**Assessing Medication Access Barriers in Patients Living with HIV**  
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**Practice Site**: University of Virginia Health – Ryan White Clinic  
  
**Background:** The management of HIV requires daily adherence to antiretroviral therapy (ART). Enrolling in access programs is complicated, with many barriers to getting ART.  At the University of Virginia Health, patients can enroll with Medicaid, Medicare, private insurance, or the Virginia Medication Assistance Program (VAMAP) to assist with prescription coverage. However, patients still experience unpredictable medication access issues. In 2016, the UVA Ryan White Clinic set up a business account with UVA Pharmacies to cover medications, including ART if no other timely access is secured. The account is charged and applied to Ryan White grants. Between September 2020 and August 2021 at the UVA Ryan White Clinic, 96 patients incurred 172 emergency medication charges to the clinic business account, or a mean of 15 emergency medication charges per month. Frequent and unpredictable medication access barriers can lead to increased time off ART, cause financial strain to the clinic, and decrease clinicians’ ability to provide other essential services.

**Objective:** We aim to decrease emergency medication charges for patients at the UVA Ryan White Clinic to less than 13 charges per month by March 2022.  
  
**Methods:** An interdisciplinary team of stakeholders involved in the process of reducing emergency medication charges was formed. Plan-Do-Study-Act (PDSA) cycle methodology was utilized. Quality improvement (QI) tools included process mapping, cause and effect diagram, Pareto chart, priority matrix, and statistical process control (SPC) charts. Balance measures were assessed, and counter measures were developed.

**Results:** Copay assistance, insurance rejection, loss of private insurance, and VAMAP non-formulary medications accounted for 80% of emergency medication charges. Of the total 96 patients, 34 accounted for 108 recurrent charges, with a mean of 2 charges per patient. The main reasons for recurrence were the same as those in the overall group. Implemented countermeasures included utilizing manufacturer coupon cards to offset emergency medication costs and training the embedded clinical pharmacist on managing insurance rejections. Upon implementation of the countermeasures, average monthly charges from October through March were reduced to approximately 12 charges per month. Charges were increased in January following 200 patients losing VAMAP access. At the end of March, the clinic was notified that this fund can no longer be used to cover ART, which will impact future results. The data presented is preliminary as the PDSA cycle is still ongoing.

**Conclusion:** While this data is inconclusive as the PDSA cycle is incomplete, there was a trend towards reduced monthly charges following the implemented countermeasures. The team plans to continue the current countermeasures in place and re-evaluate how changes to covering ART will be measured in the future.