

Best Practice Solutions to HIV Prevention at Health Centers Community of Practice Session 2: Structural Barriers to Access

**Dr. Christopher Roby, Dr. Kevin Ard, and Dr.
Whitney Irie.**

Date: 01/29/2026



**NATIONAL LGBTQIA+ HEALTH
EDUCATION CENTER**

A PROGRAM OF THE FENWAY INSTITUTE

Attendance

- Please add your name, pronouns, role, organization, and state in the chat!

Learning Objectives

- Review the impact of integrated models of care on staffing
- Discuss task shifting in Pre-Exposure Prophylaxis (PrEP) programming
- Describe the patient experience and opportunities for PrEP engagement
- Explain how to leverage telemedicine to increase PrEP provision
- Discuss financial resources to support PrEP provision





Session 2: Structural Barriers to Access

Dr. Christopher Roby

What is an integrated model of care for PrEP in FQHCs?

- An integrated PrEP model embeds HIV prevention into routine primary care workflows, rather than treating PrEP as a separate or specialty service. PrEP responsibilities are shared across a multidisciplinary care team (medical, behavioral health, pharmacy, case management, outreach).

Key benefits of integrated
care models for PrEP
uptake in FQHCs

Normalizes PrEP as routine preventive care

Why it matters

- PrEP is often perceived as “specialty HIV care”
- Stigma and provider discomfort reduce screening and prescribing

Integrated model benefit

- PrEP is treated like:
 - Vaccinations
 - Hypertension screening
 - Contraception
- Sexual health discussions become standard, not exceptional

Impact

- More consistent risk screening
- Increased patient acceptance
- Reduced stigma for patients and staff

Increases identification of PrEP-eligible patients

Structural barrier

- Providers often lack time for in-depth sexual health assessments

Integrated model benefit

- Medical assistants or nurses conduct screening
- Standardized tools embedded in intake or annual visits
- Electronic Health Record (EHR) prompts flag PrEP eligibility
- Use of Community Health Workers to do education

Impact

- More patients identified early
- Less reliance on provider memory or comfort level
- Reduced missed opportunities

Improves workflow efficiency and reduces provider burden

Structural barrier

- PrEP viewed as “extra work”
- Providers overburdened in FQHC settings

Integrated model benefit

- Task shifting distributes work:
 - MAs: screening
 - Nurses: education and labs
 - Pharmacists: adherence and refills
 - Providers: prescribing only
- Standing orders streamline care

Impact

- Faster PrEP initiation
- Increased provider willingness to offer PrEP
- Improved staff satisfaction and retention

Reduces patient drop-off across the care continuum

Structural barrier

- Patients lost between:
 - Screening
 - Labs
 - Prescription
 - Follow-up visits

Integrated model benefit

- Clear handoffs between team members
- Care navigators track patients
- Embedded follow-up workflows

Impact

- Higher PrEP initiation rates
- Better retention in PrEP care
- Improved adherence and outcomes

Structural barrier

- Transportation, work schedules, stigma, mistrust

Integrated model benefit

- PrEP offered in familiar primary care settings
- Telemedicine integrated into routine care
- Navigation support for insurance and medication access

Impact

- Improved PrEP access
- Improved uptake among:
 - Black and Latino patients
 - Uninsured or underinsured individuals

Structural barrier

- Stand-alone PrEP programs are fragile and grant-dependent

Integrated model benefit

- PrEP embedded into existing services
- Less dependence on individual “champions”
- Easier onboarding of new staff

Impact

- Long-term sustainability
- Easier scaling across sites
- Alignment with HRSA quality improvement expectations

Aligns with structural competence

Why this matters

- Differences in PrEP access is driven by systems, not behavior

Integrated model benefit

- Shifts responsibility from patient to system
- Addresses stigma, access, and workforce design
- Embeds prevention into whole-person care

Impact

- Structural solution to structural inequities
- Strong alignment with funding and policy priorities

Telemedicine for PrEP

KEVIN L. ARD, MD, MPH

MEDICAL DIRECTOR, NATIONAL LGBTQIA+ HEALTH EDUCATION CENTER, THE FENWAY INSTITUTE

DIRECTOR, SEXUAL HEALTH CLINIC, MASSACHUSETTS GENERAL HOSPITAL

ASSISTANT PROFESSOR OF MEDICINE, HARVARD MEDICAL SCHOOL

Advantages of telePrEP

- Many core components of PrEP provision – eliciting sexual and drug use histories, counseling about the medication – can be performed virtually.
- May improve convenience for patients
- May improve access for people with transportation or scheduling constraints
- May overcome some confidentiality or stigma concerns

Disadvantages of telePrEP

- Need for laboratory studies
- Home-based syphilis testing may not be optimal for those with prior syphilis
- Dependence of uninsured patients on at-no-cost laboratory testing provided in limited locations
- Injectable medications may be required for sexually transmitted infection treatment
- Lack of technology or privacy to engage in telePrEP
- CAB and LEN must be given by a health care professional

Can we provide injectable PrEP via telemedicine?

Step in PrEP care	Amenable to fully virtual care?	Potential solutions
Risk assessment and counseling	Yes	None needed
Benefits navigation	Probably, depending upon the documentation required	None needed
Medication administration	No	Community-based administration, home health visits
Baseline and monitoring laboratory studies	No – there is no FDA-approved home HIV RNA assay	New assay development/validation, hybrid care models

One clinic's experience: a menu of options for PrEP care may be best.

- During the early Covid-19 pandemic, many clinics pivoted to near-total virtual care.
- Differences in PrEP uptake and persistence were seen nationally in this setting.
- One clinic's approach differed: The clinic continued to offer a full range of in-person services as well as formal telemedicine visits and telephone check-ins.
- In this setting, the clinic saw no differences in PrEP persistence in their cohort.

Financial resources to
support PrEP provision

Why this matters for FQHCs

In non-expansion states, PrEP access is limited by:

- High uninsured rates
- Coverage gaps for labs and visits
- Reliance on safety-net funding

Despite this, **PrEP provision is still financially feasible** when multiple funding streams are layered.

Ready, Set, PrEP (RSP) – Cornerstone Resource

What it covers

- Free PrEP medications (oral PrEP only)
- For uninsured patients who meet income criteria
- Nationwide program (critical in non-expansion states)

What it does *not* cover

- Clinical visits
- Lab work
- Navigation or staffing costs

Why it's important for FQHCs

- Eliminates the largest cost barrier (medication)
- Allows clinics to focus funds on services and labs
- Especially impactful in the Southern U.S.

Pharmaceutical Patient Assistance Programs (PAPs)

Key manufacturers

- Gilead Advancing Access
- ViiV Connect

What they cover

- Free or reduced-cost PrEP medications
- Support for uninsured and underinsured patients

Strengths in non-expansion states

- Can be used independently or alongside Ready, Set, PrEP
- Often faster enrollment than insurance
- Useful for patients with fluctuating coverage

What they may cover

- Lab work
- Clinical visits
- Medication costs (if not covered elsewhere)
- Navigation services

Why they matter in non-expansion states

Often the **only source** of funding for labs and visits

- Frequently supported through HIV prevention dollars
- Can be braided with Ready, Set, PrEP

 Note: coverage and eligibility vary significantly by state.

What it supports

- Staffing (navigators, outreach workers)
- PrEP implementation infrastructure
- Community engagement and linkage

Why this is key

- Can cover **non-billable services**
- Reduces reliance on clinical revenue
- Especially important where insurance coverage is limited

Relevant uses

- Integrated care model development
- Quality improvement activities
- Workforce support and training

Strategic advantage

- PrEP can be framed as:
 - Preventive care
 - Chronic disease prevention

This aligns PrEP with **core FQHC mission funding**, not just HIV-specific dollars.

340B Drug Pricing Program

How it helps

- Generates revenue from insured patients' prescriptions
- Revenue can support:
 - PrEP navigators
 - Labs for uninsured patients
 - TelePrEP infrastructure

Importance in non-expansion states

- Helps cross-subsidize care for uninsured groups
- Supports program sustainability

Common sources

- State or local health departments
- HIV foundations
- Community benefit funds from hospitals
- Private foundations focused on prevention

What they often fund

- Start-up costs
- Pilot telePrEP programs
- Outreach and community engagement
- Journey-mapping and workflow redesign

Closing

- Next Session: 2/5/26, 2 pm ET

HRSA Disclaimer

This project was supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under cooperative agreement number U30CS22742, National Training and Technical Assistance Partner (NTTAP), for \$625,000.00 with 0% of the total NTTAP project financed with non-federal sources. This information or content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS, or the U.S. Government



NATIONAL LGBTQIA+ HEALTH
EDUCATION CENTER

A PROGRAM OF THE FENWAY INSTITUTE