ESSENTIAL HOSPITALS INSTITUTE

Delivering Care Beyond Hospital Walls:

Best Practices in Mobile Health

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America's Essential Hospitals is the leading association and champion for hospitals dedicated to high-quality care for all, including those who face social and financial barriers to care. Since 1981, America's Essential Hospitals has advanced policies and programs that promote health and access to health care. We support our nearly 400 members with advocacy, policy development, research, education, and leadership development. Communities depend on essential hospitals for care across the continuum, health care workforce training, research, public health, and other services. Supported by Essential Hospitals Institute, the association's research and education arm, essential hospitals innovate and adapt to lead all of health care toward better outcomes and value. Learn more at EssentialHospitals.org.

About Essential Hospitals Institute

Essential Hospitals Institute leads research, education, dissemination, and leadership development for America's Essential Hospitals. To advance the quality, safety, and affordability of care at essential hospitals, the Institute identifies promising practices in the field, provides professional development training, promotes practice improvements, and disseminates innovative approaches to care. It does this with an eye toward improving individual and population health through community-integrated health care.

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East Alabama Health, in Opelika, Ala., partners with Auburn University College of Nursing Students to staff its mobile van.

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Introduction

Background

Essential hospitals, which often face high demand and resource constraints, use mobile health programs to extend care beyond hospital walls. Mobile health care has long played a role in expanding access to care by bringing essential services directly to patients. In today's environment, where many delay or avoid necessary care, mobile health programs offer innovative solutions, especially for under-resourced communities. These programs increase access, support community health, and enhance health system sustainability. For example, during the COVID-19 pandemic, health care systems adopted mobile health vans to bring testing and vaccinations directly to communities.

Today, vans provide primary and specialty care, health screenings, and social needs screenings, especially in underserved areas.

Mobile health delivery varies by community needs. Models include:

- **Home Visits:** Bring care directly to patients, offering personalized medical attention in the comfort of their own homes. This approach is especially valuable for individuals with chronic conditions or limited access to transportation.
- **Community-Based or Clinic Sites:** Establish mobile units at central, high-traffic locations, such as schools, community centers, shelters, or faith-based locations, to reach multiple patients efficiently.

Programs also adopt hybrid approaches, rotate service sites, and/or coordinate with local partners to maximize reach. Services are typically low or no cost, improving affordability and patient outcomes.[1]

While perceived as costly, mobile health programs offer strong returns on investment and cost savings. The initial investment can be significant, but the start-up costs of mobile health are half those of fixed sites.[2] Research from the Mobile Healthcare Association and Mobile Health Map estimates that every dollar invested in mobile health saves $18 long-term. Additionally, Mobile Health Map estimates that mobile health services have generated approximately $1.5 billion in societal economic value by translating improvements in quality-adjusted life years, a measure that captures both longer life and improved quality of life into monetary terms using a standard value per statistical life year.[3,4] By improving medication adherence, chronic condition management, and preventive care, mobile health programs lower service use and support long-term financial sustainability.[5]

For essential hospitals, mobile health programs are a powerful tool to target their unique challenges: enhancing access, promoting preventive care, supporting emergency response, fostering community engagement, and ensuring cost-effective care for underserved communities.

Role of Essential Hospitals

Despite limited resources and high patient volumes, essential hospitals can leverage their significant community presence to improve outcomes through mobile health.

Although essential hospitals account for only 6% of U.S. acute-care hospitals, they provide over 29% of all charitable care. These institutions are on the front lines, providing critical care, economic stability, and community-integrated health care to areas that have experienced long-standing structural barriers and gaps in opportunity. Nearly 75% of patients treated at essential hospitals in 2023 were uninsured or covered by Medicaid or Medicare.[6] Essential hospitals play

an important role in providing health care to rural areas. Approximately one-third of member hospitals are in rural zip codes, and an additional third of member health systems located in urban areas have hospital-affiliated clinics in rural areas.[7] Mobile health programs help hospitals meet patients where they are in the community.

Community-integrated health care—a strategy by which health care providers work with other sectors (e.g., government, private entities, social service, community development) in both complementary and collaborative ways to improve health. We envision that successful community-integrated health care yields a connected system that meets the physical, mental, and social needs of individuals and improves the structures and conditions that influence those needs.

Value of Mobile Health Programs

Mobile health is a pivotal strategy for improving health outcomes, especially for providers filling a safety net role. Evidence shows that mobile health programs improve preventive screenings and immunizations, chronic condition control, and patient satisfaction while reducing avoidable hospital visits and delivering clear value to both patients and providers.[8,9]

Through mobile medical units, outreach vans, and other innovative models, mobile health programs offer flexible, patient-centered care that bridges critical gaps in the health care system across several dimensions.

Expanding Access to Care

Mobile health programs reach rural communities where provider shortages and transportation challenges limit timely care, as well as underserved urban areas where health care infrastructure is strained. By offering preventive and primary care close to where patients live and work, mobile programs extend the reach of hospitals and clinics to populations who might otherwise delay or forego care.

Many programs intentionally focus on low-income, uninsured, and minority populations, and thus incorporate multilingual staff, culturally tailored education, and trusted community partnerships to meet patients' unique needs. For example, Memorial Healthcare System, in Hollywood, Fla., deploys mobile health units across underserved neighborhoods in Broward and Miami-Dade counties to reach individuals with no prior connection to the health system. In 2025, 77% of patients served by mobile units were new to Memorial, with nearly one in five patients referred for ongoing support for complex health-related social needs. By engaging people often disconnected from the formal health care system, mobile health programs build trust, improve continuity of care, and close gaps in preventive and chronic condition management.

Delivering Preventive and Primary Care

Mobile programs provide accessible screenings, immunizations, and health education. They play a vital role in chronic condition management, offering blood pressure monitoring, diabetes testing, and medication adherence support. For example, East Alabama Health's Opelika Neighborhood Mobile Wellness Clinic serves patients who sought care after feeling unwell and were subsequently diagnosed with diabetes requiring immediate intervention. Without access to the mobile clinic, these patients might have faced life-threatening complications. By emphasizing prevention and continuity of care, mobile health programs enable early detection of health issues, improve outcomes, and reduce the burden of avoidable complications. For essential hospitals, mobile health is a proactive strategy to close gaps in care.

Driving Cost Savings and Efficiency

By targeting health issues before they escalate, mobile health programs reduce reliance on emergency departments and prevent costly hospital readmissions. Mobile Health Map estimates that mobile health services are associated with 20,148 life-years saved and 55,717 emergency department visits avoided.[10] These programs shift care from high-cost acute care to lower-cost preventive and primary care delivered in mobile settings, easing pressure on hospital resources and supporting financial sustainability for providers filling a safety net role. They also reduce transportation costs for patients, minimizing their economic burden.

For example, at Hennepin Healthcare, in Minneapolis, pediatric mobile units provide primary and preventative care, including essential childhood immunizations. This helps reduce vaccine-preventable disease while lowering avoidable costs across the health care system.

Building Community Trust and Engagement

Mobile health programs strengthen relationships between health care providers and the communities they serve by offering care in familiar, convenient locations, such as schools, shelters, churches, and community centers. This approach meets patients where they are physically and culturally, fostering trust and comfort. Beyond direct care, these programs provide health education that improves health literacy and empowers informed decisions, reinforcing long-term community health resilience.[11] Staffed by professionals who understand the cultural nuances of the community, these programs help build trust and overcome cultural barriers, leading to improved health outcomes. At UMC El Paso, in El Paso, Texas, mobile health leadership has partnered with the local fire department, school districts, community centers, and places of worship to reach residents who are often disconnected from traditional health care settings. These partnerships support mobile unit maintenance, staffing, site placement, and community trust-building efforts.

Providing Flexibility and Rapid Response

Adaptability and nimbleness are defining strengths of mobile health care delivery. Units can be tailored to deliver a wide range of services, including maternal and child health, behavioral health, substance use treatment, and dental care. They also provide surge capacity during crises, including natural disasters and public health emergencies, when traditional health facilities may be inaccessible or overwhelmed. For example, during the peak of the COVID-19 pandemic, NYC Health + Hospitals' Street Health Outreach and Wellness program provided nearly 90,000 COVID-19 tests, 21,000 medical consultations, 9,000 vaccinations, and 60,000 social work engagements through mobile health care.[12]

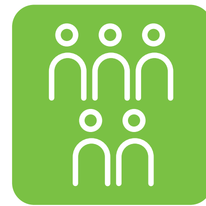
A registered nurse measures a patient's blood pressure during a home visit through Carilion Clinic's Mobile Health program, based in Roanoke, Va.

Project Activities

In 2024, Essential Hospitals Institute partnered with the Leon Lowenstein Foundation to support essential hospitals in strengthening their mobile health programs. The Institute formed a learning collaborative that uses a curriculum developed through an environmental scan and interviews with member hospitals operating mobile van programs. The scan identified best practices and informed the selection of hospitals for interviews, collaborative participation, and site visits.

Association members in the southeastern United States were invited to apply for the collaborative. A technical expert panel composed of essential hospital leaders reviewed all submitted proposals and selected five hospitals as grantees. Selected participants received expert guidance and $10,000 to enhance their hospitals' mobile health programs.

9 Monthly Learning Sessions



5 Participating Hospitals

Biannual Reports

Site Visit

Learning collaborative participants gather in front of Broward Health's mobile health bus during the site visit in Fort Lauderdale, Fla.

Sessions

From February to November 2025, grantees engaged in monthly peer-to-peer discussions focused on improving mobile van operations. Topics included general operations, key success factors, and implementation facilitators and barriers. Sessions included:

Session Topic	Speakers	Content
Staffing and Program Operation	*Kyla Rankin, HOMES project director, Parkland Health*	Strategies for recruiting, training, and supporting staff to build strong and sustainable programs
Financial Management and Sustainability	*Mary Kathryn Fallon, associate director of finance and operations, Mobile Health Map (Mobile Healthcare Association)*	Funding models, approaches to demonstrating return on investment, and methods for communicating program value to stakeholders
Collaboration, Partnerships, and Community Engagement	*Laura Bollan, retired director, Healthy Communities*	Strategies for developing authentic community engagement, collaboration with local partners, and centering community voices in program design
Regulations, Technology, and Data	*Nancy Oriol, co-founder, Mobile Health Map and The Family Van; Mary Kathryn Fallon, associate director of finance and operations, Mobile Health Map; and Kait Guild, manager of evaluation and strategic relationships, Mobile Health Map*	Evaluation strategies, outcome tracking, and overcoming common data challenges to strengthen advocacy, improve care coordination, demonstrate program effectiveness, and inform long-term planning
Leadership and Organizational Support	*Sheyanga Beecher, director of the Pediatric Mobile Health Program at Hennepin Healthcare*	Strategies for securing leadership buy-in and sustaining support amid financial constraints and leadership transitions
Safety, Security, Flexibility, and Adaptability	*Andy Cook, director of the Street Health Outreach and Wellness (SHOW) program at NYC Health + Hospitals and Yinan Lan, MD, clinical director of the SHOW program*	NYC Health + Hospitals' SHOW program's unique operating structure and approach to serving people experiencing homelessness

In May 2025, participants attended a full-day, in-person training hosted by Memorial Healthcare System and Broward Health in Hollywood, Fla. The training showcased both health systems' mature mobile van programs, which deliver comprehensive, community-based care. Participants visited two mobile clinics and learned best practices for care coordination and connecting patients to local resources.

Each hospital submitted baseline and final reports providing performance data and qualitative insight on how the collaborative sessions informed their implementation strategies. At the end of the collaborative, hospitals shared best practices and lessons learned from enhancing their programs.

Project Summaries

Carilion Clinic

East Alabama Health

Huntsville Hospital

UVA Health

WVU Medicine

CARILION CLINIC

Roanoke, Va.

Mobile Health Enhancement Project

Carilion Clinic's Department of Family and Community Medicine provides primary care to more than 230,000 Virginians through 42 practices, three virtual physicians, and a dedicated Mobile Health (MH) team. The MH team expands access through a mobile van that is staffed by registered nurses and travels directly to patients' homes. A part-time nurse practitioner offers additional support via telemedicine.

The program primarily serves individuals with mobility or transportation challenges, those with unmet care needs, and patients requiring follow-up care after hospital discharge. During home visits, nurses use remote physical exam tools integrated with a telemedicine platform to conduct comprehensive evaluations. They also provide screenings, point-of-care testing and blood draws, health education, and connections to ongoing primary and specialty care.

Throughout the mobile health learning collaborative, the Carilion MH team incorporated the MH service into the "virtual primary care" clinic within the electronic health record (EHR). Aligning mobile and virtual services was essential to create a referral and initiate nurse-visits. The MH team designed and integrated a Mobile Health referral into the EHR, which enables a primary care provider to seamlessly refer a patient for a home visit and select the services they need. Additionally, the MH team designed a "nurse visit" within the EHR, which is essential to document and record care delivery such as lab draws, patient education, medication, and care gap review.

A registered nurse brings care directly to a patient's home through Carilion Clinic's Mobile Health program.

In collaboration with Carilion Clinic's Infectious Disease (ID) team, the MH team launched an additional mobile health unit in November 2025. The ID and MH teams work together to visit patients diagnosed with Hepatitis C to deliver laboratory work and other support to ensure treatment adherence. These patients often live in rural areas and are unable to travel to the clinic site to see the ID team due to transportation barriers.

By bringing high-quality care directly to patients, this alternative model of mobile care delivery reduces access barriers, improves continuity of care, and strengthens health outcomes in rural southwest Virginia.

East Alabama Health

Opelika, Ala.

Opelika's Mobile Wellness Clinic

After a 2017 community health needs assessment identified critical gaps in access to care, East Alabama Health partnered with the Casey Foundation and the City of Opelika to launch a mobile medicine program to improve health equity in underserved communities. With generous support from First Transit, a private transportation company that donated the mobile unit, the Mobile Wellness Clinic began operations in December 2022.

The clinic serves Opelika-area communities on a weekly basis, providing on-site screenings for chronic conditions, information about disease prevention, and referrals to social services through its embedded social worker. Outreach prioritizes neighborhoods with the highest needs, with support and ongoing funding from the Casey Foundation, the local housing authority, and additional community partners.

2

East Alabama Health's Mobile Wellness Clinic offers care to the community through collaboration with the city of Opelika's social service departments.

Collaboration is central to the program's success. The mobile clinic works closely with charitable health clinics, local schools and universities, and community-based organizations to expand access, foster trust, and ensure timely referrals. These partnerships not only enhance service delivery but also strengthen the local health care system.

A defining feature of the program is its integration of medical students and trainees into the mobile care team. East Alabama Health partners with nearby academic institutions, such as Auburn University, Tuskegee University, and Southern Union State Community College. The clinic offers medical students hands-on experience in community-based medicine—including patient intake, health screenings, chronic condition education, and preventive counseling—under the supervision of licensed clinical staff from East Alabama Health. This model not only strengthens workforce capacity for the mobile unit but also fosters a pipeline of future clinicians grounded in rural and population health.

In 2024, the program expanded its collaboration with Auburn University to include the School of Nursing, providing nurse practitioners to enhance real-time treatment when indicated prior to referral. This addition strengthens the clinic's ability to deliver timely, on-site care and improves patient outcomes by addressing acute needs before transitioning individuals to longer-term services.

Since its inception, the Mobile Wellness Clinic has had over 2,100 encounters with residents with critical lifesaving interventions and vital care, including early detection and management of life-threatening conditions like severe hyperglycemia and hypertension. By bringing care directly to the community, the program reduces barriers, targets social determinants of health, and promotes long-term wellness across East Alabama.

Health
HUNTSVILLE HOSPITAL HEALTH SYSTEM

Huntsville, Ala.

Vámonos

Since 2011, Huntsville Hospital's Mobile Medical Unit (MMU) has provided free health screenings, preventive care, and patient education throughout Madison County, Ala. Using a fully equipped mobile specialty vehicle, the Vámonos program extends essential health services to rural and urban communities with limited access to care, reaching seniors, people experiencing homelessness, and low-income or racially diverse communities.

Staffed by a nurse or physician, the MMU makes up to 22 community stops on a revolving schedule each month. Most services are provided at no cost to patients, underscoring the hospital's commitment to equity and community health. The program emphasizes health literacy, early disease detection, and preventative health behaviors, empowering patients to take a proactive role in their well-being.

Annually, the unit aims to conduct roughly 230 site visits and 6,800 screenings, along with 1,600 patient interactions at homeless shelters. By addressing social determinants of health such as transportation challenges, language barriers, and limited access to primary care, the MMU program builds trust and provides a vital safety net for uninsured and underserved residents.

Through its consistent presence and commitment to removing barriers, the Vámonos Mobile Medical Unit has become a cornerstone of community health in Madison County, advancing preventive care and closing health care gaps among vulnerable populations.

3

Left: Huntsville Hospital's MMU provides blood pressure screenings. Right: John Simms, project coordinator, Community Health Initiative and Mobile Medical Unit and Mia Crutch-Randolph, RN, nurse, help bring quality care to communities through Huntsville Hospital's mobile medical unit.

UVA Health

Charlottesville, Va.

UVA Health Mobile Care Clinic

In August 2024, UVA Health launched its Mobile Care Unit to expand access to preventative and primary care across Charlottesville and the surrounding region. Aligned with UVA Health's strategic goal of cultivating healthy communities and improving health outcomes, the unit uses a data-driven approach to identify patients with unmet health needs, access challenges, or barriers contributing to poor health outcomes.

Staffed by nurse practitioners, a registered nurse, a community paramedic, and other clinical, financial, and social support providers, the Mobile Care Unit delivers a comprehensive range of services, including:

- Primary care and chronic condition management
- Point-of-care testing and screenings for social drivers of health
- Telehealth access
- Care coordination, referrals, medication management, and home safety assessments

The program is supported by UVA Health stakeholders across informatics, data science, patient access, financial aid, and interpreter services, ensuring seamless integration of medical and social support for patients.

Operating in close collaboration with UVA Health Population Health, Family Medicine, The Center for Telehealth, and UVA Health Pharmacy, the Mobile Care Unit complements UVA Health's broader mobile health portfolio, including the Mobile Mammography Van, which served over 1,600 patients in fiscal year 2025.

In its inaugural year, the Mobile Care Unit reached approximately 150 residents, prioritizing neighborhoods identified through the MAPP2Health District 10 needs assessment and the Area Deprivation Index. Partnerships with the Fifeville Neighborhood Association, Habitat for Humanity, Blue Ridge Health District, the Virginia Department of Health, Greene County Supervisors, and local food hubs integrate medical services with support for food security and other social needs identified through social drivers of health screening.

By bridging health care delivery with community-based resources, the Mobile Care Unit strengthens UVA Health's connection to the communities it serves, reduces barriers and increases access to care, and advances health outcomes across Charlottesville and the surrounding areas.

4

UVA Health's mobile care unit brings essential health services directly to communities surrounding Charlottesville.

WVU Rockefeller Neuroscience Institute

Morgantown, W.Va.

Mobile Comprehensive Opioid Addiction Treatment (COAT)

WVU Medicine is expanding access to essential care by delivering prevention and treatment services directly to communities across West Virginia, a state where geography often limits access to health care. Through its mobile health fleet—including Bonnie's Bus, a mobile mammography unit, and Lucas, a mobile lung cancer screenings unit—WVU brings high-quality screening and early detection services to residents in even the most remote areas. Operated by WVU Hospital and the WVU Cancer Prevention and Control team, in partnership with local clinics, businesses, and community providers, these units ensure rural patients receive timely, lifesaving care close to home.

5

WVU Medicine's mobile unit, parked outside the Erikson Alumni Center in Morgantown, W.Va., operates under the health system's Healthy Minds initiative.

Building on this model, WVU Medicine operates the Mobile Comprehensive Opioid Addiction Treatment (COAT) program to support individuals and families affected by the opioid crisis in rural areas. Serving about 100 patients, the COAT program offers flexible levels of care on a weekly, bimonthly, or monthly basis, based on patients' needs. Services include medication-assisted treatment, individual and group therapy, health screenings, and wraparound support.

The Mobile COAT program is more than a treatment model; it is a community-centered approach. By collaborating with peer recovery specialists, quick-response teams, and local community providers, the program helps patients address social determinants of health, such as housing instability, food insecurity, and transportation challenges. Delivering care in a mobile setting helps reduce stigma, foster trust within communities, and remove logistical barriers that often prevent individuals from seeking help.

By integrating cancer prevention, primary care, and substance use disorder treatment into its mobile health strategy, WVU Medicine demonstrates how bringing care to the patient strengthens community health, advances equity, and responds directly to some of West Virginia's most urgent health needs.

Mobile Health and Financial Sustainability

Financial sustainability is a shared, ongoing challenge. Programs in this learning collaborative receive support through a mix of philanthropic grants, donations, billing, and health system operational budgets.

While three of the five participating programs are billing for services provided, some participants reported that navigating the reimbursement process is challenging, especially since their patients are predominantly under- or uninsured. Learning how other programs navigate billing for mobile health services and understanding which services are reimbursable were key components of the learning collaborative curriculum.

No matter the funding source, all participants agreed that demonstrating mobile health's return on investment—in both operational value and impact on patients and community—is critical to ensuring program stability.

Lessons Learned and Best Practices

The learning collaborative empowered participants to turn collective insight into measurable progress. By learning from one another's models and experts in the field, participants translated shared learning into meaningful action, including expanded services, strengthened partnerships, and refined operational strategies. Through peer exchange, data sharing, and continuous reflection, participants identified what works in their communities for mobile health, giving other participants the tools to apply those lessons to improve efficiency, extend reach, and deepen community impact.

Impacting Mobile Care Delivery via Peer Learning

As participants learned about other hospitals' data systems, operational models, and sustainability efforts, the power of peer exchange became a defining feature of the collaborative. Participants noted that exposure to other models—ranging from school-based clinics to volunteer-driven units—sparked new ideas for service delivery, staffing, and outreach. Many left the experience with a renewed focus on collaboration, increased problem-solving skills, and a deeper understanding of the shared challenges faced by mobile health programs nationwide. For example, Carilion Clinic leaders evaluated the hospital's door-to-door patient visit model and brought in larger teams, including oncology, to collaborate and potentially reach more patients. Additionally, the WVU Mobile Unit team appreciated learning about staffing structure from East Alabama Health, which uses volunteers to staff its unit. Peer exchange accelerated

innovation by allowing programs to adapt proven models and avoid common pitfalls.

Expanding Reach and Services

Several hospitals expanded their mobile operations, adding new service sites, streamlining referral and scheduling systems, and introducing new clinical offerings.

- **Carilion Clinic** developed new processes to coordinate referrals and track patient encounters more efficiently.
- **East Alabama Health** increased clinical capacity by integrating pharmacy residents and social work teams through a partnership with the local police department. The hospital introduced A1C testing to better serve patients at risk for or living with diabetes.
- **Huntsville Hospital** created an online request form and published its mobile schedule to simplify event coordination and increase community engagement.
- **UVA Health** grew its mobile clinic capacity from four to 11 clinic days per month with its latest expansion in March 2026.
- **WVU Medicine** began planning to expand its behavioral health program to additional sites, informed by new partnerships and data tools.

Strategic process improvements and community-informed planning enabled programs to deliver more care, more effectively, to more people.

Building Strong, Cross-Sector Partnerships

Partnerships emerged as a central theme across all participating programs. As programs grew, many recognized that sustaining momentum required trusting relationships across sectors to address the complex needs of their communities. Programs built and strengthened relationships with academic institutions, public health agencies, social service organizations, and local governments to extend their reach, address the needs of their communities and build staff resources.

- **East Alabama Health** cultivated an extensive partnership network that includes Auburn University's pharmacy and nursing programs, Tuskegee University, and the Opelika Police Department, which provided the program with clinical and social support.
- **Huntsville Hospital** leveraged connections with academic institutions, such as the University of Alabama College of Nursing, to assist with staffing the mobile unit.

These collaborations not only increased service capacity but also connected patients to critical social support such as housing, food assistance, and literacy programs, illustrating how mobile health can act as a bridge between clinical care and community well-being.

Using Data to Demonstrate Impact

Participants learned strategies for effectively leveraging data to demonstrate value, align priorities, and advocate for continued program investment and sustainability. Many teams focus on using metrics that demonstrate the impact of increasing access to care while generating revenue. The emphasis on data visualization and outcome tracking, particularly inspired by Mobile Health Map resources, encouraged programs to adopt more robust key performance indicators and dashboards.

- **Carilion Clinic** is refining outcome tracking through electronic referrals and service documentation.
- **WVU Medicine** is developing a dashboard to evaluate behavioral health outcomes and sustainability.

Data-driven storytelling emerged as a key strategy for communicating community benefit and guiding program growth.

Conclusion

The momentum generated through shared learning inspired a deeper commitment to continuous improvement and community-centered innovation. The lessons from this cohort demonstrate the power of peer learning to strengthen mobile health programs and expand access to care for all communities. Sustaining this progress will require strong partnerships, executive leadership support, and clear demonstrations of impact, both within the community and across the hospital or health care system. While each organization may take a different approach, the exchange of ideas and best practices helps drive what works and refine what doesn't. The collaborative reinforced that mobile health thrives through adaptability, feedback, and collective progress.

Resources Appendix

Mobile Healthcare Association

The Mobile Healthcare Association (MHA) is a national membership organization serving as a leading voice for mobile health programs across the United States. MHA provides education, networking, advocacy, and resources to support the growth and sustainability of mobile health initiatives. Its mission is to advance access to care and reduce health disparities by strengthening the mobile health sector, equipping providers with tools to deliver high-quality, community-based care directly to patients.

Mobile Health Map

Mobile Health Map is a collaborative research and resource hub led by Harvard Medical School in partnership with mobile health programs nationwide. With a mission to advance health care for all, Mobile Health Map ensures mobile health programs have the data and resources needed to effectively reach underserved communities, improve population health outcomes, and advocate for policy change. It provides tools, training, and evaluation support to help mobile clinics measure their impact, demonstrate value to stakeholders, and strengthen financial sustainability.

The Family Van

The Family Van, run by Harvard Medical School, is a long-standing mobile health clinic that delivers free or low-cost preventive care and health education to underserved neighborhoods in Boston. The van's multidisciplinary team provides health screenings, counseling, referrals, and support to address both medical and social needs, meeting patients in their own communities. Its mission is to improve health care access by empowering individuals with knowledge, resources, and care that reduce barriers to care and promote long-term wellness.

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