IMPACT OF MOBILE HEALTH CLINICS
Literature Review

New research shows that mobile health clinics improve health outcomes for hard to reach populations in cost-effective and culturally competent ways. A Harvard Medical School study determined that for every dollar invested in a mobile health clinic, the US healthcare system saves $30 on average. Mobile health clinics, which offer a range of services from preventive screenings to asthma treatment, leverage their mobility to treat people in the convenience of their own communities. For example, a mobile health clinic in Baltimore, MD, has documented savings of $3,500 per child seen due to reduced asthma-related hospitalizations. The estimated 2,000 mobile health clinics across the country are providing similarly cost-effective access to healthcare for a wide range of populations.

Many successful mobile health clinics cite their ability to foster trusting relationships. Qualitative research in such mobile health clinics has found that patients value the informal, familiar environment in a convenient location, with staff who “are easy to talk to,” and that the staff’s “marriage of professional and personal discourses” provides patients the space to disclose information themselves. A communications academic argued that mobile health clinics’ unique use of space is important in facilitating these relationships. Mobile health clinics park in the heart of the community in familiar spaces, like shopping centers or bus stations, which lend themselves to the local community atmosphere.

More broadly, mobile clinics incorporate several recommendations from the Institute of Medicine’s Committee on Understanding and Eliminating Racial and Ethnic Disparities in Health Care, including (1) community health workers, (2) patient-centered care that focuses on patient education and empowerment, (3) cultural competency training for staff, (4) stability and consistency of service provision within communities, and (5) staff diversity. All of these elements have been shown to overcome access-related barriers resulting from poor patient-provider communication, mistrust, and disempowerment in minority communities. Moreover, mobile clinics remove financial barriers to accessing services, including the need for health insurance and copayments as well as logistical constraints like long commutes, difficulties making appointments, excessive waiting times, or complex administrative processes. Of note, mobile clinics successfully attract men, who tend to have poorer health-seeking behavior.

It is notable that mobile health clinics did not see a decline in visitors after Massachusetts Healthcare Reform was implemented 2006; in fact, most individuals who chose to visit mobile clinics had health insurance. This is consistent with evidence from Massachusetts that there continue to be barriers to primary care services, even after the health care reform, which include waiting times, copayments, complexities of navigating the system and feelings of
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intimidation. These are barriers that mobile clinics are designed to overcome. As an alternative service delivery model, Emergency Departments in Massachusetts have also continued to experience high utilization rates for non-emergent issues despite the health care reform; these rates are highest rates among patients who are publicly-insured, as opposed those who are uninsured. Thus, by providing care that is less expensive than emergency department visits, mobile health clinics can potentially help reduce healthcare costs. Massachusetts has near universal insurance coverage and is an example of what other states may achieve with National Healthcare Reform. This suggests that national demand for mobile clinics will not decline as insurance coverage increases with the provisions in the Affordable Care Act.

Studies demonstrate that mobile health clinics are effective conduits for disease management. For example, data from Boston-based mobile health clinic the Family Van show that mobile clinic attendance is associated with 32.2% and 44.6% reductions in the relative risk of heart attack and stroke, respectively. While hypertension is theoretically very manageable, nationally only one in two individuals diagnosed with the condition has it under control. This is not simply due to lack of insurance, as 80% of those with uncontrolled blood pressure are insured. The challenge with hypertension management is sustaining adherence to medication and adopting appropriate lifestyle changes. The evidence from the Family Van suggests that mobile health clinics may help hypertensive patients in addressing these challenges. Furthermore, mobile clinics may facilitate disease management for a range of other health conditions, such as diabetes and hypercholesterolemia, which have similar health behavior barriers. Therefore, to the extent that mobile health clinics support adherence and educate patients on chronic disease management, their ability to improve on blood pressure management may be representative of benefits in other domains.

Mobile health clinics serve a unique role for the underserved populations in our society. They deliver care to the full spectrum of at-risk populations, from medically complex patients who may not be able to effectively navigate the health care system and rely on emergency departments for care, to the homeless, uninsured, and those living in rural environments with limited access to care. Mobile clinics are often the provider of last resort in places where the mainstream health care system has not provided a point of access. As policymakers look for effective ways to control health care spending while increasing access to care, they should consider mobile health clinics as a potentially cost-effective and clinically beneficial model of health care delivery.

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