.

Barriers to Obtaining a 30-Day Supply of Antiretroviral Medication on the Day of the First HIV Care Provider Visit Among HIV Care Facilities Attended by People With Diagnosed HIV, Overall and by RWHAP Funding Status—Medical Monitoring Project, United States, 2021

Barriers	All Facilities			RWHAP Funded			RWHAP Nonfunded			Rao Scott χ^2 p
	N	Weighted Col%	95% CI	N	Col%	95% CI	N	Col%	95% CI	
Patient preference	41	28.5	20.7 to 36.4	18	23.5	13.2 to 33.8	23	31.1	20.5 to 41.7	0.313
Prescription not given because test results are not available	81	55.6	46.9 to 64.3	43	63.9	51.7 to 76.0	38	51.4	39.9 to 62.8	0.143
Delay getting medication paid for	65	48.7	40.0 to 57.4	25	38.3	25.9 to 50.6	40	54.1	42.7 to 65.5	0.069
Antiretroviral starter packs are not available to be given to patients	52	35.9	27.6 to 44.2	25	34.8	22.9 to 46.7	27	36.5	25.5 to 47.5	0.838
Lack of trained staff to submit patient assistance program applications for free antiretrovirals	10	8.6	3.5 to 13.7	1	1.6*	0.0 to 4.8*	9	12.2*	4.7 to 19.6*	0.02*
Patient cannot afford copayment	41	30.7	22.6 to 38.8	13	16.8	7.8 to 25.8	28	37.8	26.7 to 48.9	0.005
Providers are not committed to immediate antiretroviral initiation	16	11.8	6.1 to 17.4	6	8.4*,†	(1.7 to 15.0)*,†	10	13.5	5.7 to 21.3	0.328*,†
Facility administration is not committed to immediate antiretroviral initiation	7	4.4	1.0 to 7.8	4	5.1*,†	(0.0 to 10.2)*,†	3	4.1*,†	(0.0 to 8.6)*,†	0.767*,†
Lack of a standardized protocol for all clinicians to follow	14	10.2	4.9 to 15.5	6	9.0*,†	(1.8 to 16.3)*,†	8	10.8*,†	(3.7 to 17.9)*,†	0.729*,†

Numbers are unweighted, and percentages are weighted.

* Estimates with a coefficient of variation ≥ 0.30 were considered to be unstable and, therefore, should be interpreted with caution; associated statistical testing based on 1 or more unstable estimates should also be interpreted with caution.

† Estimates with an absolute CI width ≥ 30 , estimates with an absolute CI width between 5 and 30, and a relative CI width .130% should be interpreted with caution.