Scaling Up: Strategies for Growing Your Mobile Health Program

Part 1: Data-Driven Needs Assessment, Service Models, and Financial Sustainability

Masterclass Series

06/02/2026

mobile healthcare association

The Mobile Healthcare Masterclass Series is provided by:

Direct Relief

Masterclass Series: Getting Started

Meeting Guidelines

- ✓ All participants are muted.
- ✓ Change your screen name to your name and organization.
- ✓ Reminder: CMEs are available to those who attend in person.
- ✓ Redemption instructions will be shared at the end and via email.
- ✓ Thank you for your patience and cooperation!

Meet Your Facilitators

Chelcie Oseni, MBA, BSN, RN

- Clinical Manager of School Health at Methodist Le Bonheur Community Outreach.
- Manages grant- and philanthropically-funded school-based community outreach programs.
- Serves Memphis, TN, and multiple rural West Tennessee counties.
- Nearly 10 years of leadership experience with Le Bonheur.

Meet Your Facilitators

Shawn Oprisiu

- Shawn, Dental Outreach Director at Swope Health
- Led the development of two mobile dental units serving 95 schools across the Kansas City MO/KS metro area.
- 2025 Dental Hygienist of the Year (Benco Dental)
- 2025 Denobi Award
- 2024 Tellie Award for Teledentistry Innovation

Needs Assessment & Strategic Scaling

Determining Readiness

Expansion Signals

Demand > Capacity

- Consistently booked 80–90%+.
- Waitlist is growing weekly or new counties are requesting services.

Operational Stability

- Clinics run smoothly without leadership "firefighting" daily.
- Staff roles are clear and systems are documented.

Financial Margin

- The current unit is financially viable on its own.
- Revenue/funding is predictable and covers operating costs.

Expansion Readiness Scorecard

Know Your Numbers

Service Utilization ≥ 85%	**No-Show Rate** ≤ 10%	**Cost Per Visit** Stable or declining
Revenue Per Day Consistently predictable	**Staff Turnover** < 20% annually	**Cash Runway** 6+ months
Referral Waitlist Growing weekly	**If 5 of 7 are met**	You are expansion-ready

Core Data You Must Track (Weekly & Monthly)

The Pulse of Your Program

1 Demand Data

- Appointments booked per route or per site
- Referral sources (schools, shelters, employers, FQHCs)
- Waitlist length by type of appointment
- Missed service days due to capacity limits

2 Operational Data

- Patients per hour or per day
- Setup/teardown time
- Drive time per site
- Chair idle time
- No-show and cancellation rates

3 Financial Data

- Cost per mile
- Cost per patient
- Revenue per mobile unit
- Net margin per route/day
- Staff cost per visit

Slide 9

LB1 I would want to be sure Shawn can answer questions about how you get some of these data points. Especially the Financial Data.
Laura Bollan, 2026-04-24T15:49:52.841

Break-Even Test

1. **20% overhead**
   If one mobile unit cannot fund itself plus a 20% administrative overhead, do not add another.
2. **Formula**
   Daily Revenue – (Staff + Fuel + Supplies + Maintenance + Admin) = Expansion Margin
3. **90 Day Positive**
   Your Expansion Margin must be consistently positive for 90 days before committing to growth.

Market Expansion Checklist

Question	Data Source
Is there unmet need?	Medicaid rates, school FRPL %, HRSA data
Are there referral partners?	School districts, shelters, local clinics
Is travel efficient?	Route mapping and drive-time analysis
Is reimbursement viable?	Payer mix analysis
Can you staff locally?	Workforce availability and local licensing

When NOT to Expand

Warning Signs

- **Team Burnout**
  High turnover or staff morale issues.
- **Cash Flow Swings**
  Inconsistent revenue or recurring monthly deficits.
- **Declining Quality**
  A dip in clinical quality scores or patient safety metrics.
- **Operational Dependency**
  Leadership is still required for daily "firefighting" to keep the mobile unit on the road.
- **Rising No-Show Rates**
  Signals a breakdown in patient engagement or scheduling systems.

Key Takeaways:

1. **Scaling is Strategic, Not Reactionary:** Expansion is driven by documented community needs and internal readiness.
2. **Respect the Scorecard:** Use objective metrics like the 85% utilization rate and the 90-day Break-Even Test to validate your readiness before committing resources.
3. **Stability First:** Never scale a chaotic system. Focus on optimization before adding a second mobile unit or new service line.
4. **Validate the Market:** Use data—not just anecdotes—to confirm unmet needs, referral partnerships, and reimbursement viability in any new territory.

Poll

Which of the three expansion signals is most evident in your program right now?

A. **Demand > Capacity:** Our waitlist is growing and we are consistently booked at 85%+.
B. **Operational Stability:** Our systems are documented and clinics run without daily "firefighting."
C. **Financial Margin:** Our current mobile unit consistently funds itself plus administrative overhead.
D. **None of the Above:** We are currently focused on stabilizing our foundation.

Scaling Models

Models for Scaling

Add a New Route
Maximize your current mobile unit by extending hours or adding new sites.

Add a New Unit
Launch a second mobile unit to duplicate or specialize.

Add a New Service Line
Integrate new clinical or wraparound service

Partnership Scaling
Expand reach by sharing resources, staff, or mobile units with another organization.

Model 1: Add a New Route

Extending your current mobile unit's schedule by adding new sites or increasing hours of operation.

When to Use	Pros	To Consider
When utilization is >85%, but the budget or demand doesn't yet support a second unit.	Low capital investment (no new vehicle cost). High Return on Investment (ROI) by maximizing current staff and equipment.	Increased wear and tear on the mobile unit. Potential for staff burnout if not managed carefully.

Model 2: Fleet Expansion: *Duplication*

Launching a second mobile unit that replicates the exact services, staffing model, and workflows of your first successful unit.

When to Use	Pros	To Consider
When your current unit is consistently at 90% capacity. When the community need is high but the geographic reach is limited by a single vehicle.	Uses a proven "playbook" for clinical and operational success. Shared inventory, supplies, and backup staffing across the fleet.	Significant upfront investment (often $500k+). Doubles the requirements for maintenance, fuel, and staffing.

Model 2: Fleet Expansion: *Specialization*

Expanding the fleet by adding a second unit designed for a specific subset of services to optimize workflow.

The "Swope Health" Model

Unit 1: Dedicated to high-volume preventative hygiene (high turnover).

Unit 2: Dedicated to complex restorative or specialized procedures (long chair times).

When to Use

"When "long-chair-time" procedures are creating a bottleneck for routine preventative care.

When the patient population requires a mix of specialized and general services.

Pros

Increased Throughput: Unclogs the schedule by separating fast and slow procedures.

Staff Optimization: Allows you to place specialized providers on the unit where they are most effective.

Model 3: Add a New Service Line

Integrating a new clinical specialty into your existing mobile platform to provide more comprehensive, "whole-person" care.

When to Use

When your needs assessment shows high referral volumes for a specific specialty you don't currently provide.

When you have secured funding specifically for a high-priority health gap (e.g., reducing maternal mortality rates).

Pros

Dramatically reduces transportation barriers for patients needing multiple types of care.

Examples

Maternal Health: Adding prenatal screenings, or postpartum care to a unit.

Behavioral Health: Integrating a licensed counselor or social worker to provide on-site mental health support.

Model 4: Partnership Scaling

Expanding reach by sharing resources, staff, or mobile units with another organization.

The "Co-Utilization" Strategy

Shared Assets: Partnering with another agency to use their vehicle on your "off" days.

Staff Sharing: One organization provides the vehicle/driver; the other provides the clinical providers.

When to Use

When capital for a new unit is unavailable, but staffing is ready.

When an existing unit in the community is underutilized (sitting idle).

Pros

Lower Financial Risk: Shared overhead and maintenance costs.

Resource Efficiency: Maximizes the use of expensive equipment.

Community Buy-in: Built-in patient pipelines from partner organizations.

Slide 21

LB1 I agree with everything about this slide, but what also comes to mind when we are talking about partnership scaling is when you partner with others in the community to put on a larger event. It brings lots of services together in one location for patients. Patients might come for one service initially, but when there are more offerings, they tend to visit all the services. This can increase services for all the programs represented and gives a great presence in the community.
Laura Bollan, 2026-04-26T19:01:23.846

Activity: Your Scaling Questions

1

Model for Scaling

- Select one of the four models that best fits your program's current readiness or a model you are interested in exploring.

2

Task

- Grab a sticky note, post the critical questions you should have the answers for before this model can launch.
- What do you need consider for this service model?
  - Staffing
  - Partnerships
  - Equipment
  - Financials

3

Return and Share

Be prepared to share 1-2 key questions from your group when we return.

Financial Planning and Sustainability

Building the "Funding Quilt"

Diversifying revenue sources for financial sustainability

Goal	Strategies
Maintain 3–4 diverse funding sources to ensure stability	Aim to cover the majority of salaries (which typically represent 70% of your total budget).
	Use grants, fundraisers, and donations to cover supplies, fuel, and outreach.
	Create profit generation services to fund mission-driven work.

Building the "Funding Quilt"

Faith-Based Partnerships

These institutions often provide consistent, multi-year funding or "zero-rent" parking and utility access in exchange for serving their local congregants and neighborhoods.

Civic & Service Organizations

Target groups like Rotary International for "Capital Replacement Grants" specifically for new vehicles or expensive medical equipment.

Direct-to-Employer Contracts

Partnering with local industries (e.g., agricultural hubs, factories) to provide mobile occupational health or wellness screenings on-site for a flat contract fee.

Other Sources

- Professional Associations
- Insurance companies with foundations

Total Cost of Ownership and Indirect Costs

- The cost of an expansion is more than the invoice for the vehicle.
- Increased mileage and engine hours lead to accelerated repair schedules for generators, HVAC systems, and tires.
- Parking a larger fleet is a significant logistical cost. If "zero-rent" parking isn't available, you must account for secure, fenced, and lit storage.
- Scaling volume increases costs like insurance premiums, billing software, and the administrative time needed for multi-unit compliance.

Financial Planning Key Takeaways

1. Aim for "3-4 Sources of Funding." Your billable services should strive to cover 70–90% of your personnel costs to protect against grant fluctuations.
2. Use revenue-producing partnerships like corporate wellness bundles or drug screening contracts—to subsidize your mission-driven community work.
3. Expansion costs aren't just one-time capital. Factor in the 20% admin buffer, specialized maintenance, and a 10-year depreciation set-aside.

Key Takeaways & Reflections

Miro

- What is one key takeaway about scaling that you've learned today?

Please use the link in the chat to add your thoughts to our Miro.

Key Takeaways

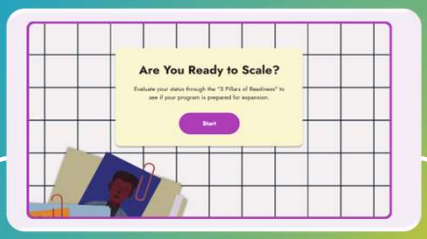
1. Scale by Data, Not Intuition
2. Match the Model to the Problem
3. Systems First, Expansion Second
4. Sustainable Growth is Value-Based

Coming Up in Part 2:

Sustainability in Action

1. Partnerships and Stakeholder Engagement
2. Operational Logistics
3. Monitoring, Evaluation, and Continuous Improvement

Microlearning



You will receive instructions about the accompanying microlearning in a follow-up email.

Q&A

Time to ask questions!

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1. As a member of MHA, you will receive 1.25 CE hours for today's session.
2. You will receive instructions in a follow-up email.
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Take Our Post–Session Survey

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- Point your camera at the QR code.
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Option 2:

- The survey will open in your browser when you close your Zoom window.

Complete the survey

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Thank you!