NEVADA STATE HEALTH DIVISION

AIDS Drugs Assistance Program (ADAP) Profile

Kenny C. Guinn, Governor

Michael J. Willden, Director
Department of Health and Human Services

Alex Haartz, MPH, Administrator
Nevada State Health Division

Bradford Lee, MD
State Health Officer

Communicable Disease Program
ADAP Profile 2005
Data Source: ADAP Database, December 2005, Clients Receiving medications

AIDS Drugs Assistance Program (ADAP) Profile

The following describes the profile of the AIDS Drug Assistance Program (ADAP). The data was generated from the ADAP database for the month of December 2005 for clients receiving medications. Trend data *was extracted for a period of January 2001 through December 2005.*

Table I

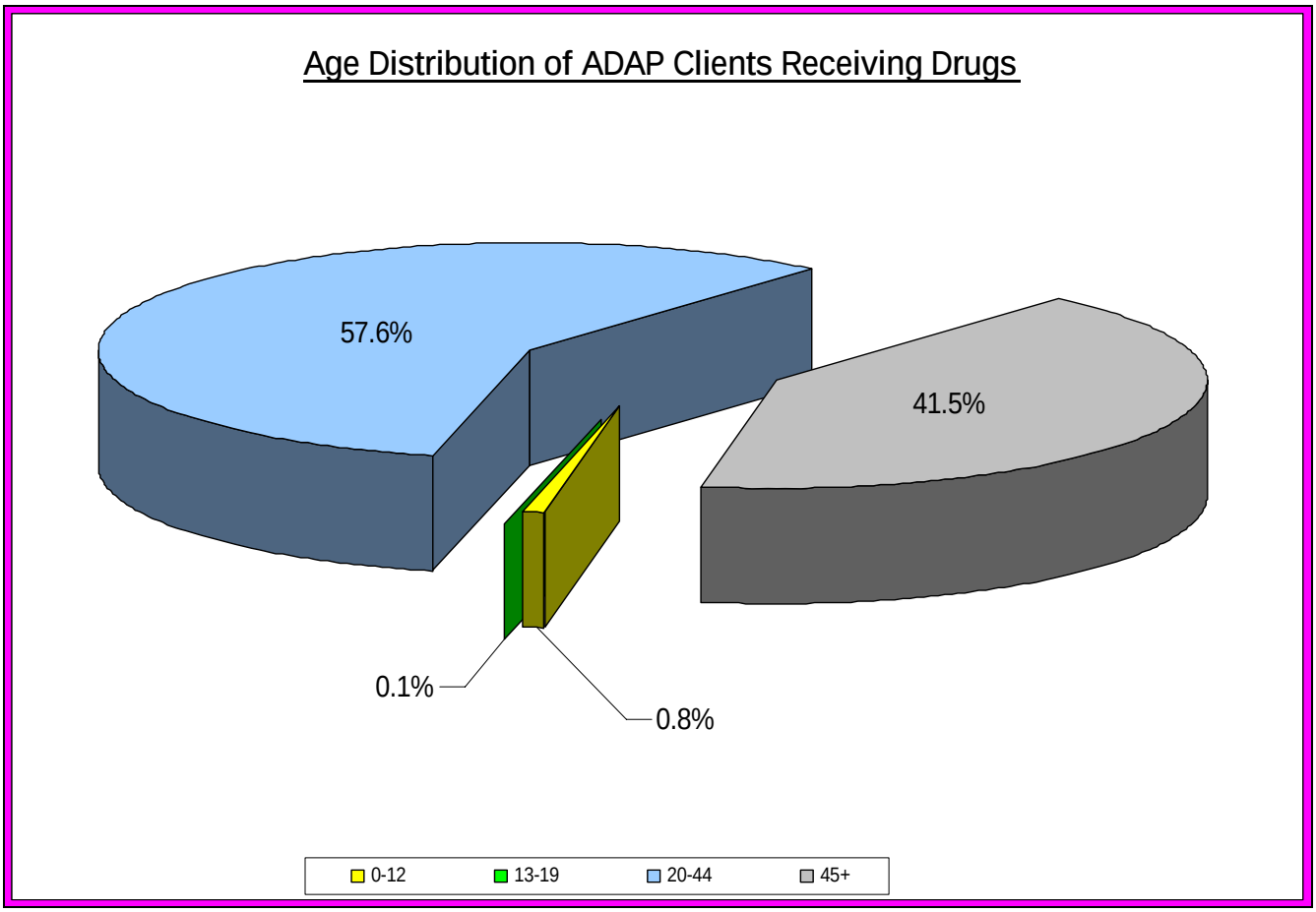


Table I shows the age distribution of ADAP clients receiving medications. As the table indicates that over 57% of clients are in the 20-44 age range and 41.5% are over 45 years old. The smallest age groups represented are youngest age groups (0-12 and 13-19 years of age).

Table II

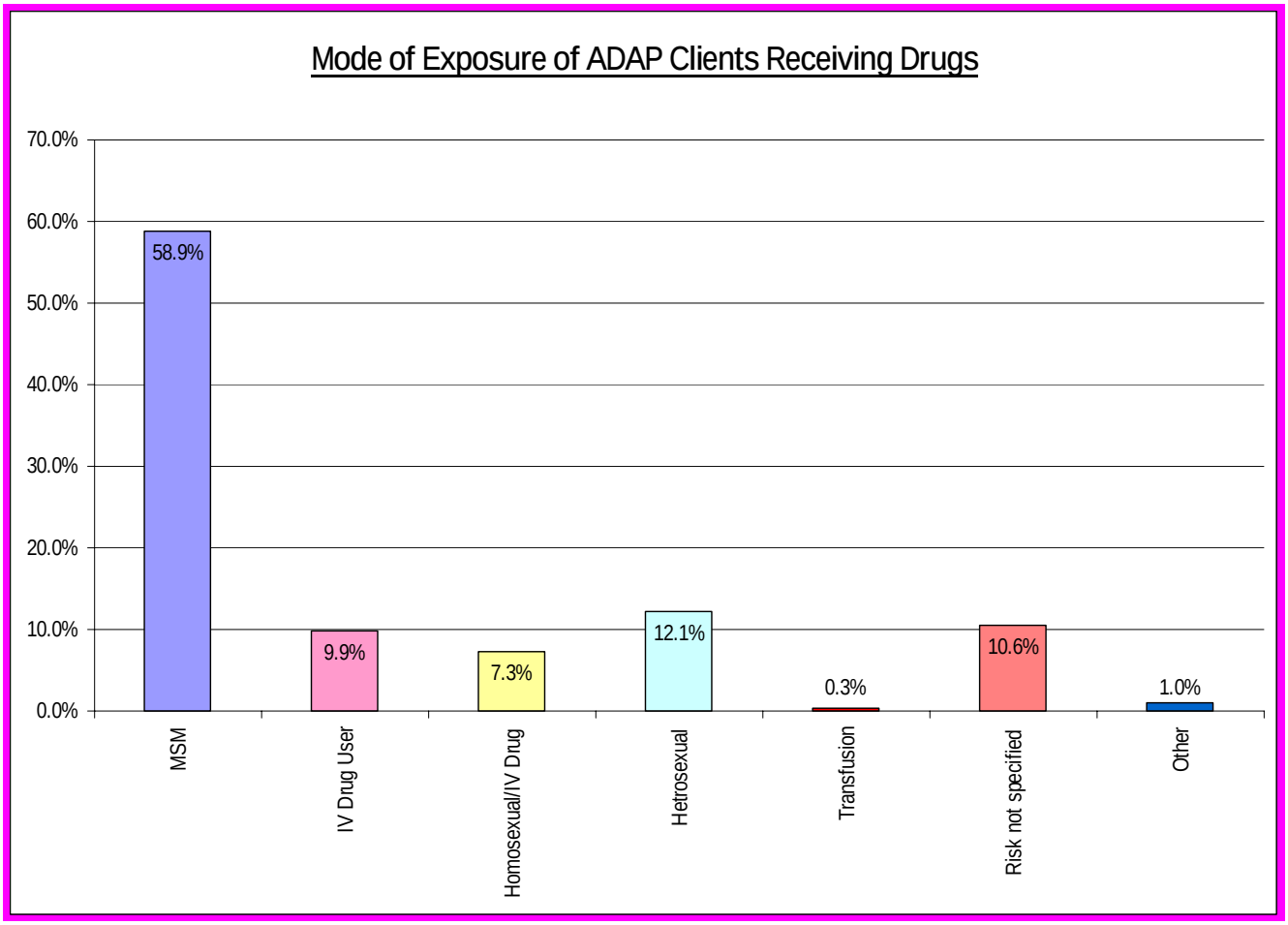


Table II shows the mode of exposure to HIV/AIDS. The most common mode of exposure reported (58.9%) is men who have sex with men (MSM), with heterosexual contact the second most mode of exposure (12.1%). Intravenous Drug Use was reported as the mode of exposure in almost 10% of the cases.

Table III

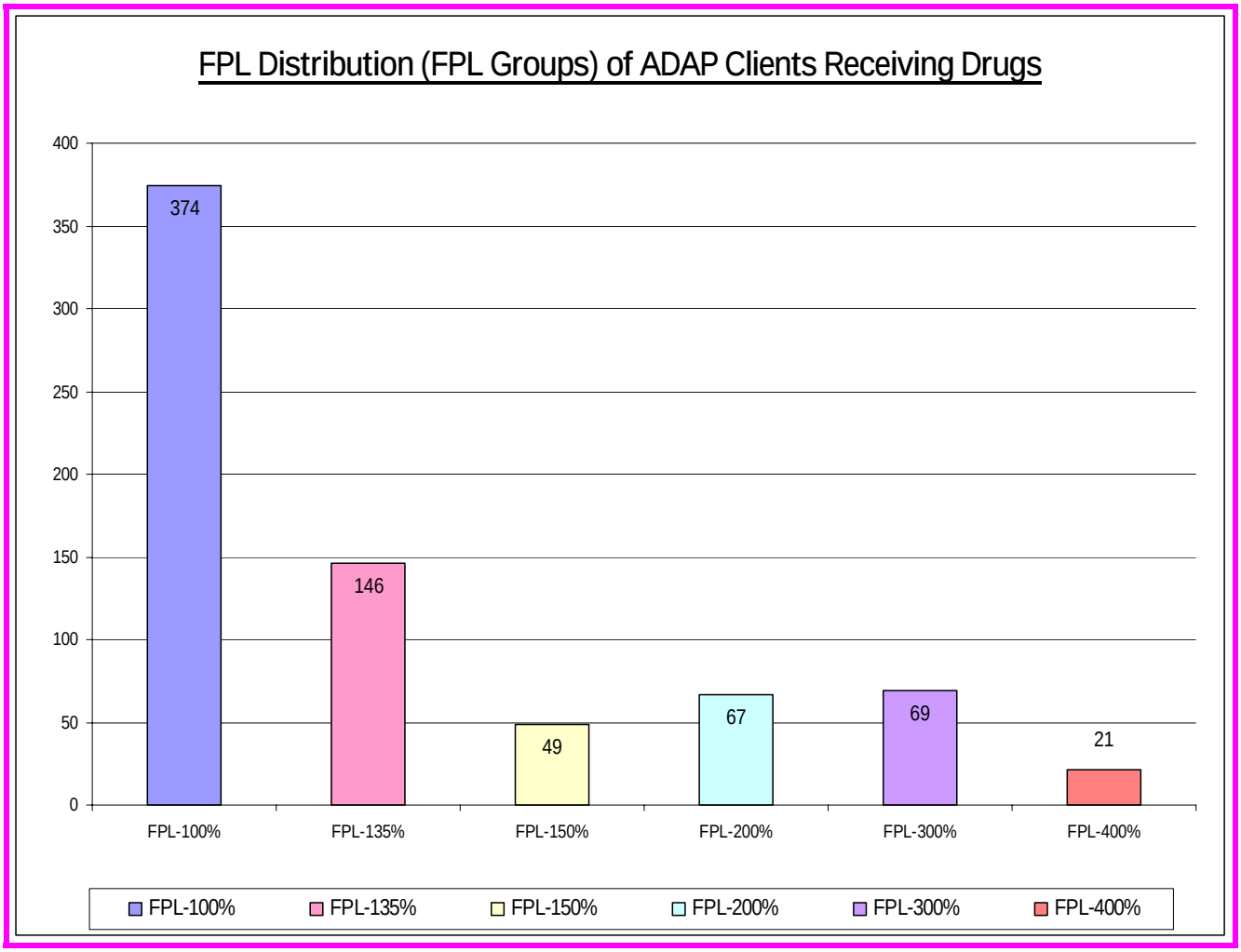


Table III summarizes Federal Poverty Level (FPL) breakdown of clients. The majority of the ADAP caseload falls into the 0-100% Federal Poverty Level range (51.5%). Over 71.6% are at or below 200% FPL. Only 2.9% of the caseload is at 400% FPL.

Table IV

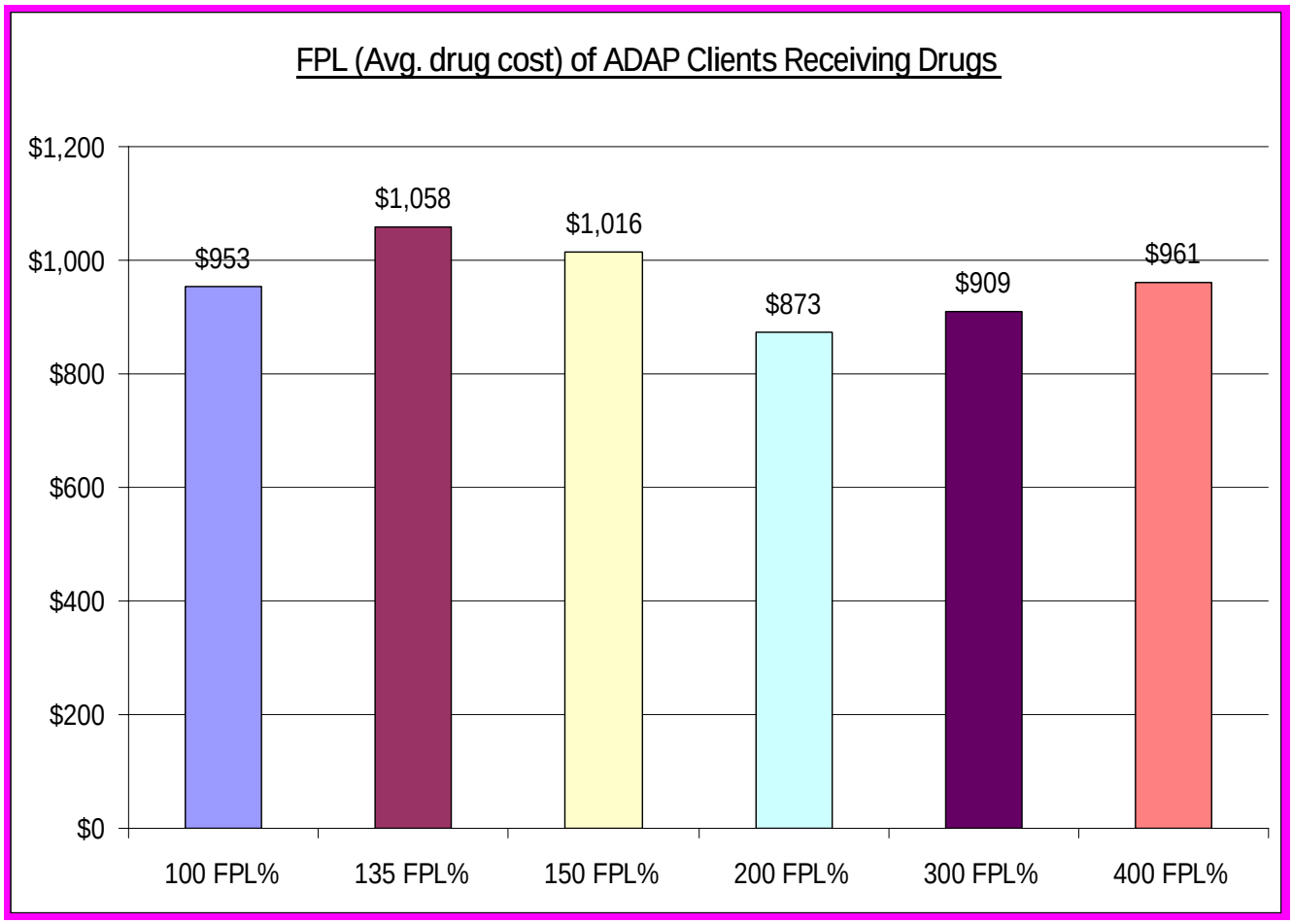


Table IV compares Federal Poverty Level with Average monthly cost of drugs. The average monthly cost of drugs is $ 941. Those clients at the 135% and 150% FPL have average monthly costs above $ 1,000. Clients between 151% and 200% FPL have the lowest average monthly cost ($ 873). The category of clients between 151% and 200% FPL is slightly smaller, however, there was not a specific variable that accounted for this lower cost.

Table V

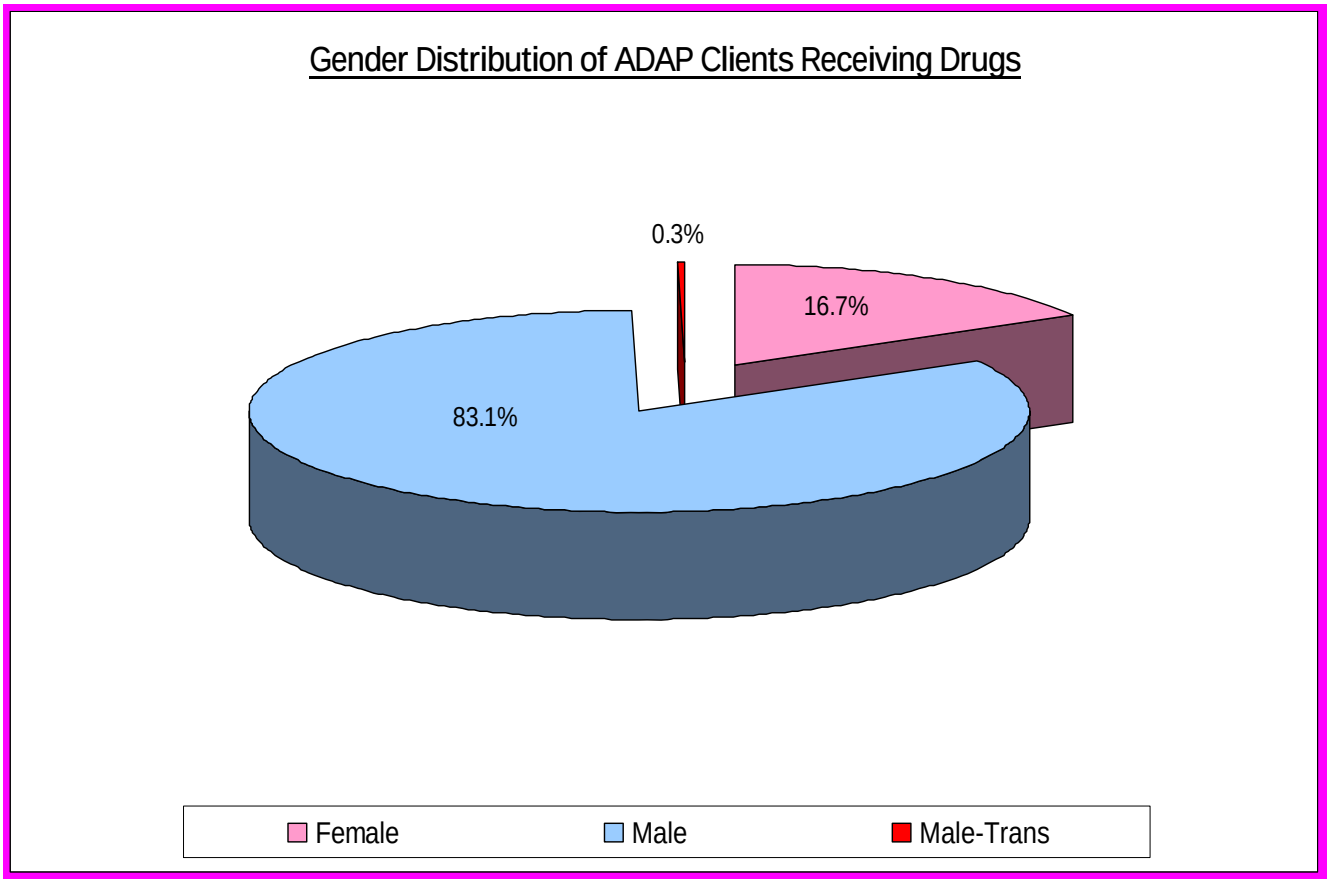


Table V shows the gender distribution of ADAP clients. Slightly over 83% of the clients are male (83.1%), with females comprising 16.7% of the caseload and .3% being transgendered.

Table VI

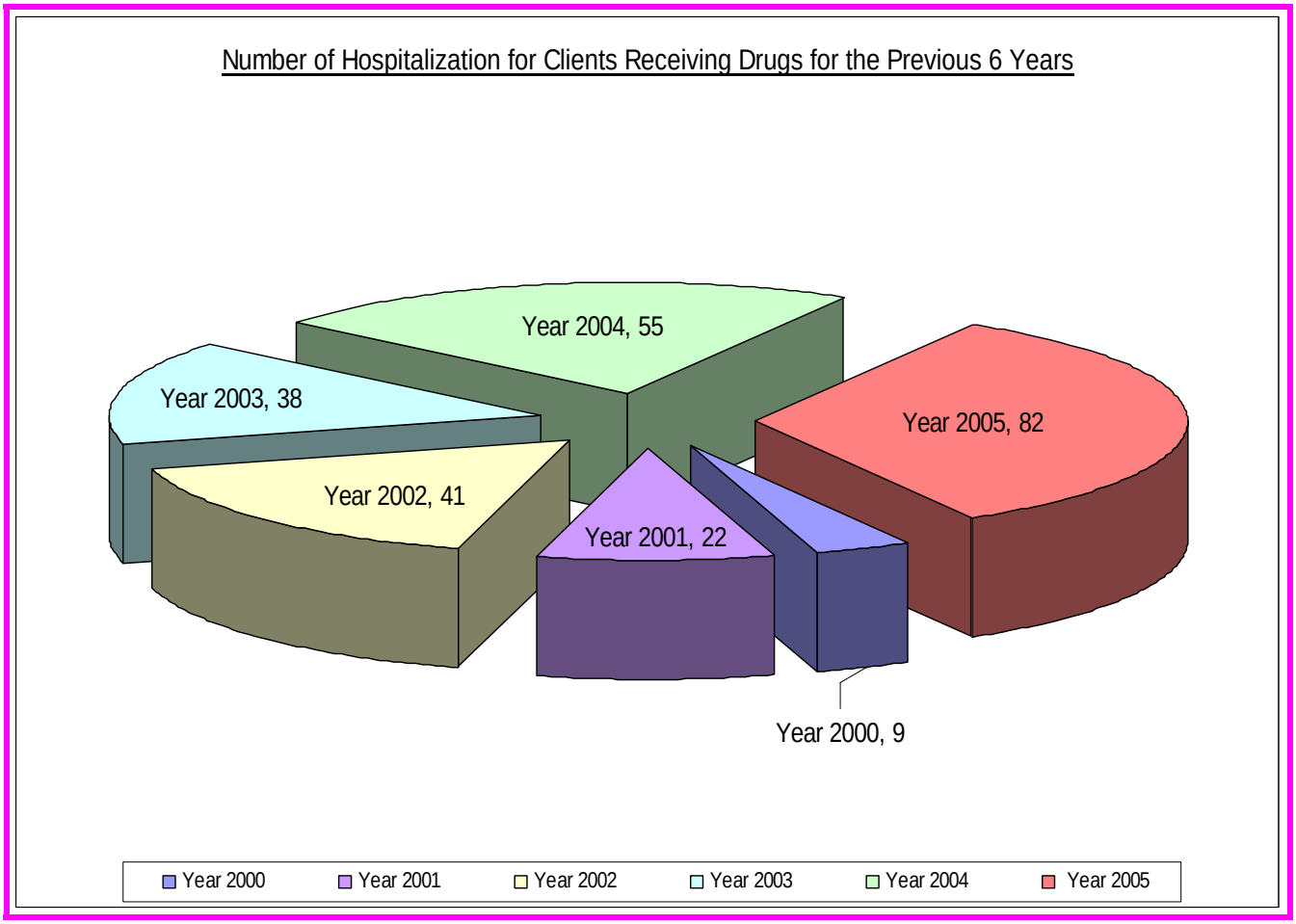


Table VI shows the number of hospitalizations by year. Reported hospitalizations were the lowest for 2000 and 2001. However, caseloads were also lower for these years.

Table VII

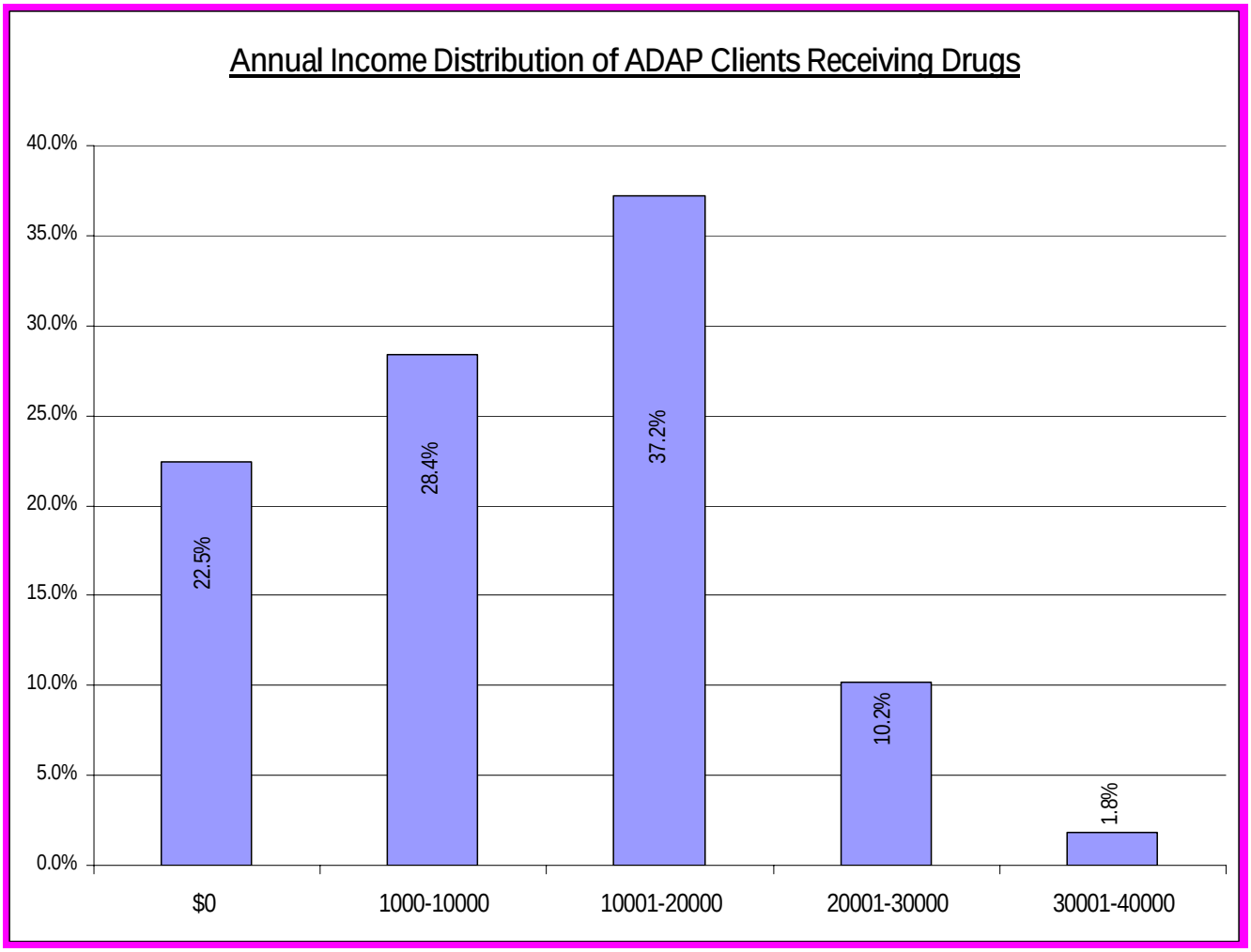


Table VII summarizes the annual income of ADAP clients receiving drugs. The majority of clients falls in the $ 10,001-$ 20,000 annual income range (37.2%). Slightly over 88% of clients on ADAP have an annual income at or below $ 20,000. Only 1.8% falls in the income bracket of $ 30,001-$ 40,000.

Table VIII

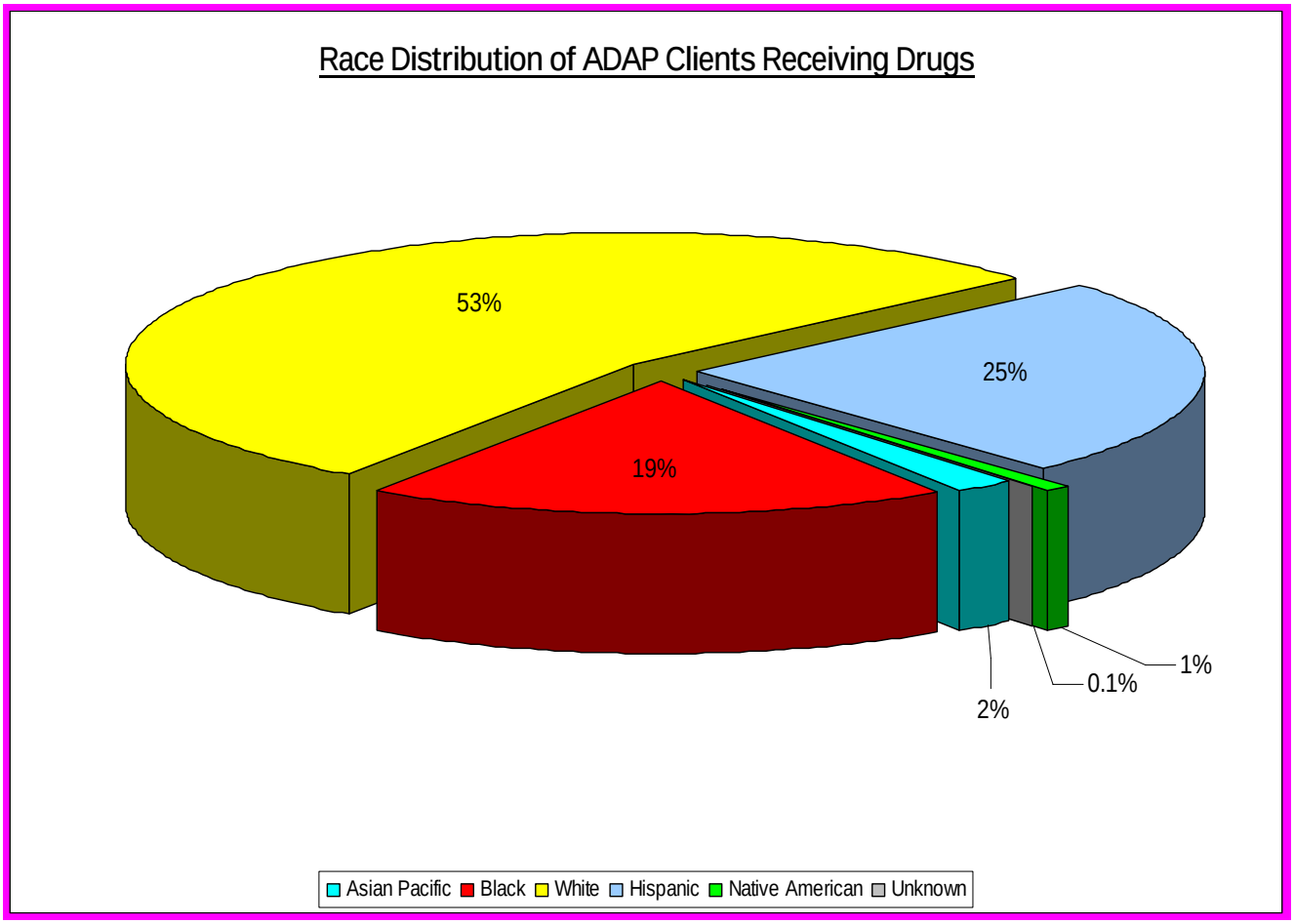


Table VIII profiles the race/gender of ADAP clients. Over 53% are white, 25% are Hispanic, 19% are African American, 2% are Asian Pacific Islander, 1% are Native American and .1% are unknown.

Table IX

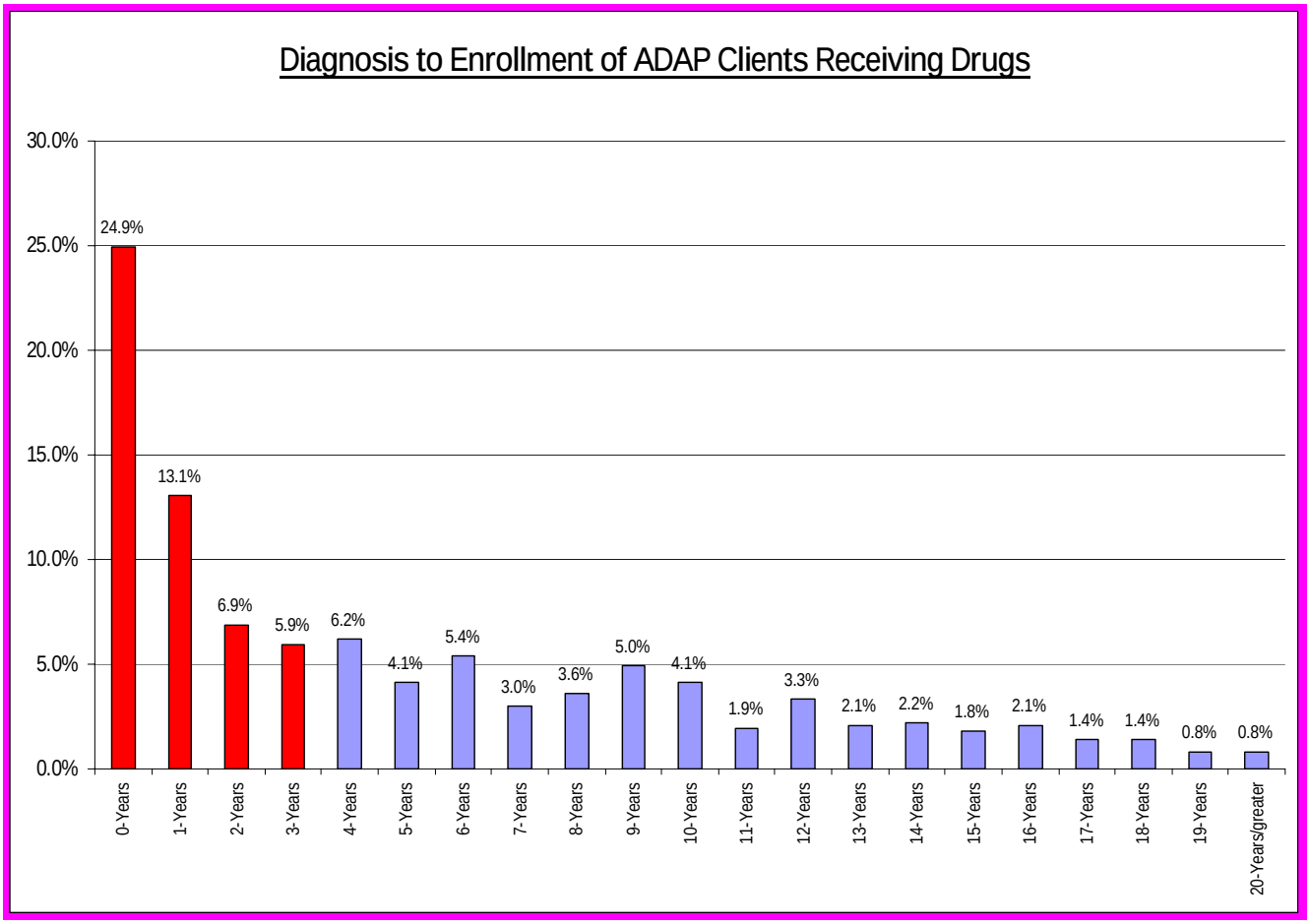


Table IX shows the time from diagnosis of HIV or AIDS to enrollment in ADAP. Note that over 50% of cases enrolled within the first 3 years of diagnosis, with almost 25% enrolling within the first year.

Table X

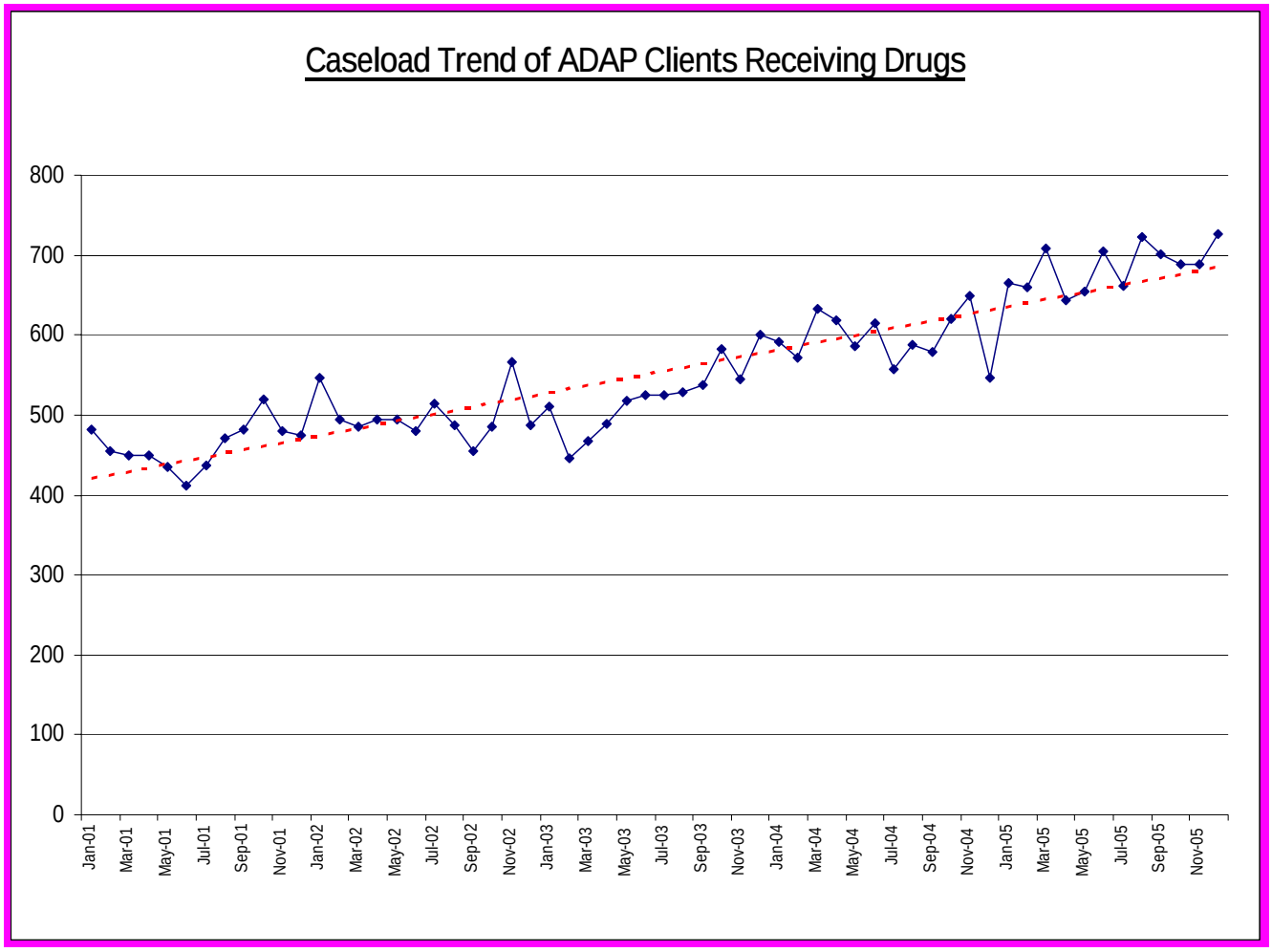


Table X shows the caseload growth and trend of ADAP clients receiving medications from 2001 through the end of 2005. A steady increase, with some dips in 2003 and 2004, has been the trend during this time period.

Table XI

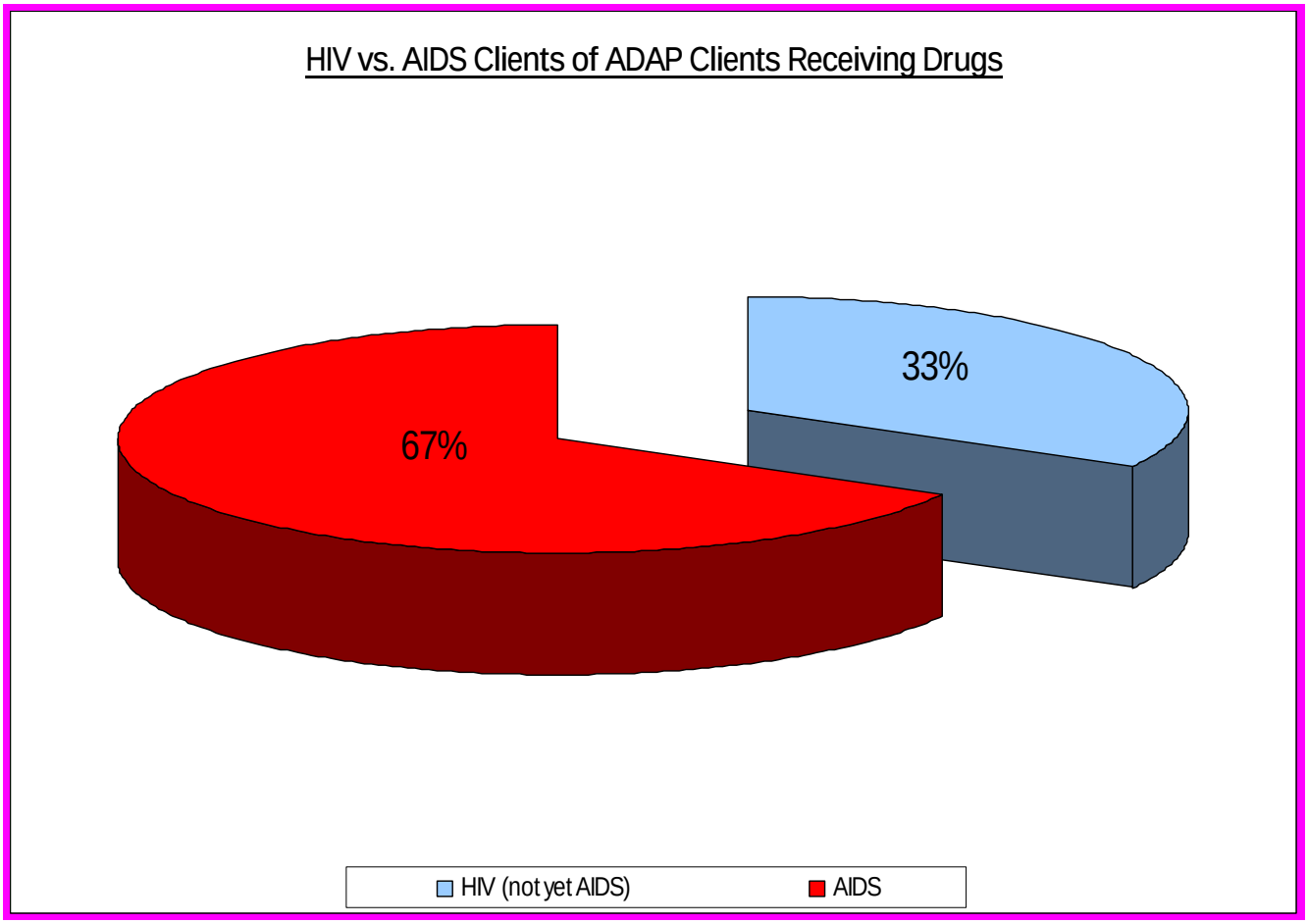


Table XI shows the percentage of clients on ADAP who are diagnosed with HIV (not yet AIDS) versus AIDS. Sixty-seven percent of ADAP clients have been diagnosed with AIDS.

Table XII

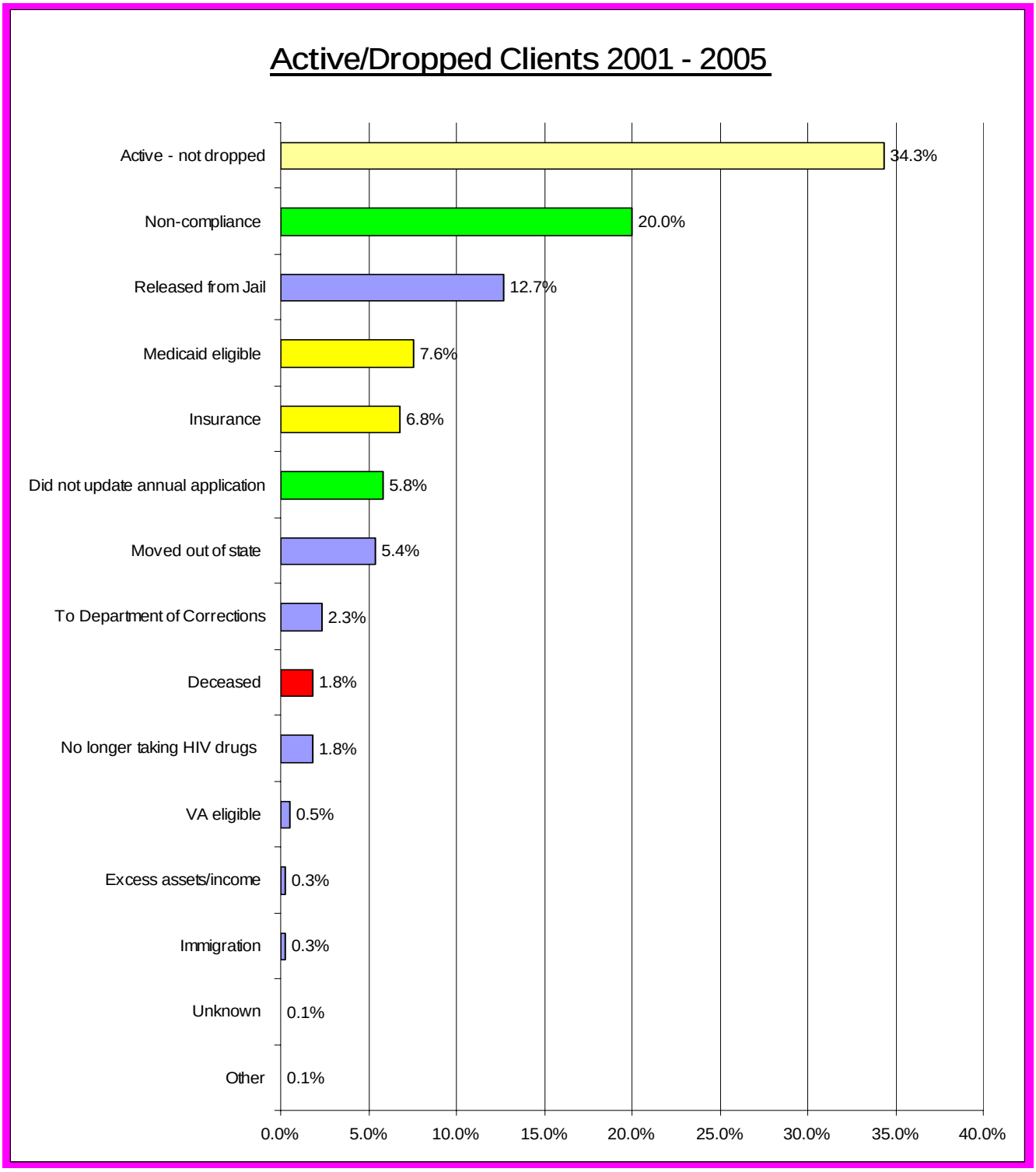
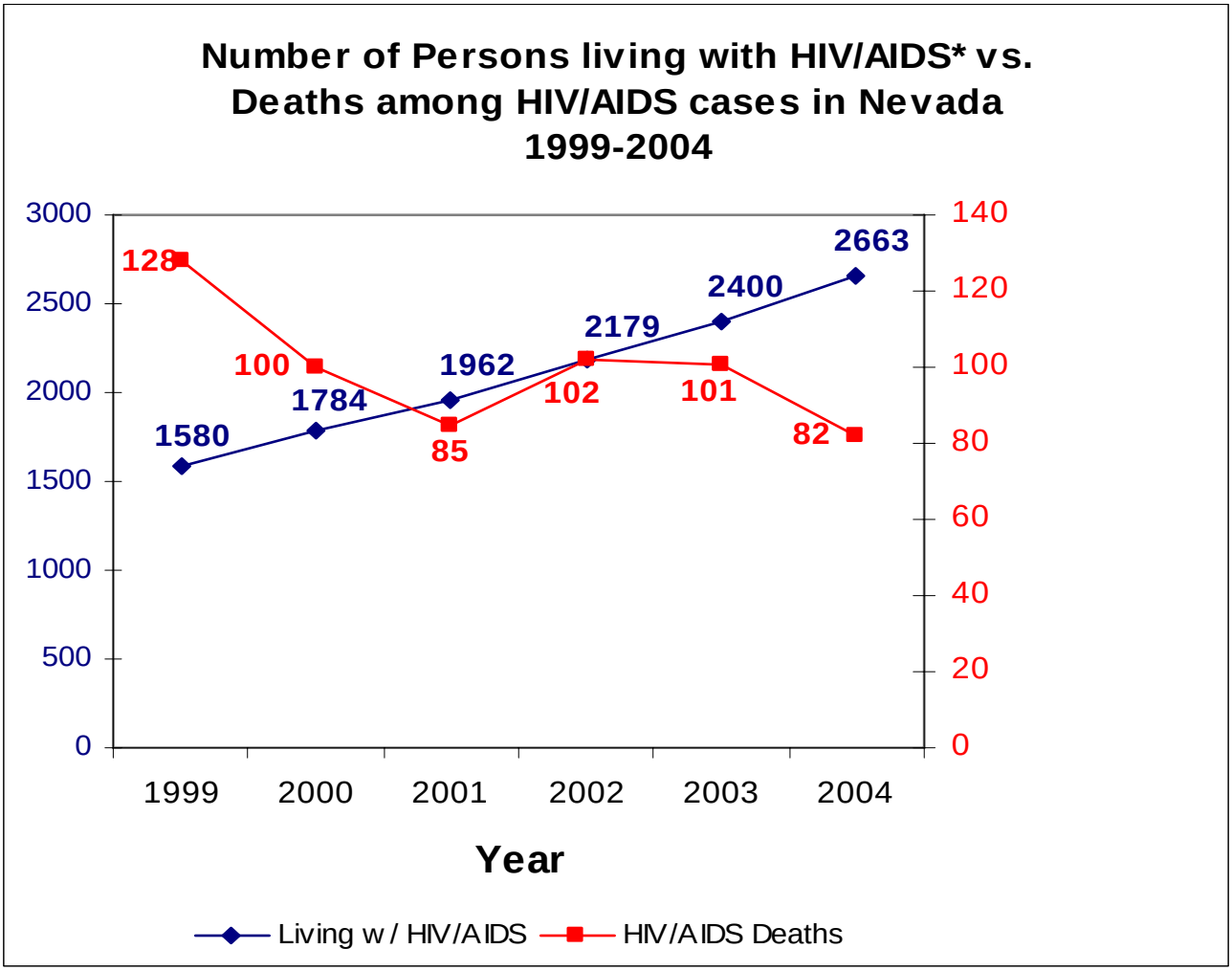


Table XII summarizes the status of all active ADAP since 2001 (over 2300 clients). The largest percentage remains enrolled in the program. The most frequent reason for closure reported was non-compliance, 20%. Only 1.8% were dropped due to death.

Table XIII



The final table shows the number of persons living with HIV/AIDS (HIV not yet AIDS and AIDS cases combined) versus deaths among the same population. The number of individuals living with HIV/AIDS shows an almost linear increase, while deaths show a sharp decline in 2000 and 2001 with an increase in 2002 and decreases in 2003 and 2004.

Literature search findings regarding antiretroviral cost effectiveness

A literature search overwhelming indicates that antiretroviral therapy is cost effective in its reduction of hospital costs and overall healthcare costs for people with HIV/AIDS. The following are 11 excerpts from five articles, including studies of this topic.

(1) ". . . data from a study from Saint Vincent's hospital in New York City, which showed a rather striking decline in hospital rates, also going along with the introduction of protease inhibitor combination therapy. . . Quite a fall, almost a halving of the rates of hospitalization" (Moore, 1997).

(2) ". . . a study from Dallas, Texas, Parkland hospital, which was just presented at the ICAAC [International Conference on Antimicrobial Agents and Chemotherapy] in San Diego, which also documents the decrease over the past two years, in hospital admission rates…As they have gone from very little use of HAART, almost none, to greater than 50-54 percent use of combination therapy in their patients. Again, halving, just as was found in the New York situation" (Moore, 1997).

(3) "One other study, we have gone from the east coast to the middle of our country to the west coast, this is in Los Angeles. And again a decrease in hospital days, overall, per patient, 62 percent decrease" (Moore, 1997).

(4) "Now other studies have shown this same decrease in Europe and in Canada" (Moore, 1997).

(5) Referencing his experience at Johns Hopkins in comparing the sickest patients (CD4 counts of less than 50) before and after the introduction of triple combination therapy, Moore says: "Similar to what others have found, we have been halving, decrease by half, in the cost of hospitalization" (Moore, 1997).

(6) “Something I have not talked about, but is important, is potential reduction in new infection due to lower viral loads and something that can have a tremendous cost benefit potential . . . increased stability and longevity of families, fewer orphans, more stable families. . . “ (Moore, 1997).

(7) As a result of a 44 month study at a Veterans Administration hospital, “Highly active antiretroviral therapy (HAART) is associated with decreased opportunistic infections, hospitalization, and HIV related health care costs over relatively short periods of time. . . Hospital costs decreased from $1275 per patient per month in the first quarter to less than $500 per patient per month in each of the third and fourth quarters” (Keiser et al, 2001).

(8) A six month study of patients admitted to the New York – Cornell Medical Center in New York City in 1995, concluded: “Since the introduction of potent antiretroviral therapy, a significant decrease in the incidence of hospital admission and opportunistic infections has occurred” (Simon et al, 1999).

(9) “HIV-positive individuals who receive medical care and HAART are healthier and able to work and therefore contribute tax revenue to local, state and federal budgets . . . The use of HAART reduces the risk of HIV transmission by about 60%” (NASTAD, April 2005).

(10) “. . . if we look at the average length of [hospital] stay for individuals who are receiving a PI [protease inhibitor]-based regimen, we can see a decrease in the number of days in hospital for people on therapy versus those individuals who are not on therapy. Hospital costs decrease substantially for those individuals who are on therapy versus those that are not” (Clay, 2004).

(11) A sample study of 2,864 HIV-positive patients in 28 cities and 25 clusters of rural counties found, “The mean [healthcare] expenditure was $1,792 per patient per month at base line, but it declined to $1,359 for survivors in 1997, since the increase in pharmaceutical expenditures were smaller than the reduction in hospital costs. . . the expenditure for drugs

had increased from $618 to $821 per patient per month, and hospital costs had declined from $878 to $550 per patient per month" (Bozzette, 2001).