



Closing the Distance to Care in Underserved Communities with Mobile Health Programs

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Mission Mobile Medical & the Association of Clinicians for the Underserved

INTRODUCING OUR SPEAKER



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The Power of Proximity

Closing the distance to care in underserved communities

Presented by: **Mollie Williams, DrPH, MPH**

Proximity

(n) nearness in place, time, or relationship.

Diliges proximum tuum sicut te ipsum.

Too often mobile healthcare planning and funding **stops with the vehicle.**

What is the alternative?



What proximity means for patients

Convenient

Care at a familiar site patients can reach on a predictable schedule.

Clear

Patients understand privacy, services, costs, and next steps in their own language.

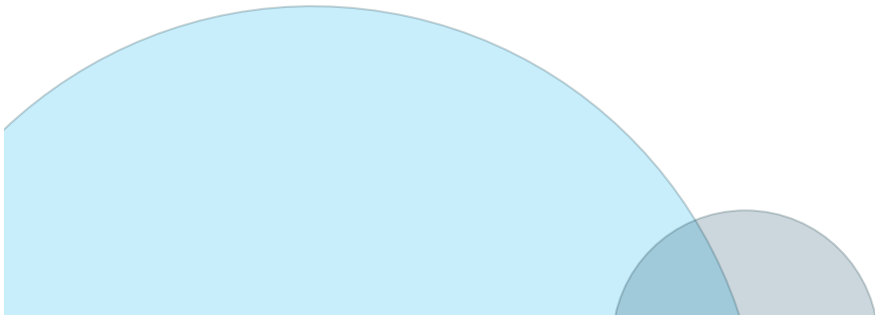
Connected

The visit is documented, shared, and tied to a clinical home that follows up.

Today

Five practices for a strong mobile program

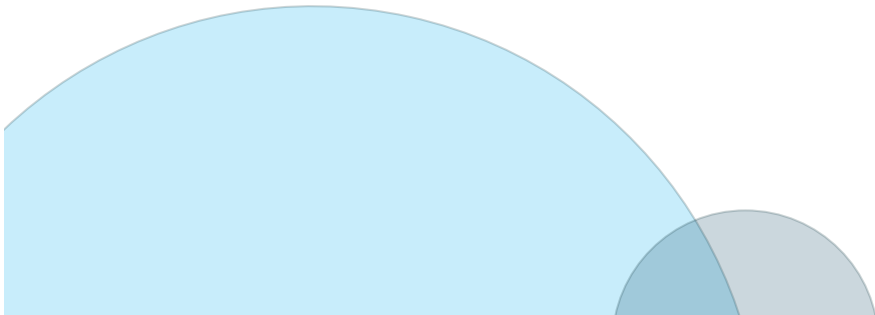
- 1 Site selection
- 2 Team design
- 3 Referral closure
- 4 Measurement
- 5 Value-based payment



Poll

Where does your program hit roadblocks?

- A** Choosing sites
- B** Staffing the team
- C** Showing results
- D** Sustaining funding
- E** Still planning a program





The landscape

**More clinics.
More visits.
More research.**

3,600+

mobile clinics operating
nationwide

10M

patient visits each year

470+

research studies

Sources

Mobile Health Map, Harvard
Medical School (2025); Mission
Mobile Medical Evidence Library
(missionmobilemed.com/evidence-library)



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EVIDENCE & INSIGHTS

Evidence Library

The research base for mobile healthcare: studies, outcomes, and data on how mobile clinic programs expand access and improve quality.

470
STUDIES

299
JOURNALS

86
YEARS OF RESEARCH

 Search by title, author, journal, or keyword...

All service types ▾All settings ▾All populations ▾All study designs ▾All years ▾

All Studies
470 studies

Rural
96 studies

Dental
37 studies

Substance Use
57 studies

Primary Care
164 studies

Infectious Disease
52 studies

Mammography
45 studies

Preventive/Screening
35 studies

Visit our Evidence Library at missionmobilemed.com/evidence-library

87%

of buprenorphine patients would not have started treatment that day without the van (Shah et al., 2026)

25% → 41%

share of patients from the most socially vulnerable communities, after geospatial targeting (Twiner et al., 2024)

What separates programs that last

Programs that flounder

- Sites: chosen for parking and convenience
- Team: limited staffing, hidden work
- Referrals: handed to the patient
- Measurement: visit counts
- Funding: vehicle purchase and a startup grant

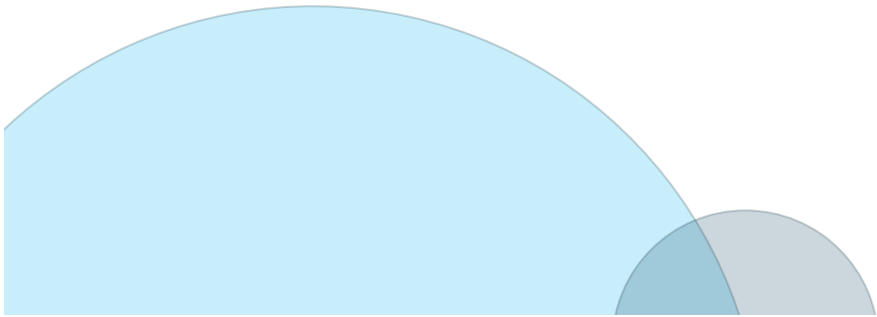
Programs that last

- Sites: based on need and community input
- Team: every role named and budgeted
- Referrals: tracked to completion by a named owner
- Measurement: reach, closed referrals, experience
- Funding: five-year forecast across billing, grants, contracts, and value-based payment

A mobile clinic creates a healthcare space.

A **mobile program creates access.**

- 1 Site selection
- 2 Team design
- 3 Referral closure
- 4 Measurement
- 5 Funding





One way to identify sites

1. Start from patients who are covered, referred, or due for care and remain unreached
2. Look at where they live, work, and already go
3. Ask community partners which sites feel safe, familiar and private
4. Favor recurring sites: same place, same day, same team
5. Confirm parking, power, and safety

Team design

What makes someone an ideal mobile team member?

List

Outreach
maple
maple
maple
maple

Referral closure

Give every step of the loop an owner

Ask: Where does the loop break most often for your patients?

01

Receipt

The receiving provider has the referral

Owner: _____

02

Scheduling

The appointment is booked with the patient

Owner: _____

03

Completion

The patient was seen and the result came back

Owner: _____

04

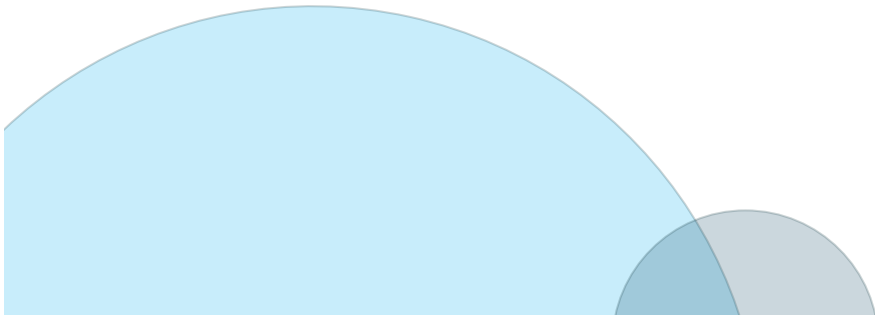
Re-engagement

Patients who missed a step were contacted

Owner: _____

Measures beyond visit counts

- 1 Reach: share of patients from target communities
- 2 Services: preventive services done; conditions detected
- 3 Referrals: share of referrals completed
- 4 Follow-up: follow-up visits completed
- 5 Experience: a brief survey at each site
- 6 Revenue by site: revenue and cost per site



Suggested measures: reach and access

Domain	Measure	Suggested calculation or definition	Why it matters
REACH	Unique patients served	Count each patient once during a defined reporting period	Shows how many people received care
	Patient encounters	Total completed visits during a defined period	Shows service volume
	Intended population reached	Number served from the intended population divided by the estimated number eligible or in need	Connects activity to community need
ACCESS	New patients	Patients with no previous visit to the program divided by unique patients served	Shows whether the program is extending access
	Time to service	Median time from request, referral, or eligibility to completed service	Identifies delays
	Geographic access	Distance or estimated travel time between a patient's community and the nearest fixed-site alternative, using a documented method	Describes the access barrier addressed

Suggested measures: care, experience, and health

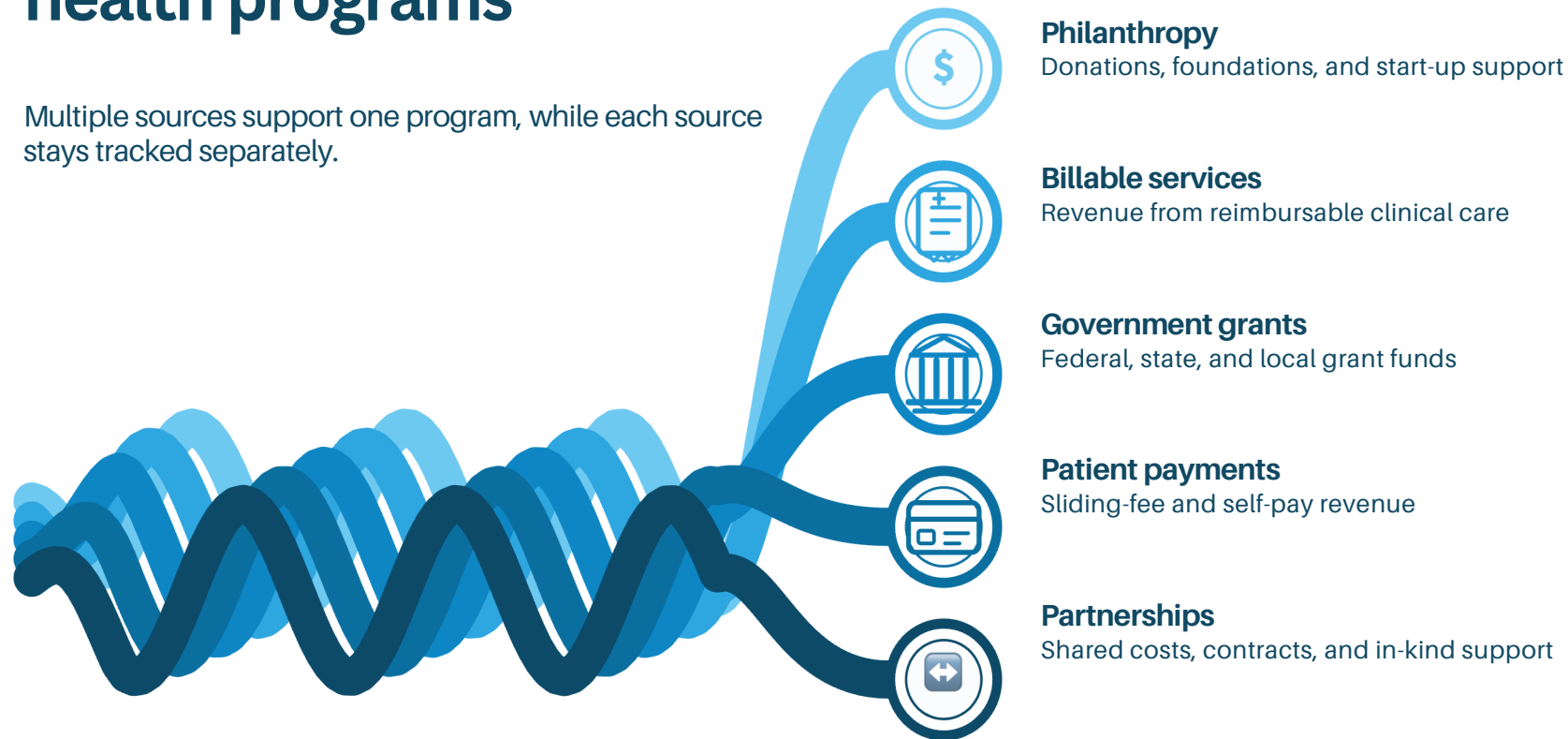
Domain	Measure	Suggested calculation or definition	Why it matters
CARE DELIVERY	Screening completion	Eligible patients who received the screening divided by eligible patients seen	Measures delivery of an intended service
	Referral completion	Referred patients who completed the referral within a defined period divided by patients referred	Shows whether connections lead to care
	Follow-up completion	Patients completing the planned follow-up within a defined period divided by patients due for follow-up	Measures continuity
EXPERIENCE	Respect and trust	Patient-reported experience measured with clearly worded questions or a validated instrument	Shows whether patients experience care as respectful and trustworthy
	Needs addressed	Patients reporting that the visit addressed their main need divided by patients responding	Connects services to patient priorities
HEALTH	Condition-specific outcome	Change in a clinically appropriate measure over a defined period	Assesses whether health status changed
	Patient-reported outcome	Change in symptoms, function, quality of life, or confidence using an appropriate instrument	Captures changes patients can report directly

Suggested measures: equity, cost, and sustainability

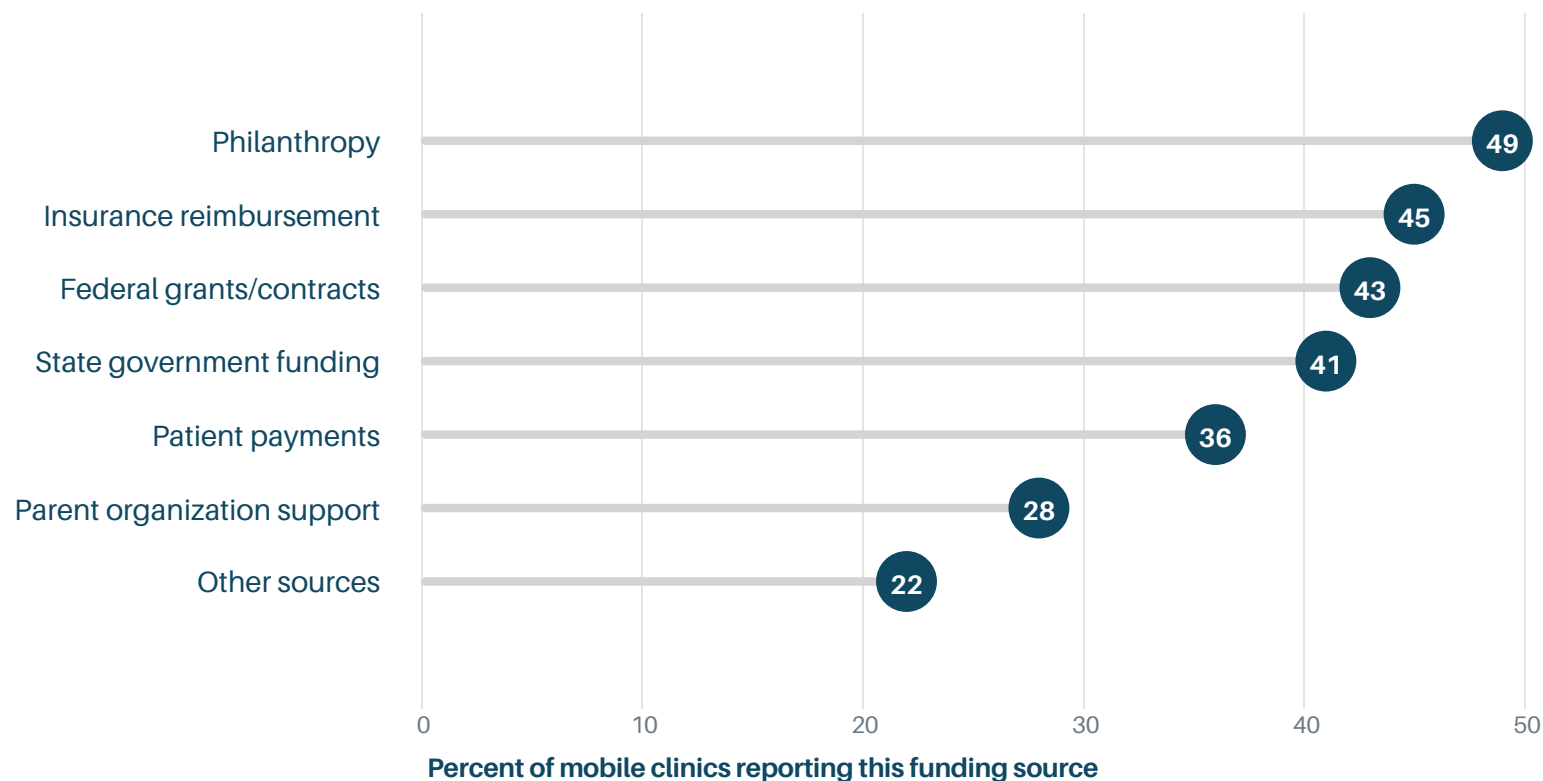
Domain	Measure	Suggested calculation or definition	Why it matters
EQUITY	Reach and outcome differences	Report key measures by relevant population, geography, language, payer, or other justified characteristics	Shows who benefits and where gaps remain
COST	Operating cost per encounter	Total program operating cost divided by completed encounters	Supports budgeting and comparison over time
	Operating cost per unique patient	Total program operating cost divided by unique patients served	Shows resource use at the patient level
IMPLEMENTATION	Service delivered as planned	Completed delivery elements divided by elements specified in the program model	Measures consistency and fidelity
	Site reliability	Completed mobile service days divided by scheduled mobile service days	Shows operational reliability
SUSTAINABILITY	Funding concentration	Share of annual revenue supplied by the largest funding source	Identifies financial dependence
	Program continuation	Whether the service remains active at a defined follow-up point, with changes documented	Measures maintenance over time

Braided funding for mobile health programs

Multiple sources support one program, while each source stays tracked separately.



How mobile clinics are funded



Programs report multiple sources, so percentages exceed 100. Source: Mobile Health Map 2025 Impact Report

Budget for the long game

Mobile health programs take time to pay for themselves. Be intentional about your financial goals and strategies.



Payer Mix

- Medicaid
- Medicare
- Private Insurance
- Uninsured
- Other (e.g. CHIP)



Service Mix

- Primary Care
- Specialty Care (GYN, Pediatrics)
- Pharmacy
- Dental
- Vision
- Enabling Services



Plan 3 to 5 years ahead, not just year one

Most programs take a few years to break even as patient visits grow and other revenue adds up. Planning several years out keeps expectations realistic with funders and leadership.

YEAR 1

Getting started: launch, build trust, and fine-tune your routes and schedule.

YEARS 2 TO 3

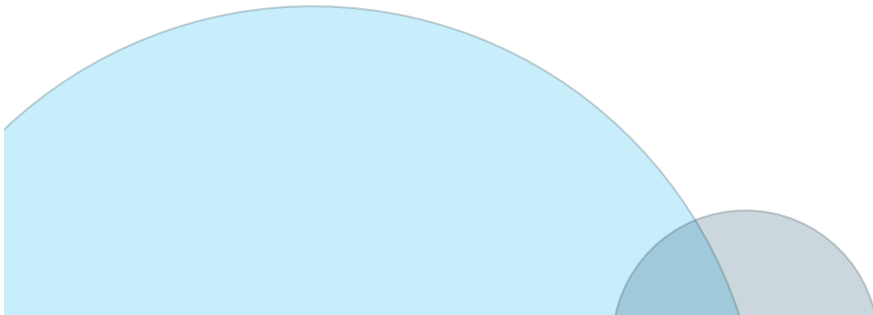
Growing: more visits, referrals, and payments move you toward break-even.

YEARS 4 TO 5

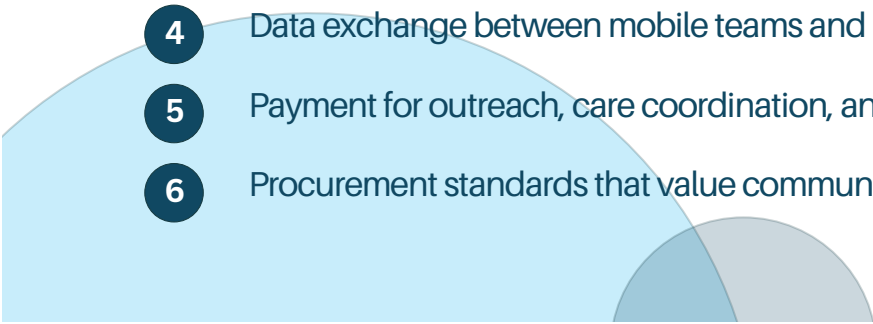
Steady: stable operations and a clear return you can measure.

What patients should experience

- ☐ The site is familiar and easy to reach
- ☐ The schedule is predictable
- ☐ The team explains privacy, services, costs, and next steps
- ☐ The patient communicates in their preferred language
- ☐ Care is documented once and shared with the right provider
- ☐ Referrals include help with scheduling and follow-up
- ☐ The provider returns, or the patient knows where to go next



Advocate. Help advance the field.

- 1 Billing guidance: clear Medicaid and Medicare guidance for mobile settings
 - 2 Workforce support: training and tools for CHWs, navigators, and care coordinators
 - 3 Startup funds tied to sustainable operating plans
 - 4 Data exchange between mobile teams and receiving providers
 - 5 Payment for outreach, care coordination, and referral completion
 - 6 Procurement standards that value community trust and clinical integration
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Questions

Contact

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WHITE PAPER • 2024

The Power of Proximity

Closing the Distance to Care
in Underserved Communities

What mobile healthcare is, where it works best, and what it takes to design a program that meaningfully improves access to comprehensive, quality care.



Access the White Paper

The Power of Proximity: Closing the Distance to Care in Underserved Communities

