

Perspectives of HIV Clinic Staff on the Implementation of a Client Financial Incentives Program Targeting Viral Suppression

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We present perspectives of health care providers and clinic staff on the implementation of a financial incentive program for clients living with HIV in three Louisiana clinics. Interviews were conducted in May-June 2015 with 27 clinic staff to assess their perspectives on implementation of the Health Models financial incentive program, which was initiated in September 2013. Many providers and staff welcomed the program, but some were concerned about sustainability and the ethics of a program that paid patients to receive care. Most said they eventually found the program to be helpful for patients and clinic operations in general, by facilitating partnerships between providers and patients, improving appointment keeping, providing opportunities for patient education, engaging patients in care, and helping patients form new prevention habits. The findings can improve understanding of staff and leadership perceptions of incentive programs and can inform planning and implementation of these programs in the future.

(Journal of the Association of Nurses in AIDS Care, ■, 1-14) Copyright © 2017 Association of Nurses in AIDS Care

Key words: health care providers, HIV treatment, incentive program, program implementation, viral suppression

Inconsistent adherence to antiretroviral therapy (ART) for HIV may result in reduced treatment efficacy (inability to achieve viral suppression), more

resistant viral strains, and progression to AIDS (McNabb et al., 2001). Many programs have aimed to improve medication adherence and rates of viral suppression for persons living with HIV (PLWH) by providing education about the importance of adherence, technology to remind patients to take their medication, and financial incentives to remain adherent (Nieuwlaat et al., 2014). Because failure to attend clinic visits is a significant predictor of treatment failure, medication adherence programs have also targeted appointment keeping (Lucas, Chaisson, & Moore, 1999).

Programs that aim to improve rates of viral suppression for PLWH must consider external factors that impact individual ability or likelihood of attending clinic appointments or consistently taking medication. PLWH have demands that compete with health care maintenance, such as work schedules or family obligations. Stigma may impact

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appointment keeping or adherence to medication because of fears of disclosure of HIV status (Mahajan et al., 2008). Structural barriers, such as transportation, may also impact adherence (Coetzee, Kagee, & Vermeulen, 2011).

In this paper, we address a gap in research regarding financial incentive programs designed to increase viral suppression. Successful implementation of a program such as this requires an understanding of the organizational and staff contexts (Damschroder et al., 2009; Fixsen, Naoom, Blase, Friedman, & Wallace, 2005). Although research has suggested that incentives may be an effective method for improving medication adherence for PLWH (Petry, Rash, Byrne, Ashraf, & White, 2012), the success of incentive programs is dependent, in part, on their acceptability to the clinic staff who facilitate the programs. There is evidence that providers' opinions on financial incentives programs improve after implementation (Greene et al., 2014), but there is limited research on perspectives of clinic staff on incentive programs for patients with HIV, provider willingness to participate in such programs, or strategies for improving implementation. Unless clinic leadership and staff support the need for and value of new innovative strategies, the program is unlikely to be implemented well or achieve desired outcomes (Lamb, Greenlick, & McCarty, 1998). Understanding staff and leadership perceptions of such programs, which are unfamiliar and potentially controversial, can inform planning and ultimately improve the implementation of these programs.

Financial Incentive Programs

Financial incentives programs aim to impact health status by increasing the benefits of adherence to medication or other health-related behaviors. Beginning in the 1970s, monetary compensation was used to incentivize abstinence from substance use for patients with substance abuse disorders (Lussier, Heil, Mongeon, Badger, & Higgins, 2006). Financial incentives have been used to improve patient adherence to medication regimens for communicable diseases such as tuberculosis and hepatitis (Giuffrida & Torgerson, 1997; Petry et al., 2012). Similarly, financial incentives increase the

likelihood that patients will attend appointments for preventive care (Lussier et al., 2006). While the incentive amount and form (e.g., voucher, gift card) can impact the effectiveness of these programs, offering financial incentives to patients significantly increases their likelihood of abstaining from drug use and improves appointment keeping and medication adherence (Lussier et al., 2006).

Randomized controlled trials have demonstrated the effectiveness of financial incentive programs for improving some health-related behaviors and incentivizing behavior change. Financial incentives have successfully improved the likelihood of losing weight and of smoking cessation in randomized controlled trials (Volpp et al., 2008; Volpp et al., 2009). But, in a study of persons with diabetes, peer mentoring was a more effective intervention for controlling glucose than financial incentives (Long, Jahnle, Richardson, Loewenstein, & Volpp, 2012). For patients with severe mental illness, financial incentives were associated with an increase in adherence to psychiatric treatment, although the effect did not persist after incentives were removed (Burton, Marougka, & Priebe, 2010).

Recent literature reviews related to financial incentives for HIV treatment adherence recommended that such programs consider how economic and external factors affect individual client behaviors by including components of both economic theory and behavior change theory (Bassett, Wilson, Taaffe, & Freedberg, 2015; Galárraga, Genberg, Martin, Laws, & Wilson, 2013). For example, in the Galárraga and colleagues (2013) conceptual model, which illustrated the multilevel determinants of medication adherence, individual client factors such as motivation and self-efficacy, along with the time and financial costs of ART, impacted client medication adherence and, ultimately, their viral loads. These relationships occurred within the context of individual (insurance, socioeconomic status), interpersonal (stigma, social support), and societal factors (social services); contexts impacted access to care and likelihood of seeking care and, consequently, remaining adherent to ART (Galárraga et al., 2013).

Research on the effectiveness of financial incentives programs for PLWH has been mixed. Several randomized controlled trials have investigated the effect of financial incentive programs on viral load,

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