Developing and Sustaining Mobile Health Clinics for HIV Treatment and Prevention

Sustaining effective HIV treatment and prevention is challenged by the need to maintain consistent engagement in care over the long term and satisfy the diverse needs of communities affected by HIV. This requires overcoming barriers to engagement such as limited access to transportation and medical providers. As longer-acting options for HIV treatment and PrEP become available, addressing these barriers to longer-acting antiretroviral therapy (ART) and PrEP will require going beyond traditional care in brick-and-mortar clinic settings. Mobile health clinics are increasingly used to improve access to healthcare more broadly, offering significant potential to improve uptake and persistence of HIV treatment and PrEP. Mobile health clinics offer an opportunity to combine the promise of these modalities for greater flexibility with novel engagement methods that reduce barriers to HIV treatment and prevention services. They are used for primary care, substance use disorder (SUD) treatment, eye care, stroke treatment, diagnostic and radiology services, and dental care. Mobile clinics also expanded greatly during the COVID-19 pandemic, providing testing and vaccine administration.

There is a strong evidence base demonstrating that mobile health clinics improve access for underserved populations by providing primary and preventive care, screening, and chronic disease treatment.[1] Evidence demonstrates mobile clinics increase screening, early diagnosis, prevention, and treatment initiation.[2,3] Mobile health clinics reach populations that traditional sites often cannot by reducing barriers such as transportation, opportunity/time constraints, and concerns about trust, stigma, and privacy.[1,2,4] Mobile health clinics deliver services at locations and times where target populations live or spend their time,[5,6] and disproportionately serve vulnerable groups, including uninsured patients, racial and ethnic minorities, women, people experiencing homelessness, migrant workers, and rural communities.[1,7,3] They function as a bridge between community settings and the formal health system by addressing both medical and social needs.[2,8] Mobile health clinics excel at reaching key populations with integrated, same-day services, which can be complemented by digital tools to support adherence and engagement along the care continuum, though both require further evaluation of cost-effectiveness, scalability, and long-term retention.[5,10]

POLICY ACTIONS FOR EXPANDING MOBILE HEALTH FOR HIV TREATMENT AND PREVENTION

Mobile health clinics are widespread but their use for HIV treatment and prevention is limited. Policy actions can help the HIV community effectively reach populations impacted by HIV using mobile health clinics.

MEET PEOPLE WHERE THEY ARE

- Conduct community needs assessments to identify HIV services priorities
- Establish partnerships between HIV organizations and primary care providers to operate mobile health units
- Foster collaboration among mobile health clinics providing HIV treatment and prevention

USE RESEARCH AND DATA TO OPTIMIZE MOBILE HEALTH

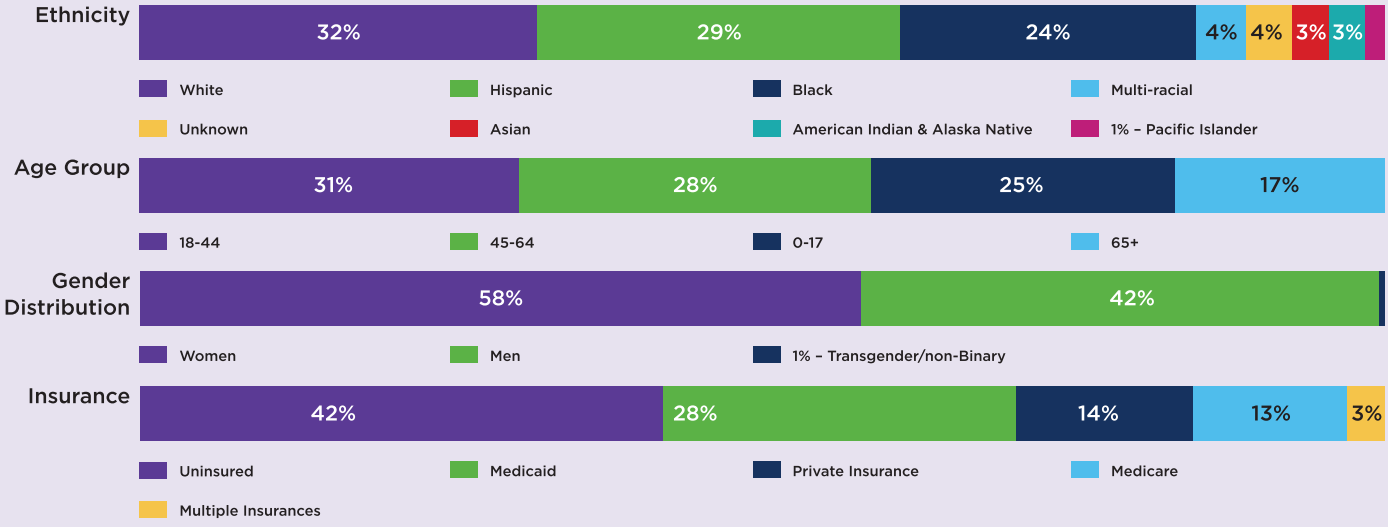
- Utilize existing data sources to identify where to prioritize mobile health clinics
- Develop data sharing agreements across agencies and organizations to integrate care for recipients of mobile health services
- Evaluate mobile health HIV prevention and treatment services delivery to increase impact
- Collect data to articulate the benefits and cost-effectiveness of expanded mobile health clinics

SUSTAIN ADEQUATE FINANCING FOR MOBILE HEALTH

- Leverage philanthropic funding as bridge support until sustainable streams are established
- States must take action to maximize current billing and reimbursement mechanisms

MOBILE HEALTH REACHES UNDERSERVED POPULATIONS

PEOPLE SERVED



Source: Mobile Health Map. (2026). Mobile clinic impact tracker. Harvard Medical School. Retrieved August 21, 2026

SERVICES PEOPLE SEEK FROM MOBILE HEALTH CLINICS

A mobile health pharmacy in Connecticut provides an illustrative example of the types of services mobile health clinics provide, showing that underserved communities are seeking medications provided by primary care services. These communities would benefit from HIV testing, PrEP and treatment initiation; however, they are not primarily seeking those services.

Medical Purpose of Drug	Percentage
Diabetes	21.1
Anxiety and Other Mental Health	18.8
Hypertension	13.3
Pain	5.7
Hyperlipidemia	5.0
Vaccination	3.7
Pulmonary Conditions	3.5
Opioid Use	1.9
HIV Prevention (PrEP)	1.4
HIV Treatment (ART)	1.3
Alcohol Use (AUD)	1.2
Other	23.1

Source: InMOTION Mobile Pharmacy and Clinic, Yale School of Medicine.

Mobile clinics are also being used to provide HIV treatment and prevention and sexual and reproductive health services. Evidence across the United States and globally demonstrates their promise. In Cape Town, South Africa, the Tutu Teen Truck integrated PrEP into comprehensive sexual and reproductive health services, yielding 585 PrEP initiations over two years with high acceptability among adolescent girls and young women.[9] Mobile clinics also engage more men and younger patients than conventional clinics and reach a higher proportion of first-time HIV testers.[5,6]

A peer-navigator model in rural KwaZulu-Natal, South Africa, linked 2,269 youth to mobile sexual health clinics, achieving 92.7% HIV testing uptake and initiating 62 newly diagnosed individuals on ART.[11] In South Florida, a mobile PrEP program used HIV molecular cluster data to focus on neighborhoods with high rates of HIV transmission, addressing disparities among Black and Latino men who have sex with men (MSM).[12] In Brockton, Massachusetts, a mobile addiction and SUD treatment unit reached more patients from underserved racial and ethnic populations than the same organization's brick-and-mortar clinics did.[13] Participants at a mobile retail pharmacy and clinic in Connecticut were more likely to initiate PrEP than those referred through patient navigators.[14] While populations already served by traditional HIV treatment and prevention services have increasing access to longer-acting modalities, uptake has been slow.[15] Moreover, uptake of both oral and longer-acting PrEP remains low among the populations with the highest need. To increase uptake of longer-acting treatment and prevention among populations not currently being served, HIV treatment and prevention must go to them instead of

waiting for them to show up in a clinic. For some, this means delivering health and social services outside of traditional clinics and developing mobile health models for these communities.

1. MEET PEOPLE WHERE THEY ARE

People seek healthcare where they can get it. For many, this means going to hospital emergency departments (EDs) for non-life-threatening conditions due to limited access to primary care, perceived urgency, convenience, and a belief that hospital services offer superior diagnostics and expertise.[16,17] People often turn to EDs when they cannot easily schedule an appointment with a general practitioner.[18] People without a primary care provider are also far more likely to use walk-in clinics, such as urgent care, or EDs. Limited operating hours at health clinics, with little or no night time and weekend availability are also a major driver of non-urgent ED visits. Shorter distance to an emergency department is associated with higher non-urgent utilization.[19] Urgent care and emergency department visits are driven chiefly by primary care inaccessibility and patient perceptions of hospitals as superior sites for care.[17,20]

Given the competing time demands and personal priorities, HIV treatment and prevention are often not the primary drivers of engagement in healthcare. Mobile health clinics seeking to deliver HIV treatment and PrEP should serve as low-barrier entry points to address the needs of people living with or at risk for HIV by providing medical and social services that people most often seek. Clinics that deliver a wide range of services and build trust among communities that are most impacted by HIV are more likely to see engagement with HIV treatment and prevention services.[5] Increasing access to quality healthcare for entire communities will also benefit populations most impacted by HIV.

POLICY ACTION:

Conduct community needs assessments to identify HIV services priorities.

Before mobile health clinics are developed, community needs assessments should be conducted to determine which services populations need most. For some, this may extend beyond medical care, and include services related to food and nutrition, legal assistance, social services linkage for housing and employment, or other needs. For mobile health clinics to be sustainable, they must be located in areas, whether urban, suburban, or rural, where people can access them. For some populations, this may shift depending on the time of day or the season. Mobile health clinics should be co-located in areas frequented by the populations most impacted, such as day shelters, parks, rest locations, churches and universities. Needs assessments also can identify which providers a community needs—such as general practitioners, pharmacists, nurses, physician assistants, or others. For communities most impacted by HIV, needs assessments should also focus on people who are homeless or marginally housed, people who use drugs, MSM, and transgender women.

COMMUNITY NEEDS ASSESSMENTS ARE CRITICAL

Community needs assessments should be used by local health authorities, community-based organizations, brick-and-mortar clinics, and hospitals to ensure the community they seek to serve participates in developing mobile health services, using community-mapping and community-based participatory research to:

- Identify populations not currently being served by existing services.
- Identify service priorities, including primary care, housing, mental health, harm reduction and other services.
- Ensure mobile clinics complement existing brick-and-mortar services, and if necessary, provide a low-barrier model to access existing services through mobile health clinics.
- Understand how stigma may prevent communities from engaging in HIV, sexual and reproductive, and substance use disorder services.
- Brand the mobile unit so that an association with HIV does not prevent communities from engaging.

POLICY ACTION:

Establish partnerships between HIV organizations and primary care providers to operate mobile health units.

Developing trust in communities does not happen overnight. Healthcare providers should work with existing community-based organizations (CBOs) already embedded within communities to develop mobile health services. This includes HIV/AIDS service organizations, with a particular emphasis on organizations led by Black, Latine, and transgender people and by people in recovery. Research and practice have shown that increasing demand for and uptake of HIV prevention and treatment services means also engaging communities around a range of health and social needs. While mobile health units are being deployed for HIV treatment and prevention, and sexual and reproductive healthcare more generally, most mobile health clinics in the U.S. provide a range of primary and specialty care services. This presents an important opportunity to integrate HIV treatment and prevention services into existing units, reaching

BUILDING UPON EXISTING NETWORKS TO SUPPORT MOBILE HIV TREATMENT AND PREVENTION

Several organizations exist to support new and existing mobile health services. HIV organizations should partner with these organizations and develop networks to advance mobile health for HIV treatment and prevention:

- **Mobile Health Map** (http://www.mobilehealthmap.org/) supports a national network of more than 1,300 mobile clinics working to expand access to high-quality, community-based healthcare. It offers free tools, data, and an "Impact Tracker" to help mobile health providers demonstrate their value, improve services, and advocate for health equity.
- **The Mobile Healthcare Association** (http://www.mobilehca.org/) strengthens mobile health by providing education, networking, best practices, field data, and funding and advocacy resources to new and current programs seeking to increase access to care and promote health equity.
- **Driving Health Forward** (http://www.drivinghealthforward.org/) raises awareness about systems change needed to remove barriers, coordinates policy advocacy, and amplifies the value of mobile healthcare.
- **National Association of Community Health Centers** (https://www.nachc.org/) supports mobile clinics run by Federally Qualified Health Centers. NACHC provides competitive awards to support staff training, outreach, and technology/operations expansion so mobile clinics can increase their reach and capacity.

populations that engage in existing health services and may have HIV treatment and prevention needs not currently being addressed. HIV/AIDS organizations should partner with existing mobile health services to provide testing, PrEP initiation, administration of longer-acting PrEP, and primary care and administration of longer-acting HIV treatment.

POLICY ACTION:

Foster collaboration among mobile health clinics providing HIV treatment and prevention.

While community needs assessments and partnerships among HIV/AIDS organizations and mobile health providers can support the development of mobile HIV treatment and prevention services, development of mobile health clinics and sustainable service provision will require shared-learning opportunities for providers and organizations to effectively serve communities. As the evidence base for mobile HIV services is still developing, implementation can be advanced through collaboration and convenings of providers and organizations, to better respond to barriers to care, develop more effective referral and linkage processes, optimize provider capacity, and fill service gaps. This can build on current efforts. To better serve the HIV community in developing mobile health clinics, resources specific to HIV treatment and prevention and learning collaboratives should be established to disseminate research, share practices, and advance the implementation of mobile health clinics for HIV treatment and prevention.

2. USE RESEARCH AND DATA TO OPTIMIZE MOBILE HEALTH

Mobile health units have long reached people whom brick-and-mortar clinics struggle to serve. Peer-reviewed evidence shows that by bringing care directly to the curbside, mobile clinics succeed in engaging marginalized populations. These include people experiencing homelessness and housing instability, who are frequently disconnected from traditional healthcare settings.[2] They also have proven acceptable and effective for people who use drugs, a group at heightened risk for HIV and hepatitis C and often alienated from fixed care settings.[21] Yet the field still lacks a robust research base on how mobile programs can most effectively engage communities, particularly in areas where clinics are distant or inaccessible, in order to sustain that engagement over time.

What evidence exists points to consistency as a linchpin. Mobile programs build trust and keep patients connected when they maintain a predictable location and schedule and deploy the same staff, so that clients can reliably find care and be found for it. High turnover and shifting sites erode the relationships on which retention depends.[22] This challenge is exacerbated by a critical lack of reliable and timely data. Continuity of care depends on information following the patient, but fragmented electronic health record (EHR) systems open dangerous gaps as people move between settings. This is especially true at the clinical care/criminal-justice interface, where care delivered in prisons remains disconnected from community providers.[23] In the case of PrEP adherence, evidence also points to community-centered models in which staff share lived experience with clients, which encourages more frequent visits and reduces medical mistrust and HIV stigma.[17] Closing those gaps, and building the evidence for mobile delivery, will require deliberate investment in research and data infrastructure. The recommendations below identify where that investment can most strengthen the reach, quality, and durability of mobile HIV prevention, care, and treatment.

POLICY ACTION:

Utilize existing data sources to identify where to prioritize for mobile health clinics.

States and programs do not need to start from scratch in deciding where to deploy. Harvard Medical School's Mobile Health Map, for example, classifies clinics by the populations they reach, including people who are unhoused, uninsured, veterans, immigrants, LGBTQ+, and rural residents, building a national picture of where mobile care reaches and where it is absent.[24] Public tools can sharpen targeting further. The CDC's Social Vulnerability Index, built from census data on poverty, housing, and transportation access, is designed to identify the communities in greatest need, precisely the areas where mobile deployment can do the most good.[25] Geospatial mapping of travel time and gaps in nearby care can steer units toward primary-care shortage areas and neighborhoods far from an emergency department or federally qualified health center. The COVID-19 response offers a proven template. Mobile units delivered vaccines to underserved communities including Black, Hispanic, and uninsured communities and generated utilization data to guide future deployment.[26] The same methods can direct mobile HIV and PrEP services toward areas, such as regions with hospital closures or without Medicaid expansion, where fixed care is receding.

POLICY ACTION:

Develop data sharing agreements across agencies and organizations to integrate care for recipients of mobile health services.

Data sharing is a critical component of ensuring patients are treated appropriately across multiple care centers, including mobile health clinics. Fragmented EHR systems make this difficult. To serve mobile health clients who already have a provider, both the mobile program and the patient's existing provider must see prior labs, comorbid conditions, and medication history. For mobile units embedded in an existing clinic, this is straightforward. But people moving between systems — those released from incarceration, those in the Veterans Affairs (VA) system, or patients of other networks such as hospitals — are likely to fall through the cracks. Clinicians need access to the timeliest and most relevant patient health information to make healthcare decisions. Across the U.S., less than half of hospitals routinely engage in functional exchange of health information.[27] In prison settings, a study found only 5% of eligible individuals filled HIV medications within ten days of release from prison, and mortality in the two weeks post-release was twelve times that of the general population.[28] Furthermore, VA record modernization remains incomplete despite years of investment, and correctional systems commonly run separate EHRs.[29] National efforts to advance health-information sharing are underway but uneven in reach.[30] Mobile health programs should therefore establish formal data-sharing agreements and use health information exchanges across clinics, corrections, the VA, and other partners to follow patients across settings.

POLICY ACTION:

Evaluate mobile health HIV prevention and treatment services delivery to increase impact.

Mobile clinics improve HIV testing rates and linkage to care, but the evidence guiding their use to deliver ongoing HIV treatment and prevention remains limited.[31] Building this evidence base requires programs to measure the outcomes that matter. This includes continuity of care, retention and loss to follow-up, treatment adherence, and viral suppression. Electronic health records should be used to track these outcomes over time. Real-time utilization data on who arrives at each site can then refine both where units go and which services they offer. Early programs already hint at the promise. A Washington, D.C. clinic scaling longer-acting injectable HIV treatment reported 96% viral suppression among participants, compared with 83% on daily oral therapy.[32] Retention, however, remains the persistent gap. Mobile programs must contend with severe weather, community instability, staff turnover, and the mobility of patients' lives. Fragmented schedules and staff turnover directly undermine adherence and trust.[2] Rigorous evaluation of models built to retain patients in care, including outreach that re-engages those who have fallen out of clinic-based services, could show which approaches most durably improve HIV outcomes and warrant wider financing.

POLICY ACTION:

Collect data to articulate the benefits and cost-effectiveness of expanded mobile health clinics.

The case for mobile health rests partly on economics, and the early signals are encouraging. Mobile clinics can divert costly ED use. In one Toronto program, 37% of clients said that without the clinic they would have gone to the ED, while 18% would not have sought care at all.[33] By engaging people early, screening for HIV at far higher rates than fixed clinics and starting prevention and treatment before disease advances, mobile units can also avert expensive downstream care. Yet the economic evidence remains incomplete. Rigorous data on what mobile programs cost to operate, how much they save the health system, and whether they can be financed sustainably are still scarce, and researchers continue to call for cost-effectiveness studies.[22] States and funders should

invest now in research that quantifies operating and maintenance costs, savings from averted hospitalizations, and the long-term value of earlier HIV diagnosis, treatment, and prevention, so that mobile programs can be scaled and financed on the strength of evidence rather than promise.

3. SUSTAIN ADEQUATE FINANCING FOR MOBILE HEALTH

In 2022, Congress passed the Maximizing Outcomes through Better Investments in Lifesaving Equipment for (MOBILE) Health Care Act (PL 117-204). This law was designed to make healthcare more accessible to rural and medically underserved communities by making it easier to deploy mobile healthcare units. While the MOBILE Health Care Act did not appropriate new money, it amended the Public Health Service Act to expand the allowable use criteria for New Access Points grants, allowing existing health centers receiving Section 330 (i.e., the federal Health Centers Program) funds to establish mobile units without building another permanent site. The Rural Health Transformation Program (RHTP), administered by the Centers for Medicare & Medicaid Services (CMS), empowers states to modernize rural healthcare infrastructure and develop sustainable delivery models. RHTP funds states to build or expand mobile health programs and to support partnerships among rural hospitals, local emergency medical services, and community health centers. The Health Resources and Services Administration (HRSA) and the Substance Abuse and Mental Health Services Administration (SAMHSA) are the primary federal grant sources available to mobile health clinics, alongside state-administered opioid response and RHTP funds.[34] Title X supports mobile reproductive and sexual health services, although funding has been subject to significant disruption. States should explore how existing policies can be adapted to allow the administration of longer-acting HIV treatment and prevention through existing mobile health units, whether through paramedicine, crisis response, or standard primary or specialty care. While philanthropic funding is currently complementing grants and funds provided by federal, state, and local programs, long-term sustainable financing from the government is needed. State legislatures and Medicaid State plan amendments and waivers can better support mobile health and have done so across the country.[35]

POLICY ACTION:

Leverage philanthropic funding as bridge support until sustainable streams are established.

Mobile clinics are typically financed by philanthropy, federal, state, or local governments, insurers, and patient payments. Governmental grants typically cover vehicle purchase and the first year of operating costs via the MOBILE Act and RHTP. These sources alone are not sufficient to maintain mobile health units.[36] Standard billing codes reimburse only for direct clinical encounters, and traditional billing models offer few to no mechanisms to claim reimbursements for operational costs required to run a mobile health clinic. Mobile health units often deliver services that

POLICY TO SUSTAIN MOBILE HEALTH CLINICS

The Georgetown University Center on Health Insurance Reforms (CHIR) identified federal and state policies and funding streams that affect mobile health programs, reviewing statutory law, legislation, grants, and state Medicaid documents enacted or effective between January 2015 and June 2025. CHIR developed policy recommendations across government levels to expand and sustain mobile health clinics. We have highlighted some of their recommendations here:

- Develop payment methodologies that reflect the cost structure of mobile delivery, including bundled, per diem, or prospective payments where appropriate.
- Explicitly recognize mobile services as covered when delivered in mobile settings, either by defining mobile models as covered services or by clarifying place-of-service and encounter rules.
- Ensure that mobile providers are integrated into managed care networks and referral pathways.
- Support grantees of state and federal programs in developing Medicaid and commercial payer billing capacity.
- Provide structured technical assistance on licensure, scope of practice, data reporting, and compliance requirements.
- Facilitate peer learning among grantees to reduce duplication of effort and surface common challenges.
- Remove arbitrary geographic or setting-based restrictions that undermine access goals.

To learn more, read From Evidence to Implementation: *Federal and State Policy Pathways for Scaling Mobile Health*. Georgetown University, 2026, chir.georgetown.edu/wp-content/uploads/From-Evidence-to-Implementation.pdf

target social determinants of health such as health risk assessments, food distribution, and housing navigation, which are all essential for sustained engagement with communities. However, these services are not universally reimbursable. Mobile programs rely on philanthropic grants or local subsidies rather than self-sustaining clinic revenue for this work. Philanthropy should continue to support mobile health clinics, specifically for uninsured patients and those ineligible for the AIDS Drug Assistance Program (ADAP). Philanthropy also can support HIV-specific mobile health programs and services, and fund peer-learning collaboratives to aid providers and organizations when developing and improving mobile health clinics.

POLICY ACTION:

States must take action to maximize current billing and reimbursement mechanisms.

Mobile health clinics in the U.S. face billing and reimbursement barriers rooted in fragmented payer policies, inadequate coding mechanisms, and financial constraints that threaten program sustainability.[37,38] These challenges span commercial insurance, Medicaid, and Medicare, with no single reimbursement pathway providing adequate coverage. Under HRSA policy, a mobile health unit is treated as a site of the health center included within the center's organization. However, whether a state Medicaid agency treats the mobile unit as within the health center for reimbursement purposes depends on state law and state agency determination.[39] The result is wide variation across states in whether a mobile clinic can earn maximal rates. Mobile clinics could also use capitated payment models (i.e., per-member-per-month, PMPM payments) that pay a flat monthly rate for managing the care of every enrollee and can include add-on payments outside of the capitated rate that account for the upkeep of the mobile unit itself. The Michigan Mobile Health Unit Program, for example, combines upfront bundled rates for prevention services with PMPM rates for remote management.[40] States should explore how Medicaid and private managed care organizations can set reimbursement rates that reflect the cost savings mobile clinics produce. Those savings come from diverting avoidable emergency department visits and from identifying preventable and chronic conditions early enough to treat them before they advance, averting the higher lifetime cost of late-stage disease such as HIV/AIDS.

THE TIME IS NOW

Mobile health clinics serve populations that face geographic, economic, and structural barriers to traditional healthcare, and identifying these populations requires analysis of demographic and geospatial data as well as community engagement. To realize the promise of innovative, longer-acting options for HIV treatment and prevention, mobile clinics must earn the trust of the communities they serve and offer not just HIV services but the widest possible range of health and social services to meet differing community needs.

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