

**Telehealth Models in PrEP Delivery: From Barriers to Benefits**

**Iowa TelePrEP: A Public Health Partnered Telehealth Model for PrEP Delivery**

**Webinar Q&A**

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| **Provider/Staffing** |
| **How did you get pharmacists to 'sign on' to deliver PrEP? What is their role in this process?** |
| We integrated clinical pharmacist providers into the development of our model. Under a collaborative practice agreement with an MD, these providers offer all PrEP initiation and monitoring services / conduct all visits with the patients of the program. Our initial providers were a clinical pharmacist with experience working on telehealth delivery models and a clinical pharmacist who has a long history of working with PLWH through the Ryan White Part B&C program. When we expanded our team we enlisted a pharmacist who had been working in specialty pharmacy administration for a number of years and was looking for an opportunity to participate in direct patient care. |
| **The PrEP navigator works with EVERYONE from all over the state. Is that their only job or does the person have multiple duties?**  Correct. We have a central point navigation model – where all individuals interested in PrEP are driven to a single point. This comprises 1 FTE – though he also does brief contact case management to work with clients after the initial navigation contact to workshop challenges related to retention (job changes, insurance changes, etc.). |
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| **Can you discuss again the breakdown of how much it would cost to implement a TelePrEP program with 1 FTE provider/1 FTE navigator?**  This is variable dependent on salary range and benefits rate. However, if you assume a total staff cost of $146,000 for 1 FTE Pharmacy Provider + $75,000.00 for 1 FTE Navigator = $221,000 staffing cost + supplies cost (assumed at 10% of salary) = $22,100.00 + Telehealth Software Cost = $25,000 the total annual cost of the program would be ~ $268,100.00.  Assuming that the only revenue is 340b cost savings – you would need to carry an active margin generating a patient caseload of about 16 to cover the total annual costs of the program. This could be offset further if capable of/ interested in billing for telehealth visits.  **How did you get all providers/test sites to buy into one navigator?**  Our program never supported point of care navigation services for PrEP – so it was easy to roll out this model in the developmental stage. It’s important to note that having a central navigator increases efficiency, increases data access, and allows for a more streamlined response. For example, given the rapidly evolving nature of PrEP coverage it is much easier to keep 1 individual in the loop and up to date on emerging changes than to ensure understanding and implementation across many individuals in a variety of settings.  **I am a new navigator. I could really use some help with the EOB that you mentioned for patients under 26 on their parents health insurance. I am not familiar with the EOB and that documentation needed to keep PrEP confidential. Could you share some documents or resources on this?**  I would encourage you to contact our Navigator directly to discuss this issue and receive technical assistance. They can be reached via email at [seth-owens@uiowa.edu](mailto:seth-owens@uiowa.edu) |
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| **Practice** |
| **How was the logistical shift from in- person to telehealth for PrEP even before COVID-19? So if some agency wanted to create a similar program what would that process entail?**  The patients who have enrolled in our program were either offered TelePrEP as part of the navigation and linkage to care process OR self-selected to the program from a traditional access model. We did not actively transition any patients previously on PrEP into this model – so it was built from the ground up to focus on telehealth delivery.  **Have you faced resistance from medical providers not wanting to ask specific and personal questions? (Such as number of sex partners, sexual activity) If so, what techniques have you used? What about resistance from pharmacists?**  The providers within our TelePrEP program are well trained in these areas and we have no issues with our internal workforce. Like every state, Iowa has encountered providers (both medical and pharmacy) who face discomfort in this realm. While it would be ideal to provide capacity building and education to address this discomfort (which we do through another program) – that type of growth can take time – so TelePrEP becomes the optimal solution for these patients who do not have current access to local culturally competent care.  **Do you arrange financial support for PrEP users who do not have insurance, have high deductible, or other financial barriers?**  We do not provide any local financial support to overcome these barriers, but utilize the existing patient assistance programs in combination with our navigation strategies to reduce (and often time eliminate) these barriers.  **What type of support are you offering for adherence/persistence?**  We provide traditional support mechanisms such as pill carriers, key chain pill holders, etc. in combination with drug persistence counseling during patient appointments that are designed to meet their individual needs. This is one of the benefits of having a pharmacist as the provider – where they are uniquely equipped to address these issues with patients.  **Are you only providing PrEP daily or will your providers prescribe 2-1-1? Are clients asking about PrEP 2-1-1?** |
| We do have clients who inquire about incident based dosing. Our protocol does not account for this type of prescribing but the medical director can (and has) at his discretion recommend it in specific cases. |
| **At-Home Tests / Labs** |
| **With the use of telehealth and the Emory home test kits, did this completely elevate the need to have an in person vision and what was the adherence rate for the at home testing?** |
| At home testing would, in best practice, eliminate the need for in-person visits of any type (except in cases where STD treatment requires evaluation and/or administration). We had collection issues when piloting our kit so there were times when folks did need to also present to a partner site or a commercial lab to complete testing – though this is not ideal.  More data on the adherence rate for home testing will be available in an upcoming publication. |
| **How have you assisted uninsured patients with the cost of visits and labs?**  We do not bill for visits and for those who are uninsured we can coordinate labs through our statewide network of public health funded rapid testing and STD testing sites. These costs are covered through our statewide safety net testing program.  **Getting agreements with labs across the state sounds like a huge undertaking. What more can you share about how you went about this and effective strategies learned to achieve this?**  It absolutely is. We went slow and grew our program in terms of coverage in coordination with the building of these relationships to ensure that patients always have a place to go. This also takes ongoing care – as staff changes, leadership changes, etc. may impact the needs outlined in the agreements. As it stands we have our agreements written in such a way that they require annual review/revisions.  **How did you develop the clinical protocol? Was it the medical director and the clinical pharmacists who developed labs, who would look at them, etc. to approve for PrEP?**  The protocol and collaborative practice agreement are protocol driven documents that require review and approval by multiple folks. This was developed in partnership between our medical provider and our pharmacy providers. Under the agreement the pharmacists can provide all care (initiation, lab ordering, lab review, monitoring, and prescribing). The pharmacists meet routinely with the medical provider to review patients and the medical provider must be consulted if there is any variation outside of the scope of the agreement. |
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| **Prescriptions** |
| **With the upcoming generic PrEP, what concerns do you have about 340b pricing and income generated by that?**  The margins on Truvada are quite high – and while a single generic coming to market will impact the cost savings associated with PrEP as it relates to 340b. We do estimate sustainability will not be impacted since operational costs are so low in proportion to the number of patients that can be seen through this model.  **Do the pharmacists mail the naloxone? When is the Rx for PrEP sent?**  For PrEP – Rx are sent as soon as we have documentation of a negative HIV test. Refills may be withheld if additional laboratory studies have not been obtained.  For Naloxone – pharmacists mail dual Narcan kits.  **Does Iowa's program mail all their medications to patients? Is it a partnership with the specific pharmacy?**  For TelePrEP we use the specialty pharmacy department within the healthcare institution that houses the program (as the preferred pharmacy) – but patient choice remains our priority and we will send prescriptions to wherever they want or as required by insurance provider. |
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| **Data** |
| **What is you patient volume and how long do patients stay on the program?**  A data sheet was provided with the resources upon the conclusion of the webinar. Additional information on retention can be found on our website. <https://www.prepiowa.org/teleprep-resources>  **Did you see any significant differences in your population by race/ethnicity and/or age?**  A data sheet was provided with the resources upon the conclusion of the webinar.  **Please point us to your TelePrEP navigator’s manual.** |
| <https://www.prepiowa.org/teleprep-resources> |
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| **Visit the TeleHealthHIV Webinar Archives and Additional Resources at**  [HealthHIV.org/TeleHealthHIV](http://healthhiv.org/TeleHealthHIV) |
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