



MOBILE HEALTH CLINICS ACT OF 2019

PROVIDING COMPREHENSIVE ACCESS TO MEDICAL SERVICES

Exploring the need for
legislation to
fund Mobile Health Centers
in the United States

A Report Prepared by
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Purpose

The *Mobile Health Clinics Act* is being proposed to improve access to medical care for underserved populations. Its goal is to amend the Public Health Service Act.

Scope of Legislation

Regular primary and preventive care can prevent and address acute conditions and lead to earlier diagnoses of chronic or severe medical issues when they are treatable; improving health outcomes and reducing the use of hospital emergency rooms. Given these particulars, this legislation aims to provide funding for primary health services, including screenings, primary care, mammograms, dental care, substance abuse, and mental illness. Where appropriate, treatment opportunities could also include treatment for acute diseases, mandatory immunizations for school/work attendance, flu/pneumonia/shingles vaccines, as well as chronic conditions such as diabetes, HIV-related conditions and asthma/pulmonary disease. In summary, preventive care has shown to be effective healthcare tool. Providing access to this care is invaluable, but not all populations can access care equally. Some areas do not have enough doctors to serve patients. This scenario is true in both urban and rural settings and can lead to inadvertent inequities for people living in the same state simply because of their zip code.

To address current inequities, the legislation targets new funding for mobile medical clinics in specific communities. The below populations would directly benefit from the Mobile Medical Clinics Act:

- Urban or rural areas determined by the Secretary to have a health workforce shortage or gaps in medical treatment access.
- Migrant health and federally qualified community health center patients. Such patients include: the homeless, public housing residents, children of undocumented residents, and others living in areas experiencing a shortage of healthcare services.

Overview of Current Landscape

According to the Mobile Health Map report, approximately 1,500 Mobile Health Clinics (MHC) currently operate nationwide.¹ These MHCs deliver care through about 6.5 million patient contacts yearly and work in every state, including Washington, DC and the Commonwealth of Puerto Rico. Based on this detail, it is clear that current medical care infrastructure still fails to provide equal and equitable access to care for all Americans. MHCs, in particular, effectively provide care in areas where health care access is limited. Barriers to care include financial status and insurance coverage, language, educational level, health literacy, transportation, cultural constraints and differences, and general life stresses.

¹ "Impact Report." Impact Report | Mobile Health Map. Accessed February 15, 2018. <https://www.mobilehealthmap.org/impact-report>.

For example, the rising aging population in the United States has coincided with an increase in age-related chronic diseases, along with the related costs of providing appropriate care and services.² People who live closer to a clinic that accepts their insurance are more likely to see a doctor in comparison to those who live further and lack access to appropriate transportation. MHCs can also provide care to people who may not have access to adequate care because of obstacles caused by the healthcare system itself. These include: including feelings of intimidation, long wait times to see a provider, and the complexities of navigating the healthcare system.³

The benefits of a MHC's use go beyond providing access to underserved and remote populations. Given advances in medical technologies, patients do not have to go to multiple locations to get certain services, including x-rays, lab tests, and even obtain prescription services. In ideal scenarios, a MHC may allow patients to receive multiple services in a single setting, reducing the total time required by patients to seek care while also cutting on the individual patient's transportation costs.

Aiming to Improve Current Community Linkages to Mobile Health Care

By offering essential services, including the aforementioned, MHCs can be more effective at delivering vital services than traditional clinics. For example:

- **Screenings:** A study of mobile health clients in Baltimore found that a higher percentage of clients agreed to undergo HIV screening, and subsequent treatment, at a mobile clinic versus a traditional clinic.⁴
- **Maternal care:** Women in Miami, who visited MHCs rather than traditional clinics, were more likely to start receiving prenatal care services earlier in their pregnancies. Patients receiving care from MHCs experienced significantly lower rates of pre-term and low-birth-weight infant births than patients who accessed regular clinics (4.4% vs. 8.8%).⁵

² Brown-Connolly, N. E., Concha, J. B., & English, J. (2014). Mobile health is worth it! Economic benefit and impact on health of a population-based mobile screening program in New Mexico. *Telemedicine journal and e-health : the official journal of the American Telemedicine Association*, 20(1), 18–23. doi:10.1089/tmj.2013.0080

³ Yu, Stephanie W. Y., Caterina Hill, Mariesa L. Ricks, Jennifer Bennet, and Nancy E. Oriol. "The scope and impact of mobile health clinics in the United States: a literature review." *International Journal for Equity in Health* 16, no. 1 (2017). Accessed February 15, 2018. doi:10.1186/s12939-017-0671-2.

⁴ Ellen, Jonathan M., Sekhar Bonu, Jaime S. Arruda, Michael A. Ward, and Ruth Vogel. "Comparison of Clients of a Mobile Health Van and a Traditional STD Clinic." *JAIDS Journal of Acquired Immune Deficiency Syndromes* 32, no. 4 (April 1, 2003): 388-93. doi:10.1097/00126334-200304010-00007.

⁵ O'Connell, Erin, Guoyan Zhang, Fermin Leguen, and Jennifer Prince. "Impact of a Mobile Van on Prenatal Care Utilization and Birth Outcomes in Miami-Dade County." *Maternal and Child Health Journal* 14, no. 4 (July 2010): 528-34. doi:10.1007/s10995-009-0496-8.

Ensuring Equity of Care in Urban, Rural and Suburban Areas

Mobile clinics serve communities that have the most inadequate access to health services in the United States. By visiting these communities and offering affordable or free services, mobile clinics remove logistical constraints such as transportation, as well as financial barriers such as health insurance requirements and copayments.⁶ Approximately 47% of MHCs serve **both** rural and urban communities, 14% serve only rural areas, and 39% serve only cities.⁷

According to the Health Resources & Services Administration (HRSA), there are approximately 84 million people that live in areas of the country that have a shortage of primary care health professionals.⁸

- These are areas where the ratio of primary care doctors to people is higher than 3,500 to 1.⁹
- Of this underserved population, 24 million live in rural areas, 43 million live in non-rural areas, and 17 million live in areas that are a mix of rural and urban.
- 63 million people live in areas that are underserved by dentists, and 124 million people live in areas that are lacking access to mental health professionals.

Research Shows that Mobile Health Clinics are Cost-Effective

MHCs are cost-effective and can help reduce the burden on hospitals, insurers, and government entities who manage health programs. MHCs can generate these cost savings by primarily reducing the need for medically unnecessary emergency department visits. Analyzing the cost of operation versus emergency care visits yields the following findings:

- The average cost of a MHC is \$429,000 per year.¹⁰
- The average number of yearly visits for an MHC is 3,200.
- The average cost per mobile health visit is \$155.¹¹

⁶ US Department of Health and Human Services, Agency for Healthcare Research and Quality 2011. National healthcare disparities report. <http://www.ahrq.gov/research/findings/nhqrdr/nhdr11/>. Published April 2012.

⁷ "Impact Report." Impact Report | Mobile Health Map. Accessed February 15, 2018. <https://www.mobilehealthmap.org/impact-report>.

⁸ Bureau of Health Workforce. "Designated Health Professional Shortage Areas Statistics." Health Resources and Services Administration (HRSA). February 3, 2018. Accessed February 15, 2018. https://ersrs.hrsa.gov/ReportServer?/HGDW_Reports/BCD_HPSA/BCD_HPSA_SCR50_Smry_HTML&rc:Toolbar=false.

⁹ Ryan, Melissa. "Health Professional Shortage Areas and Scoring." <https://nhsc.hrsa.gov/corpxperience/aboutus/nationaladvisorycouncil/meetingsummaries/06-2016-shortage-designation.pdf>. June 22, 2016. Accessed February 15, 2018. <https://nhsc.hrsa.gov/corpxperience/aboutus/nationaladvisorycouncil/meetingsummaries/06-2016-shortage-designation.pdf>.

¹⁰ "Impact Report." Impact Report | Mobile Health Map. Accessed February 15, 2018. <https://www.mobilehealthmap.org/impact-report>.

¹¹ Ibid

- Each MHC visit saves \$200 on average due to avoided Emergency Department visits and \$1,600 from the long-term savings impact of preventive services, adding up to \$1,800 in total.¹² Thus, there is a significant 12-to-1 average return on investment for MHCs.¹³
- The Mobile Health Map estimates that MHCs per year generate approximately \$561,220 in savings on avoidable emergency department visits.¹⁴

Mobile Health Clinics Provide Real Returns on Investment

Mobile clinics have proven their ability to address some of the most intractable problems faced by marginalized communities in rural areas and urban neighborhoods by delivering services directly at the curbside in communities of need and adapting their services based on the changing needs of the target community. These programs have shown that they achieve positive patient outcomes, boast impressive returns on investment, and reach underserved communities that may not be effectively reached by traditional healthcare delivery models.

- The HABITS for Life chronic disease screening clinic in New Mexico estimated an ROI of \$15 for every \$1 spent.¹⁵
- The Southern California Breathmobile Asthma Clinic, focused on serving children with asthma, assessed a \$7 return on investment for every \$1 spent.¹⁶

Health disparities between wealthy and working-class Americans add a heavy financial burden on the nation's healthcare system. A 2013 CDC report found that eliminating health disparities in just the lowest quartile income areas would result in approximately 500,000 fewer hospitalizations and save \$3.6 billion in hospitalization costs.¹⁷ MHCs effectively improve healthcare access in low-income census tracts.

Federal Investment Has the Potential to Foster Healthy Communities

Funding has been the most significant barrier to the development and maintenance of MHCs and their resources. Underserved communities sometimes see MHCs come and go due to inconsistent funding sources.

¹² *Ibid.*

¹³ *Ibid.*

¹⁴ Yu, Stephanie W. Y., et. al. "The scope and impact of mobile health clinics in the United States: a literature review." *International Journal for Equity in Health* 16, no. 1 (2017). Accessed February 15, 2018.

¹⁵ Brown-Connolly, Nancy E., Jeannie B. Concha, and Jennifer English. "Mobile Health Is Worth It! Economic Benefit and Impact on Health of a Population-Based Mobile Screening Program in New Mexico." *Telemedicine and e-Health* 20, no. 1 (January 1, 2014): 18-23. doi:10.1089/tmj.2013.0080.

¹⁶ Morpew, Tricia, Lyne Scott, Marilyn Li, Stanley P. Galant, Webster Wong, Maria I. Garcia Lloret, Felita Jones, Mary Elizabeth Bollinger, and Craig A. Jones. "Mobile Health Care Operations and Return on Investment in Predominantly Underserved Children with Asthma: The Breathmobile Program." *Population Health Management* 16, no. 4 (August 2013): 261-69. doi:10.1089/pop.2012.0060.

¹⁷ Centers for Disease Control and Prevention, *Morbidity and Mortality Weekly Report Morbidity and Mortality Weekly Report* (2013), <https://www.cdc.gov/mmwr/pdf/other/su6203.pdf> (last visited Feb 22, 2018).

The funding challenge makes it more difficult for mobile health providers to gain the trust of the communities that they serve.¹⁸ With additional Federal support, MHCs would be able to invest in purchasing, maintaining, and upgrading mobile units. Federal funds can also be leveraged to increase the number of staff, dispense more medication, and advance the use of efficient information technology for health purposes. With a savings of \$12 for every \$1 invested, this is an effective and inexpensive way to cut the overall U.S. health bill and provide much-needed health services for underserved communities.

Community-Based Organization Partnerships Maximize Potential Positive Outcomes

By partnering with community health clinics, rehabilitation facilities, social service agencies, religious organizations/houses of worship and food pantries facilitate referrals that help find vulnerable populations who need assistance beyond the resources of referral agency. These local considerations, including the extent of need, help design the model of the program and ensure that it is responsive to community-based needs.

Clients of MHCs may have a diverse background of social circumstances and cultural beliefs. Wherever possible, the medical staff should be representative of the communities they serve. Additionally, the forms and patient education materials should be translated into several target languages. Pursuing culturally sensitive approaches will promote a holistic approach, one that is more likely to successfully help make patients and those in underserved communities more aware of their health and ways to live a better lifestyle.

Conclusion

Mobile Health Clinics represent an essential component of a modern healthcare system that serves vulnerable, at-risk, and diverse populations while promoting high-quality care at a competitive cost. An estimated 1,500 mobile clinics are receiving 5 million visits nationwide per year. Mobile clinics improve access for a variety of populations, bolster prevention and chronic disease management, and reduce costs. Expanded coverage and delivery reform increase opportunities for mobile clinics to partner with hospitals, health systems, and insurers to improve access and quality of care while reducing total costs.

¹⁸ Dorothy Mayernik et al., Parish Nurse–Initiated Interdisciplinary Mobile Health Care Delivery Project, 39 Journal of Obstetric, Gynecologic & Neonatal Nursing 227–234 (2010).