No Unit, No Problem

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Mobile Health Program

Introduction

Program Mission
To improve the health of the medically underserved communities in our region by providing premier, community-informed health care, and by providing appropriate access to health care services.

Program Overview
Physical mobile units are a great tool to create convenient access to care for identified populations, but they are not the only strategy for creating access in the communities that we serve. For many community-based organizations, the development of a mobile program has inherent financial barriers to entry including the purchase and upfit of a mobile unit and ongoing maintenance. Additionally, a custom unit may take a significant amount of time to build.

Leaders at Atrium Health Wake Forest Baptist (AHWFB) did not let the absence of a mobile unit stop their efforts to improve access to primary care in the most vulnerable communities of Winston-Salem, NC.

The Mobile Health Program (MHP) started in fall 2019 as a once-a-month service with volunteer providers, to help bridge access to care. Due to operational challenges with the unit, the team turned to a site-based primary care program in June 2021. Our site-based model embeds clinics in community partner facilities, building on established trust and familiarity. Our weekly locations include faith homes and community centers. The clinic is also designated as a Free and Charitable clinic solely focusing on the uninsured populations in the area.

The selection of care sites was a key step in addressing the access gaps that existed in the community. To identify the best locations for care, the MHP utilized Area Deprivation Index (ADI) mapping - a measure created by the Health Resources and Services Administration (HRSA) and Community Assets and Resources Map for Forsyth County to guide community conversations. This approach helped the team identify disadvantaged areas as well as healthcare deserts for targeting of community partners and clinics.

Since July 2021, the Mobile Health Program has had over 4,600 clinic visits. The clinic operates four days a week and offers extended operations twice a week to accommodate community members that may be unable to access the clinic during “traditional” hours.

Services provided through our clinic are similar services that would be received in a “traditional” primary care environment although we are limited in our ability to gynecological services due to space and/or privacy concerns (Figure 3).

Through our diverse community-based partnerships and care locations, the mobile clinic has established itself as a trusted service for our Hispanic/Latino community – a group that traditionally has had less access to quality medical care where they live. Since opening, 80% of our patients have identified as this ethnicity.

Program Assessment

Physical Space: Thanks to the site-based model, we have more space to work with patients and medical students, training with the clinic. Weather considerations are no longer a major concern although internal temperature can impact the clinic environment

Location: Patients can come to trusted sites within their home communities for care. For our clinic, we have found having faith-based and city-based sites are important to our patient population. Community partners have increased their involvement with the clinic and mission, resulting in increased partner buy-in.

Cost: A site-based model significantly decreases the overhead needed to fund and run accessible clinic space. This approach removes many financial burdens including the initial investment in a mobile unit, ongoing operational costs such as maintenance, insurance, and a driver.

Limitations: The clinic is subject to the host site's scheduled hours and holidays, and there is reduced privacy due to the shared nature of these spaces.

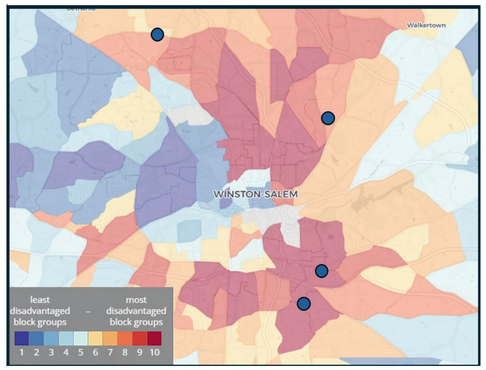

Figure 1: *The Area Deprivation Index (ADI) by census tract for Winston-Salem and the surrounding area. MHP locations identified as blue circles. University of Wisconsin School of Medicine and Public Health. 2022 Area Deprivation Index Version 4. Downloaded from https://www.neighborhoodatlas.medicine.wisc.edu/ August 8, 2024*

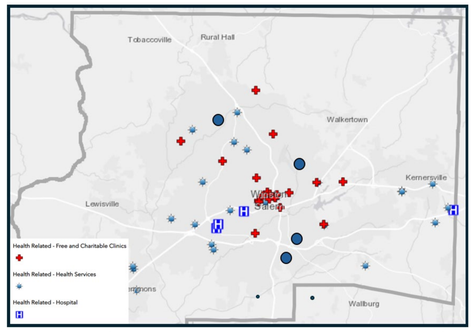

Figure 2: *The Community Assets and Resource Map for Forsyth County (NC), highlighting area healthcare facilities. MHP locations identified as blue circles.*
MapForsyth City-County Geographic Information Office. 2024 Community Assets and Resources Map for Forsyth County. Downloaded from https://www.mapforsyth.org/ August 9, 2024.

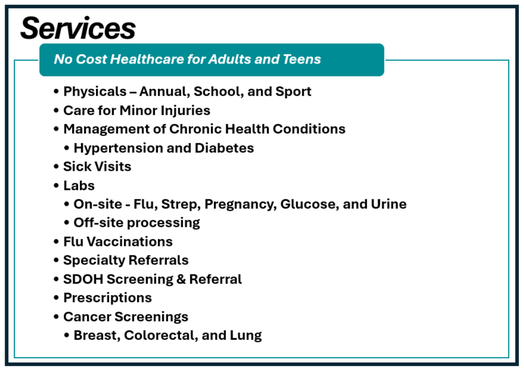

Figure 3: *Services provided by the Mobile Health Program. Areas currently out of scope include chronic pain management; biopsies; gynecological/OB care; orthopedics; infant & children’s care; imaging; dispensing of controlled Substances; dermatology; and severe wound care*

Race	Hispanic/Latino	Non-Hispanic/Latino
American Indian/Alaska Native	2	1
Asian	9	8
Black/African American	4	119
Multiracial	18	2
Native Hawaiian/Other Pacific Islander	7	3
White	108	93
Unreported[2] – *Only Reported Ethnicity*	1,140	19
Sub-Total	1,288	245
Unreported[3]	60	
TOTAL[4]	1,593	

1. July 2021 – June 2024
2. Chose not to disclose race, but reported ethnicity
3. Chose not to disclose Ethnicity AND Race
4. Number unduplicated patients by Ethnicity and Race

Figure 4: *Patient Ethnicity and Race (July 2021 – June 2024).*

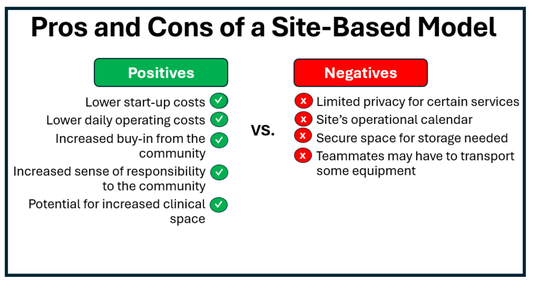

Figure 5: *A summary of Pros and Cons of our Site-Based care model*

Hypertension: Controlling High Blood Pressure – BP measure < 140/90	2023 Mobile Clinic	2023 NCAFCC (52 clinics)	2023 NC HRSA Health Centers	2023 NC DHHS ORH
	52.6%	62.6%	66.02%	66.1%
Hemoglobin A1c Poor Control – Estimated Percentage of Patients with A1c >9% or No A1c Test Performed (lower results signify better performance)	**2023 Mobile Clinic**	**2023 NCAFCC** (52 clinics)	**2023 NC HRSA Health Centers**	**2023 NC DHHS ORH**
	36.4%	25.2%	26.74%	28.1%

Figure 6: *Program outcomes for metabolic conditions. Between July 2021 and June 2023, a registered dietitian was contracted with the program to provide nutrition counseling to patients 2 days a week. The loss of this resource adversely impacted outcomes.*

Next Steps

Services
To increase the comprehensiveness of our services and to better meet the needs of our patients, MHP Leadership is working to address care gaps such as:

- *Acute Social Needs*: Integrate a community health worker (CHW) to assist patients with the navigation of social needs and the health system as well as increased health literacy; emergency food boxes.
- *Women’s Services*: The expansion of gynecological services is essential in establishing the clinic as a medical home for all patients.
- *Point of Care Testing:* Expediting test results, reducing the number of necessary visits for our patients.

Clinical Outcomes
Hypertension and Diabetes Management: 40% of patients seen by MHP have a cardiometabolic condition. (Figure 6)
MHP Leadership is partnering with other high performing Free and Charitable Clinics in NC to implement best practices to improve outcome measures among their patient population.

Scaling
With philanthropic support, our care model will be scaled to rural areas of our footprint within the next year, expanding the opportunity to engage vulnerable communities in their healthcare and well-being.

Figure 7:*The MHP team poses with Dr. Deacon following a lecture to medical students at Wake Forest University School of Medicine*

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