Mobile Health Care for Homeless People:

Using Vehicles to Extend Care

by

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PREFACE

In 2005–2006, 82 Health Care for the Homeless (HCH) grantees or subcontractors took their health services on the road to reach displaced people with limited or no access to fixed-site clinics.[1] This report describes the experience of 33 of these HCH projects in 24 states, based on telephone interviews conducted between August 2006 and April 2007. It is primarily intended for program administrators and direct service providers currently involved in mobile health outreach and for those who are interested in developing or participating in such programs.

The report focuses on the use of outreach vehicles, ranging from passenger vans to custom-designed clinics on wheels, to provide a variety of health services to people without stable housing. This creative use of vehicles complements and often enables outreach conducted on foot by many Health Care for the Homeless programs. Topics discussed include the rationale for mobile health outreach to homeless populations, services provided and staffing models, types and designs of mobile units, financing and administration of mobile health programs, obstacles encountered and strategies used to address them, and factors to which HCH providers attribute the success of these mobile outreach efforts.

This report is not evaluative. It describes an innovative and dynamic service modality that has emerged in Health Care for the Homeless over the last 20 years, in the words of individuals who are actively engaged in delivering mobile health services. The use of mobile clinics to reduce financial, geographic, and psychological barriers to health care for people who are homeless is distinctive yet complementary to other HCH outreach methods, such as "street medicine" provided by walking teams. Those who wish to extend care to impoverished people through mobile outreach, with the ultimate goal of facilitating access to more comprehensive care, can learn from these examples.

This document and other resources for program administrators and practitioners working in homeless health care are available on the National Health Care for the Homeless Council's website at http://www.nhchc.org/.

[1] Health Resources and Services Administration, U.S. Department of Health and Human Services. Health Care for the Homeless Grantee Profiles, 2005–2006. http://www.bphc.hrsa.gov/hchirc/directory/default.htm

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EXECUTIVE SUMMARY

This report describes the experience of 33 Health Care for the Homeless grantees and subcontractors in using mobile outreach to extend care to homeless people in 24 states. It is primarily intended for program administrators and direct service providers currently involved in mobile health outreach and for those who are interested in developing or participating in such programs. The report focuses on the use of outreach vehicles to provide a variety of health services to people without stable housing.

Information on which the report is based was derived primarily from telephone interviews conducted between September 2006 and April 2007. The mobile health programs surveyed have been in operation from 1 to 22 years. Representatives of these programs were asked to respond to a standard set of open-ended questions, which were developed in consultation with persons known to be experienced in the provision of mobile health services to underserved populations. Summaries of responses to the survey questions are illustrated with direct quotations from respondents.

The report is divided into nine sections in addition to a bibliography and appendices:
1. Introduction
2. Targeted Populations & Environment
3. Mobile Services
4. Community Partners
5. Types & Designs of Mobile Units
6. Financing & Administration of Mobile Programs
7. Outreach & Marketing Strategies
8. Program Obstacles
9. Reasons for Program Success

The bibliography lists publications on mobile health outreach to homeless populations. Appendices include the survey instrument used to structure interviews and a variety of resources which mobile health programs may find useful:

- Mobile medical outreach program descriptions and marketing materials
- Vehicle operations check lists & forms
- Targeted populations
- Equipment & inventories
- Clinical encounter & referral forms
- Job descriptions
- A list of mobile outreach programs offering technical assistance

Summary of Findings:

- **Barriers to health care for populations served:** Surveyed programs identified lack of health insurance and lack of transportation as the primary reasons why health services are inaccessible to the homeless people they serve — especially behavioral health care, specialty services, medications, ongoing primary care, and oral health care.
- **Rationale for mobile health outreach:** The main reason for mobile health care identified by respondents is the need for accessible services that are welcoming to homeless people who can't or won't go to fixed-site clinics.
- **Populations served:** Of surveyed programs, 70 percent serve both adults and children; 27 percent serve mainly adults; and 3 percent serve only children. 88 percent serve urban areas (over half of which serve suburban or rural areas as well), 39 percent provide services in rural areas, and 24 percent serve suburban areas.
- **Services provided:** 76 percent of mobile programs surveyed provide primary care services, 33 percent provide dental care, and only 18 percent offer behavioral health services on the mobile unit.
- **Service delivery:** 82 percent of all surveyed programs provide health services on their mobile units; 12 percent transport clients to services; and 9 percent provide services at remote service sites but not on the mobile unit. 52 percent schedule visits to particular sites and 18 percent do roving outreach.
- **Community partners:** Agencies with which HCH mobile outreach programs most frequently partner are emergency shelters, social service providers, and Community Health Centers. Other community partners include public health departments, hospitals, other local health service providers, drop-in centers, police, churches, and schools.
- **Type & design of vehicles:** Mobile health units include remodeled recreational vehicles, trucks, passenger vans or buses, as well as custom-designed vans with one or more exam rooms and a variety of other features. Environment and cost are among the variables dictating the size of vehicles used.
- **Funding sources:** Major sources of funding for these mobile health programs include Federal grants, city and county governments, and corporations.
- **Outreach & marketing:** Mobile programs use a variety of innovative outreach and marketing strategies; as they become better known in their communities, they tend to rely more on program reputation and word of mouth than on publicity efforts.
- **Program obstacles:** 58 percent of mobile service providers identified lack of financial capacity as the most significant obstacle they encounter; 48 percent identified vehicle or equipment problems as a serious obstacle; 39 percent said they struggle with clinical information management; and 33 percent mentioned staffing issues.
- **Strategies to address these obstacles**: Programs report using cross-training of staff, regular maintenance and repair schedules, electronic medical records and broadband Internet access, and regular opportunities for staff communication and professional growth to promote retention and prevent burnout.
- **Program success:** 82 percent of respondents attributed program success to service site selection and collaboration with community partners; 79 percent said staff rapport with homeless clients was key.

INTRODUCTION

Research on the use of medical outreach vehicles is scarce, although a number of program descriptions have been published since the mid-1990's (see Bibliography). Continued interest in the use of mobile units to extend health care to homeless people who cannot or will not obtain it at fixed-site clinics prompted this empirical investigation of Health Care for the Homeless (HCH) mobile health programs.

This report is based on information provided by 33 HCH grantees or subcontractors (approximately 40 percent of those reported to operate mobile health units in 2005–2006), selected for their geographic and service diversity. The mobile health programs surveyed have been in operation from 1 to 22 years. Representatives of these programs were asked to respond to a standard set of questions (see Appendix A), developed in consultation with persons known to be experienced in the provision of mobile health services to underserved populations, including members of the Mobile Health Clinics Network, some of whom work in HCH projects. Respondents included program administrators and/or direct service providers, most of whom answered the questions during telephone interviews conducted between September 2006 and April 2007; two individuals sent written responses. A summary of responses to the survey questions follows, not necessarily in the order in which they were asked, together with comments that are illustrative of the main points in each section.

Health Care Access Barriers for Homeless People Served by Mobile Outreach

The mobile health programs surveyed identified **lack of health insurance** and **lack of transportation** as the primary reasons why other health services are inaccessible to the homeless people they serve — especially behavioral health care, specialty services, medications, ongoing primary care, and oral health care. Difficulty obtaining documentation required for public health insurance (proof of identity and citizenship) and ineligibility due to a drug or alcohol problem or undocumented status were among the barriers to health insurance specified.

Other health care access barriers mentioned, in order of frequency, were: lack of trust in/feeling intimidated by the traditional health care system; a history of abuse, mental illness, and/or a substance use disorder; having other priorities that conflict with seeking health care; stigmatization; not knowing where clinics for uninsured people are; language barriers; chronic homelessness; and managed care (services available only at a single location that is inaccessible).

Barriers to Health care	**% respondents**
Inaccessible/ unavailable services: specialty/ behavioral/ meds/ primary care/ oral health	45%
Lack of health insurance	45%
ineligible: undocumented, Drug Addiction & Alcoholism exclusion	9%
should qualify: unaware of/ unable to get benefits	6%
enrollment barriers: required proof of ID, citizenship	6%
Lack of transportation/ geographical barrier	45%
Intimidated by traditional health system/ lack of trust	18%
Lack of resources/ financial barriers	12%
Healthcare not a priority (basic needs)	12%
History of abuse/ mental illness/ substance use disorder	12%
Stigmatization	6%
Lack of service coordination/ reliability	6%
Not knowing where clinics for uninsured are, what they do	6%
Language barriers	3%
Chronic homelessness	3%
Managed care	3%
Percentages do not add up to 100%; respondents mentioned more than one barrier.	n=33

"The number of **uninsured** people experiencing homelessness has increased and overwhelmed the health care system. Required documentation of identity to apply for benefits is a serious impediment. The number of undocumented workers has increased. The number of homeless people in suburbs has increased and suburbs haven't developed a way to address this service access problem. Demand is greater than the supply of health care services [for uninsured people] in the communities where homeless people live. All of these factors limit health care access for the people we serve on mobile outreach." – *Darcie Meierbachtol, ANP, FNP, Colorado Coalition for the Homeless–Stout Street Clinic, Denver, CO*

"Even in urban areas, there is very **little public transportation**; only those who own cars can get to health services. Busing is scarce; it stops at 5:00 p.m. and there are no suburban routes. In rural areas, there is no busing at all; people must walk miles to services. **Trust** is also a problem in a state where experiments were done on poor black people without their knowledge (at Tuskeegee)."– *Jonathan Dunning, MEd, CCS, Birmingham Health Care, Inc., Birmingham, AL*

"A large portion of outreach **clients don't know about our fixed-site services** or where they are located, even in areas pretty close to them. There's constant turnover in the homeless community." – *Matias Vega, MD, Albuquerque Health Care for the Homeless, Inc., Albuquerque, NM*

"Thousands of people lost jobs and health insurance as a result of the **hurricanes** last year. Those with access to insurance can't afford premiums. Lots of physicians whose practices were destroyed left the state or had to relocate. Getting health care here is difficult even if you have insurance. We lost major bridges connecting two cities in Hancock and Jackson counties. Driving is very difficult. People have to go many miles out of their way to get to a clinic." – *Cathy Dumal, RN, Coastal Family Health Center, Biloxi, MS*

"We see medically indigent adults at risk for long-term disability just because they **can't get the specialty care** they need. It can take up to six months to get an appointment with an orthopaedist." – *Marie Aylward-Wall, MS, RN, Clinica Sierra Vista Homeless Mobile and Respite Services, Bakersfield, CA*

"Accessing the mainstream **primary care** system is difficult. We are a county-based system. Our clinics have more clients than they can handle already. Homeless patients need more than 15-minute appointments. It's a struggle to integrate two different primary care cultures. It's even harder to get **behavioral health care** than primary care; clients need Medicaid to qualify. Lots of homeless people aren't sufficiently impaired to qualify but do have mental health issues. Clients won't keep an appointment after a referral; they may be in jail or leave town. Health care isn't their number one issue most of the time; their number one issue is survival."
— *Molly Kennedy, San Mateo County Health Services Agency, San Mateo, CA*

Rationale for Mobile Health Care

According to the HCH providers interviewed, mobile health outreach is warranted by its success in reducing some of the health care access barriers just mentioned. The main reason for mobile health care is **provision of accessible services that are welcoming to homeless people who can't or won't go to fixed-site clinics**. Mobile units are the sole source of health care in some rural communities and have also demonstrated their value in areas devastated by hurricanes, floods, and other disasters. Another justification given for mobile health outreach is **cost containment** – providing less expensive primary care alternatives than emergency rooms, and keeping homeless people with behavioral health disorders out of jail.

> "Mobile units serve individuals who would not have any other way of obtaining health care unless their condition becomes so intolerable that the emergency room is utilized. Approximately 80 percent of the people served **do not have health insurance**; other clients are **unaware of their health care benefits** or **unable to reach their primary care physician**." — *Linda Sheets, MPM, Operation Safety Net, Pittsburgh, PA*

> "The most marginalized of patients tend to be isolated. A goal of our mobile program is to reach out to them to **prevent use of ERs to meet primary care needs**." — *Wayne Centrone, MD, Outside In, Portland, OR*

> "The mobile program allows people without health insurance to get care – who don't or can't go to regular health care facilities and typically wait to seek care until they are really sick. Providing services on demand and going where clients are makes sense; it **promotes earlier access to care, at less expense**." — *Darlene Hein, Waikiki Health Center, Honolulu, HI*

> "Our HCH program went mobile because we couldn't get people to come to the clinic on their own. Mobile health care is a **good way to reach people who work during the day**. Homeless people are one of the hardest working segments of the population; they work 10 to14 hrs a day, to NOT make ends meet. Mobile health outreach is a good way to engage people in taking an interest in their own health and bringing them back into traditional clinic settings." — *Greg Morris, PA-C, Peak Vista Community Health Homeless Health Center, Colorado Springs, CO*

> "Mobile units are **a must in disasters**; clinicians can provide services in areas devastated by floods, hurricanes, and other emergencies. People in disaster areas don't have cars to get to a medical clinic or mental health services. We take services to them via our mobile units. We took these units into the Astrodome during the Katrina disaster."— *Marion Scott, MSN, RN, Harris County Hospital District – Health Care for the Homeless, Houston, TX*

> "There's a reason why a person is more comfortable going behind the Safeway to a mobile clinic than going a block away to a pretty, stationary clinic. These **clients will not go anywhere else**; if they did, you wouldn't need a mobile clinic." — *Molly Kennedy, San Mateo County Health Services Agency, San Mateo, CA*

There is general agreement, however, that mobile programs are insufficient to meet the complex health care needs of many homeless people who require "a medical home" and comprehensive services which can be delivered more efficiently in fixed-site clinics. Reported strategies used by mobile health programs to improve access to ongoing care include: compassionate, culturally competent outreach; help with transportation to clinics and other incentives to promote engagement in a therapeutic relationship (food vouchers, hygiene kits, clothing); a consistent mobile service schedule; and assistance in applying for public benefits including health insurance.

Mobile Outreach Interventions to Reduce Health Care Access Barriers	% respondents
no-cost services welcoming to homeless who can't/won't go to clinics	30%
compassionate, culturally competent care	15%
provide/pay for transportation, other incentives	15%
food vouchers, hygiene kits, clothing etc.	12%
consistent service schedule	6%
entitlement/benefits/housing assistance	6%
pay for/help get documentation	6%
holistic health care with interdisciplinary team	3%
mobile services provided onsite at detox programs	3%
service directory	3%

Percentages do not add up to 100%; respondents mentioned more than one barrier. n=33

"Although we can take mobile services out to clients, the level of care provided in the field is never as high as the level of care provided at the hub. Our plan is to **engage clients during outreach and, over time, bring them in to the fixed-site clinic**." — *Adele O'Sullivan, MD, Maricopa County Department of Public Health, Phoenix, AZ*

Distinctiveness of HCH Mobile Care

Mobile health programs sponsored or staffed by Health Care for the Homeless projects are distinctive from other mobile outreach programs in the following ways:

1. Like HCH fixed-site clinics, they employ a model of care characterized by integrated services provided by a multidisciplinary clinical team; use a holistic approach to health care that addresses psychosocial as well as medical issues; and emphasize building nonjudgmental therapeutic relationships based on trust.
2. Health care access barriers experienced by HCH clients are especially severe due to their extreme level of impoverishment and lack of social supports. Lack of health insurance and preoccupation with meeting basic survival needs partially explain why they tend to seek health care only in emergencies.
3. The multiple and complex health problems characteristic of many homeless people seen by HCH programs stretch the capacity of outreach clinicians to ensure needed follow-up care. In particular:
   - Homeless people are at higher risk for chronic, uncontrolled medical conditions (asthma, COPD, diabetes, hypertension, peripheral vascular disease, chronic liver/renal disease) than are domiciled people.
   - Transience and congregate living increase their risk for contracting and transmitting communicable diseases such as tuberculosis and HIV/AIDS.
   - Homeless people may resist treatment or have extreme difficulty adhering to a medical regimen — particularly if they suffer from psychiatric illnesses, mental retardation, and/or substance use disorders, which are common among those served by HCH mobile health programs.

(Bonin et al., 2004)

Flexibility in Outreach

Outreach, a hallmark of Health Care for the Homeless, is accomplished in many different ways. The use of mobile clinics and other vehicles is part of a continuum of outreach services that also includes outreach on foot and operation of clinics in nontraditional settings. A number of people interviewed for this report stressed the importance of program flexibility to respond to the changing faces of homelessness and the mobility of homeless people.

> "When we look at the growing population of homeless people and all the strategies we have designed to serve them, the most important thing is to **stay flexible**. The population changes — it used to be single men living in the downtown area; now we have lots of families, children, and unattached adolescents. There have been changes even during the last 5 years. Housing is so expensive in the metropolitan area that people who were marginally housed 5 yrs ago are now homeless. Lots of adults are living doubled up, in cars, or camping out. The need for verification of ID was directly related to 9/11 and the debate about immigrant rights. We couldn't have anticipated these things. We have to continue to look at what we are doing now and whom we are serving, and **evolve with the population**. We can't be static or say we know how best to serve these people. We must stay open to the likelihood that what we do today won't meet the needs of people tomorrow." — *Darcie Meierbachtol, ANP, FNP, Colorado Coalition for the Homeless–Stout Street Clinic, Denver, CO*

> "Mobile clinics are the first and sometimes only medical provider that a homeless person sees. We are able to **build trust** with and commitment to homeless people that clinics serving general populations cannot develop. We have more **flexibility** than fixed-site clinics and can change more quickly in response to client needs. Our philosophy is to **serve clients where they are**, not where you want them to be." — *Molly Kennedy, San Mateo County Health Services Agency, San Mateo, CA*

Mobile health programs are but one response to the phenomenon of modern homelessness in the United States, which extends far beyond our cities and their suburban rims to sparsely populated areas in rural areas. This report is an attempt to capture the variety of programs that employ mobile medical units and other vehicles to extend health care to homeless people. It relies on the perceptions of direct service providers in assessing the utility of these outreach efforts.

TARGETED POPULATIONS & ENVIRONMENT

Of the 33 surveyed programs, 70 percent serve both adults and children by means of mobile outreach vehicles, 27 percent mainly serve adults, and 3 percent serve only children. Three programs provide health services for women (ob-gyn and mammography) on mobile units, and several target subpopulations with special health risks, including sex workers, homeless youth, undocumented day laborers, street dwellers, and people with HIV or hepatitis.

The vast majority (88 percent) of respondents serve urban areas – 16 of these programs serve only urban areas; 10 serve both urban and rural areas; 3 serve urban and suburban areas; and 3 serve urban, suburban, and rural areas. A total of 13 programs (39 percent) provide services in rural areas, and 8 programs (24 percent) serve suburban areas; 2 programs serve only rural areas, and 1 program serves a suburban area exclusively. Although health services for indigent populations in rural areas are scarce, mobile services are expensive to provide there due to greater distances traveled, higher fuel costs, and more wear and tear on vehicles traversing rough terrain.

Populations served	**% respondents**
both adults and children	70%
mainly adults	27%
children only	3%
Environment	
urban (U=16 UR=10 US=3 URS=3)	88%
rural (R only=2)	39%
suburban (S only=1)	24%
	n=33

Age/gender

Most of these mobile health programs provide services to both adults and children; populations served at particular sites may vary by age or gender, as the following comments explain:

> "Our mobile program, which has been operational for 20 years, began as a pediatric service; now we take care of the whole family, from **birth to geriatrics**. Up to 250 families are seen at some sites. The mobile unit serves as a medical home during homelessness. Anything that can be done in an upscale doctor's office can be done in a mobile medical unit—a comprehensive medical service on wheels." — *Sharon Joseph, MD, Montefiore Mobile Health Program, New York, NY*

> "We provide primary health care services for homeless men, women, and children. We see **mainly men on the mobile unit** and serve **women and children** primarily **in shelters**. We provide HIV testing, acute care, medications and prescriptions on the unit, but don't provide ob-gyn services there." — *Sandra Stephens, Unity Health–Urban and Rural Health Care Services for Homeless Men, Women and Children, Rochester, NY*

> "The Maricopa County Public Health Department's HCH program contracts with a pediatric van out of Phoenix Children's Hospital, a new service access point. A pediatrician staffs the van with resident physicians. The van goes specifically to youth drop-in centers in Tempe used by runaway teens; services are provided only to **young people ages 18 and under**." — *Adele O'Sullivan, MD, Maricopa County Department of Public Health, Phoenix, AZ*

High-risk populations

Some mobile programs target homeless populations known to be at especially high risk for serious health problems, including communicable diseases:

"Our mobile medical program provides broad primary care services with a focus on 3 populations: 1) **commercial sex workers**, who require treatment for soft tissue injuries, infection, general cough and cold care, and STDs; 2) hard-to-serve, **homeless young adults** with chronic, poorly controlled mental illness and active intravenous drug use who require mental health care and substance abuse services; and 3) **undocumented Latino day laborers**." — *Wayne Centrone, MD, Outside In, Portland, OR*

"Our clientele includes a large farmworker population and undocumented migrants – primarily **young, single men** with untreated diabetes and hypertension. We are a major source of care for this population. There has been a huge influx of homeless people into Bakersfield because of allegedly cheap housing; the population we serve there has tripled in the last decade." — *Marie Aylward-Wall, MS, RN, Clinica Sierra Vista Homeless Mobile and Respite Services, Bakersfield, CA*

"Our mobile health program has two target populations: **homeless street dwellers** and **persons with HIV or hepatitis**. The HCH mobile unit visits places in the city where homeless people congregate. A second vehicle, which provides HIV and hepatitis screening, returns to hot spots previously identified by the District of Columbia where there is a high crime rate or high prevalence of HIV cases, drug trafficking/use, and drug/crack houses. This unit serves all populations including homeless people." — *Michelle Madison, Unity Health Care, Inc., Washington, DC*

Urban/suburban/rural

All but three programs surveyed are based in cities, yet half of these urban programs also serve displaced people living in suburban, semi-rural or rural areas.

"The mobile unit is one of 2 methods used by Operation Safety Net to provide direct care to street dwellers in 3 **urban** areas of Pittsburgh: van teams and walking teams, which work closely together. The mobile health program serves a unique population of chronically homeless individuals at each site: a large group of intravenous drug users requiring wound care and assistance connecting with drug and alcohol treatment services; a large number of homeless people who gather in the central city for primary care, dental care, and social interaction; and a group of young adults who move in and out of shelters." — *Linda Sheets, MPM, Operation Safety Net, Pittsburgh, PA*

"We provide nontraditional primary medical care in a **suburb** of Los Angeles County. We use the mobile unit as a gateway to the HCH clinic. Linkage to a fixed-site medical home is optimal; but when that's not possible, we have to meet people where they are." — *Kathy Proctor, MPH, Northeast Valley Health Corporation, San Fernando, CA*

"The environment we serve is very **rural**—a flat, agricultural area where corn, wheat, tobacco, and cotton are grown. We go out to migrant camps, often on roads that aren't paved. Our mobile units currently provide mammography and dental care. We expect to have a medical unit operational within the next 6 months." — *Sue Sutton, Goshen Medical Center–Eastpointe, Faison, NC*

MOBILE SERVICES

Types of services provided

Most of the HCH grantees surveyed (76 percent) provide primary care services, including acute, episodic, and preventive care. Ten mobile programs reported that they dispense medications; 3 give patients prescriptions to fill at fixed-site HCH clinics; and 2 programs order medications from pharmaceutical companies' patient assistance programs. Of the 16 programs (48 percent) that provide diagnostic screening, two provide only mammography, and one program provides only HIV/hepatitis testing and immunization. Thirty-three percent of surveyed mobile health programs provide dental care, 2 of which provide only dental care. Only 6 programs (18 percent) offer behavioral health services (mental health services and/or addiction counseling) on the mobile unit; others refer clients or transport them elsewhere to receive these and other services. Clients are referred for X rays/diagnostic tests and follow-up care to primary care clinics, behavioral health services, specialists, hospitals, and nutrition services.

Mobile Health Services	% respondents
primary care	76%
screenings	48%
dental care	33%
medications	30%
behavioral health care	18%
immunizations	18%
lab tests	18%
case management	15%
benefits assistance/assessment	9%
triage	6%
	n=33

"The public health department operates 2 mobile units: One provides outreach, **HIV and hepatitis testing, and immunizations**. The HCH project sends clients who need these services to the van, which parks outside the shelter once a month. The other unit is a dental van for needy children, including homeless children, which goes to local schools." — *Marianne Savarese, BSN, Mobile Community Health Team at Catholic Medical Center, Manchester, New Hampshire*

"The HOPE team provides **behavioral health outreach and medications** to people living on the street and transports them to the HCH clinic or detox centers. Many are severely mentally ill and/or recently discharged from jail. The team coordinator is an addictions counselor. A psychiatrist goes out on the van one day a week, and a psychiatric nurse practitioner goes out another day." — *Michael Cochran, I.M. Sulzbacher Health Care for the Homeless, Jacksonville, Florida*

"The Mammovan travels the entire state, providing **mammograms and breast and pelvic exams** at community centers, shopping centers, churches, and clinics." – *Vivian Hanson, Nevada Health Centers, Inc., HCH, Las Vegas, Nevada*

"We do a **syringe exchange program** through our harm reduction outreach that provides education on HIV, Hepatitis C, STDs, and safe practices. This State-funded program is the largest syringe exchange program in the Southwest. Medical services are also provided along with that outreach – direct primary care and urgent care." — *Matias Vega, MD, Albuquerque Health Care for the Homeless, Inc., Albuquerque, NM*

Service sites & service delivery models

Most mobile health programs surveyed provide services where homeless people congregate – at shelters and social service agencies, soup kitchens, campgrounds, or parks. Fifty-two percent reported that they **schedule visits to particular sites**, and 18 percent do **roving outreach** to find reclusive clients. These programs employ a variety of service delivery models: 82 percent **provide health services on their mobile units**; some of these also provide services in shelters and community service agencies. Twelve percent of surveyed programs **transport clients to services**; and 9 percent transport clinicians to and from remote sites but do not **provide services on the mobile unit** ("suitcase clinics")**.** Two programs were not operational when interviews were conducted, but were expected to be up and running again within a few months.

Service sites	**% respondents**
shelters	30%
social service agencies	30%
Community Health Centers	27%
public health departments/ hospitals	21%
drop-in centers	15%
churches	12%
schools	9%
Service delivery	
services provided on mobile unit	82%
mobile units used to transport clients to services	12%
services provided at remote sites, not on mobile unit	9%
scheduled visits to particular sites	52%
roving	18%
	n=33

"We park the dental van outside 2 downtown **homeless shelters**12 hours per week; outside a **street outreach center** for teens 4 hours per week; and at a **domestic violence shelter** 8 hours per week. The HCH Project provides primary care within each of these facilities. We make sure to overlap the dental van hours with primary care hours, so we can refer directly from the clinic inside the building to the van outside." – *John Gilvar, City of Austin Community Care Services Department, Austin, TX*

"The mobile program provides complete medical services and case management at 4 mobile service sites in **public housing** and 1 site downtown, linking clients to a variety of **health and social services** including job training, childcare, food services, and a garden where homeless people are taught how to grow their own food. (The HCH purchases the food they grow to prepare in their kitchen.) The mobile health unit is an extension of fixed-site services – a means of marketing those services and a way to bring people back to more comprehensive care." – *Jonathan Dunning, MEd, CCS, Birmingham Health Care, Inc., Birmingham, AL*

"Our mobile van provides medical care at 4 shelters. **No services are provided on the mobile unit**. Nursing staff, a receptionist, and a medical provider (physician or nurse practitioner) travel to homeless shelters with 3 suitcases of medical equipment. The HCH project also has a fixed-site clinic where shelter residents are seen." — *Lisa Seldana, Aunt Martha's Health Center, Aurora, Illinois*

"We do **2 types of outreach**: We visit the same parks every 2 weeks, at same the time on a specific day; and we use roving outreach to look for homeless people who are more severely and persistently mentally ill." – *Darlene Hein, Waikiki Health Center, Honolulu, HI*

Staffing

The number of personnel who ride on mobile health units is limited by the size and type of vehicle used (discussed in the next section). Of the programs surveyed, 28 percent carry 1 or 2 staff on each vehicle; 25 percent carry 3 to 5 staff; and 13 percent can accommodate as many as 6 or 7 personnel per mobile unit. Service providers include employees of the HCH program, its parent agency, or subcontractors. Nine respondents (27 percent) said their programs use volunteer clinicians; 2 of these programs depend entirely on clinician volunteers. Nearly two-thirds of surveyed programs send physicians, physician assistants, and/or advanced practice nurses out on mobile units, usually paying or contracting for a portion of their time; 45 percent employ outreach workers; 30 percent use other nurses; and 30 percent use social workers, case managers, or eligibility workers (to help clients with referrals and applications for public benefits). Fifteen percent have staff that fill multiple roles (e.g., drivers who double as outreach workers).

Staffing	% respondents
medical providers on staff (MD, PA, NP)	64%
outreach worker	45%
other nurses	30%
social worker/case manager/ community health/eligibility worker	30%
volunteer clinicians/students	27%
certified medical assistant (CMA)	27%
dentist	18%
dental assistant/hygienist	15%
admin assistant/office manager	15%
driver dual role	15%
mental health provider	9%
registration clerk/patient care technician	9%
addictions counselor	6%
employment worker	3%
nutritionist	3%
1-2 staff/mobile unit: 27%; 3-5 staff/unit: 24%; 6-7 staff/unit: 12%	n=33

"Our mobile unit can accommodate only one patient at a time. The sole medical provider on the unit is a **physician assistant** (myself), who is also the HCH program director and van driver. I am accompanied by a **medical assistant** who does intake." — *Greg Morris, PA-C, Colorado Springs, CO*

"Three clinicians ride the van at any one time: a **nurse practitioner**, a **RN**, and a **LPN or CMA** who works on labs." — *Jody Brandenburg, Kentucky River Foothills Development Council, Inc., Clay City, Kentucky*

"The dental van is staffed by one **dentist**, one **dental assistant**, and one **administrative assistant**." — *John Gilvar, City of Austin Community Care Services Department, Austin, TX*

"A **physician** and **2 outreach/triage nurses**, who see clients separately from the provider, ride on the van with a **certified medical assistant**, a **social worker** who provides entitlement assistance and A&D case management, and a **driver** who also registers clients and helps with Oregon Health Plan applications and referrals. The whole team is bilingual (English and Spanish)." — *Kim Tierney, MPH, HCH Program, Multnomah County Health Department, Portland, OR*

"Seven people ride the medical van at the same time: a **nurse practitioner**, **2 medical office assistants** who work at the front desk, **1 LPN, 1 RN** (outreach nurse), an **outreach specialist** (not a social worker) who goes out in field to find homeless clients, and a care advocate (**social worker**) who is responsible for referrals and benefits assistance." — *Kimberly Rice, LBSW, New Horizon Family Health Services, Greenville, SC*

"The mobile van service is mostly provided by **clinical volunteers** from the Pittsburgh area with **medical and nursing school students** participating in the education service." — *Linda Sheets, MPM, Operation Safety Net, Pittsburgh, PA*

COMMUNITY PARTNERS

Respondents agreed that close working relationships with community partners are one of the prerequisites of a successful mobile health program. Agencies with which HCH mobile outreach programs most frequently partner are emergency shelters (mentioned by 33 percent of respondents), social service providers (30 percent), and Community Health Centers (27 percent). These agencies often refer their clients to mobile programs, as well as providing space outside or inside their facilities where mobile services can be delivered. A number of programs are affiliated with public health departments which provide one or more of their mobile medical units. Only 5 respondents said their program shares use of the mobile unit with another agency. Programs that deliver primary care develop referral relationships with community hospitals (including academic medical centers), and other medical and behavioral health service providers. Partnerships with local health coalitions, drop-in centers, police, crisis centers, faith communities, and schools help mobile programs reach their target populations.

Community Partners	% respondents
shelters	33%
social service providers/ homeless service agencies	30%
CHCs	27%
public health dept(s)/hospital	21%
veterans groups	21%
substance abuse treatment services	18%
community health network/coalition	15%
medical service providers	15%
drop-in center	15%
mental health services	15%
churches	12%
university medical center/hospital	12%
police/sheriff/dept corrections	12%
crisis center	9%
schools	9%
Indian reservations	6%
private organization	6%
Walking outreach teams	6%
consumers	3%
dental providers	3%
mailman	3%

n=33

Public health departments & community health centers

"Our Project Orion vehicle, which provides HIV and hepatitis screening, is a collaborative effort with the District of Columbia's Department of Health, the HIV/AIDS Administration, and the Addiction Prevention and Recovery Administration. The HCH unit partners with Christ House, which provides medical respite services to homeless people." — *Michelle Madison, Unity Health Care, Inc., Washington, DC*

"We partner with the WATCH (Wayne Action Team for Community Health) unit, a collaborative effort with 3 other CHCs to provide mobile medical and dental care to homeless shelters and migrant camps in Goldsboro and Wayne counties." — *Sue, Goshen Medical Center–Eastpointe, Faison, NC*

Hospitals & other health service providers

"The mobile program is an extension of the Montefiore outpatient clinic and operates under the auspices of the hospital. We also partner with other area hospitals, mental health providers, dental providers, food pantries, shelters." — *Michael Lambert, MBA, Montefiore Mobile Health Program, New York, NY*

"Our partners are all of the community nonprofits that provide homeless services in the continuum of care, and all of the county departments that provide primary, specialty, emergency department, inpatient, ancillary, mental health and substance abuse services. The agencies where we provide our mobile clinic services are our other significant partners, including shelters, soup kitchens, and community centers that serve homeless people." — *Andrea DuBrow, MSW, MPH, Contra Costa Health Services Dept., Martinez, CA*

Criminal justice system

"In collaboration with Albuquerque HCH and the Albuquerque police department, we initiated an effort to decriminalize homelessness by referring homeless people to treatment and services and help them with entitlements instead of arresting them. At least two police officers go on outreach with the HCH team weekly. Although the official name is Strategic Outreach, we call it "cop-reach." — *Matias Vega, MD, Albuquerque Health Care for the Homeless, Inc., Albuquerque, NM*

"We work closely with the crisis unit, detox centers, and the sheriff's office, which established a protocol for the downtown area: Instead of arresting homeless people for public drinking or trespassing, police will call the mobile unit to take them to detox or the HCH center. We attend weekly staff meetings at the Sheriff's office." — *Michael Cochran, I.M. Sulzbacher Health Care for the Homeless, Jacksonville, FL*

"Mobile medical staff go out every other week in an unmarked police department vehicle with behavioral health outreach workers and members of the Native Americans Connection, Veterans Outreach, and Chamber of Commerce, as part of the Connection to Care program. Plainclothes police (in t-shirts and jeans) have good rapport with chronically homeless people and know who has a medical issue. Every 3 months, police do a sweep and bring homeless individuals to a central location where service providers are and make a contract with them: if they will get their health care needs taken care of, the police will drop charges. It works well." — *Adele O'Sullivan, MD, Maricopa County Dept. of Public Health, Phoenix, AZ*

Health coalitions, churches & schools

"The HCH project is part of a larger nonprofit Health Community Action Partnership which includes Head Start, adult daycare, rental properties, and a rehabilitation center. One mobile service site is adjacent to an adult daycare center across from a center for homeless families with disabilities. We also have church partners and provide blood pressure and glucose monitoring every 2 months for a local veterans group." — *Jody Brandenburg, Kentucky River Foothills Development Council, Inc., Clay City, KY*

"We partner with other agencies that serve homeless people in planning where to take the mobile unit and visit places where homeless people actually gather. We work with mental health, substance abuse and housing services, with churches and feeding programs. A group of church women who knit were encouraged to make knitted items for homeless clients to distribute via the mobile unit as incentives to seek ongoing care." — *Michael Menchaca, MS, AHNP, RN, San Fernando, CA*

"Many elementary schools wishing to teach students about homeless people have asked us to give presentations to their classes and have bought hygiene kits or items to go in them (plastic baggies filled with toothpaste, toothbrush, comb, shampoo, hand wash, HIV prevention information, condoms, etc.) which the mobile unit distributes to homeless clients." — *G.G. Greenhouse, MSW, Alameda County Health Care for the Homeless Program, Oakland, CA*

For guidance in identifying community partners for your mobile health program, contact the Mobile Health Clinics Network (mobilehealthcare@aol.com) or go to: http://www.mobilehealthclinicsnetwork.org/partners.html

TYPES & DESIGNS OF MOBILE UNITS

There's quite a bit of variability in the types, sizes, and designs of mobile units that are used to extend health care to homeless people. Of 33 HCH programs surveyed, 39 percent use mobile health units built on a recreational vehicle (RV) chassis, ranging from 26 to 38 feet in length; 30 percent use medical vans built on a 39–40 foot truck chassis; 24 percent use 15-passenger vans with or without a seat removed; and 9 percent use a remodeled (40-foot) bus. Several programs hope to purchase a larger unit with two exam rooms instead of one and more space for storage and ancillary staff. One program would prefer a smaller unit that is easier to park in the city. Another respondent dislikes the claustrophobic feel of campervans and prefers "tailgate" vans with services provided outside the back of the van, particularly for clients with severe mental illness who fear any enclosed space.

Type/ design of mobile unit		% respondents
RV/camper chassis	13	39%
truck chassis/commercial driver's license required	10	30%
passenger van	8	24%
bus	3	9%
exam rooms: 0=5, 1room=12, 2rooms=15	27	82%
waiting area/intake/triage inside unit	11	33%
bathroom	10	30%
supply/records storage/autoclave	10	30%
lab	9	27%
wheelchair lift	6	18%
wired for telemedicine/wireless Internet	5	15%
case management room/conference room	4	12%
refrigeration	3	9%
registration outside mobile unit	3	9%
X ray	2	6%
kitchen	1	3%
mobile dental equipment	1	3%
office space	1	3%
patient education space	1	3%
pharmacy/dispensary	1	3%
		n=33

In general, as one program administrator noted, shorter units are preferable in urban environments where there is limited space to navigate and park along city streets; longer units are easier to maneuver in rural areas. But there's a trade-off with respect to size, maneuverability, durability, and cost: Larger primary care units can accommodate more patients and services but are heavier and more expensive to drive long distances, more difficult to park, and require a commercial driver's license to operate. Passenger vans are preferred by programs that mainly transport clients to services or clinicians and medical/dental equipment to remote service sites ("suitcase clinics").

(Recommendations about the pros and cons of various types and designs of mobile medical units are beyond the scope of this report. Technical assistance is available from the Mobile Health Clinics Network: http://www.mobilehealthclinicsnetwork.org/ and The Children's Health Fund: http://www.childrenshealthfund.org/#.) HCH projects tend to make creative use of whatever vehicles they can afford, as the comments below vividly illustrate.

RV

"The mobile unit is a **renovated 2001 34 foot recreational vehicle**. The back bedroom was made into a physician's treatment room. The front portion of the van is a waiting area with comfortable chairs, a couch, and a mini-kitchen to provide coffee and food. The RV has nice cabinets that are used to store hygiene supplies for clients. The middle area had a built-in dresser, which was converted to store medications. The shower and bath were removed for additional storage of sleeping bags and blankets." — *Linda Sheets, MPM, Mercy Hospital/Operation Safety Net, Pittsburgh, PA*

"Our medical van, which serves both urban and rural areas, is a **36 foot Airstream** with no slides [hydraulic slide-outs that expand the space of van]. It has a waiting area that seats 3 people, a 12-foot-long countertop for outreach, a sink and work area for the nurse, storage spaces, 2 refrigerators for immunizations, and a back area with an 8 x 8 foot exam room, sink and bathroom. The single exam room limits the number of patients who can be seen at one time. If we could afford a new unit, we would get a 40 foot unit with 3 slides and 2 operational rooms instead of one." — *Clyde Drury, Metropolitan Development Council, Tacoma, WA*

Truck

"Built on a **GMC 6500 truck chassis**, our mobile unit is limited to 2 exam rooms; we could use10. There's no other source of health care in our county for people who don't have health insurance, and we're 45 minutes away from any major medical center." — *Jody Brandenburg, Kentucky River Foothills Development Council, Inc., Clay City, KY*

"We are getting a new medical van, similar to the last one: a 40 foot truck with 2 exam rooms and a central office area. It's somewhat cramped but spacious enough to do what can be done in a regular primary care office. The cab is up front and the generator in back." — *Robert Donovan, MD, Cincinnati Health Network, Inc., Cincinnati, OH*

Passenger van

"With a fairly small grant, we were able to purchase a regular, **15-passenger van with a raised roof and a wheelchair lift** that has been modified to convey a mobile X-ray unit and a folding dental chair. Our dentist built trolleys to transport the equipment into shelters." — *Villie Appoo, MA, MSW, Grace Hill Neighborhood Health Centers, Inc, St. Louis, MO*

"We use two **passenger Chevrolet caravans** with the middle seat removed. We have space for equipment and people—a nurse practitioner, an outreach worker, an employment worker, and a mental health worker. It works, but a vehicle with an exam room would help us provide services better." — *Darlene Hein, Waikiki Health Center, Honolulu, HI*

Bus

"We have 3 mobile units that provide some primary care — physical exams, some family planning, services, immunizations, a limited number of onsite laboratory tests, and treatment for STDS and asthma. All are 40 x 8 feet Bluebirds (**converted school buses**). The size and weight of the vans require a Class B driving license. All 3 units have 2 exam rooms separated by staff office space: an assigned nursing area and an assigned provider area. There is a restroom onboard and 3 functioning sinks—one in each exam room and one in the nursing area. There is space for supplies (bandages, syringes, meds), but we could use more storage space. It would also be good to have space to register patients onboard. We have awnings outside the van, where there's plenty of space for tables and chairs, but it's difficult to register patients there in inclement weather." — *Antonio de los Santos, Family Health Center of San Diego, San Diego, CA*

Custom Designed

"Four different models of mobile units are used by Montefiore, ranging in size from **33 to 35 feet in length**. Some are better equipped to provide service to adults, with a larger exam room and full-sized exam table; others are designed primarily for children. An interactive animation on the Children's Health Fund website shows different parts of the mobile unit: http://www.childrenshealthfund.org/# [*click on the blue mobile unit and follow links*]." — *Michael Lambert, MBA, Montefiore Mobile Health Program, New York, NY*

FINANCING & ADMINISTRATION OF MOBILE PROGRAMS

Funding

Grants from the Health Resources and Services Administration are a central source of financing for some of these mobile health programs – particularly Expanded Medical Capacity and New Access Points grants, which have enabled HCH projects to staff or purchase mobile units. In many cases, mobile programs have enabled HCH providers to enhance their productivity by serving larger numbers of homeless people than they would otherwise have served in fixed-site clinics alone. Their vehicles were purchased by HCH projects, their parent agencies or contractors, using a variety of other funding sources, including city and county governments, private foundations and corporations, Medicaid/Medicare reimbursements for mobile services, Federal money distributed to states for disaster preparedness, and State money from the tobacco litigation settlement.

Funding	% respondents
HRSA	45%
city/county	21%
private funding	18%
Medicaid, Medicare, other Federal	9%
State	9%
pro bono/in kind services	6%

n=33

"We have a great **grant-writing team** and over 20 different funding sources, including Bureau of Primary Health Care/**HRSA grants** (CHC, HCH, Public Housing, Black Lung Clinics Program). The van has paid for itself many times over by increasing the HCH project's productivity (number of clients served). We also receive funding from the **city and county**. — *Jonathan Dunning, MEd, CCS, Birmingham Health Care, Inc., Birmingham, AL*

"Funding has been adequate throughout the 18 years during which the mobile program has been operational. The HCH program is a network of agencies that administers the **McKinney grant**, which supports staffing for the MedVan. In additional to Federal funding, we use the **metropolitan health department**'s 5 primary care clinics for labs and pharmaceuticals." — *Robert Donovan, MD, Cincinnati Health Network, Inc., Cincinnati, OH*

"Funders understand what we do; we have established a pretty good tracking system for our mobile services, including how many clients are linked to medical, dental, and shelter services; how many people are given medications; and interventions to keep people out of jail. We receive funding from the **City of Jacksonville**, which also funds the Sheriff's office. Keeping someone out of jail saves a minimum of $800 per person (just to book them)." — *Michael Cochran, I.M. Sulzbacher Health Care for the Homeless, Jacksonville, FL*

"We just developed a fundraising plan targeting a variety of **private foundations** that support health services and want to improve the community. We initiated a plan to get **corporate sponsorship** of our mobile units by agreeing to place stickers with the company name and logo onboard in exchange for donations. Several banks provided money for one unit." — *Antonio de los Santos, Family Health Center of San Diego, San Diego, CA*

"The **Children's Health Fund** does fundraising to provide support for our program in addition to billing, which is primarily through **Medicaid** or self-pay. — *Michael Lambert, MBA, Montefiore Mobile Health Program, New York, NY*

"The new van was bought by the health department with **money earmarked for disaster preparedness**, but is used on an ongoing basis for the homeless program." — *Molly Kennedy, San Mateo County Health Services Agency, San Mateo, CA*

"A grant from the state's Comprehensive Primary and Preventive Care Fund, established with **money from the tobacco settlement**, allowed us to start the mobile clinic in 2001. In the first calendar year of operation, over 75 percent of our mobile health clients had never been seen before by the HCH project. In 2006, we received an [EMC] expansion grant from the **Bureau of Primary Health Care** to buy a new mobile unit, based on our ability to demonstrate that we were filling a large, unmet need." — *Darcie Meierbachtol, ANP, FNP, Colorado Coalition for the Homeless–Stout Street Clinic, Denver, CO*

Ownership/operation

Two-thirds of respondents said their agency either owns their mobile health unit(s) or contracts with another agency to operate one or more units. Two other programs (6 percent) that own their units were not currently operational due to staff turnover or replacement of their vehicle, but expected to resume services as soon as these matters were resolved. Nine percent said they staff a mobile unit which another agency provides.

Ownership/Operation	% respondents
own van/contractor	67%
staff but do not own	9%
own but not currently operational	6%

n=33

"San Mateo Medical Center **contracts** with the public health department for a mobile health unit that provides primary care at homeless shelters, and contracts with a private dental van that provides full dental care at the shelters every Saturday. The dental van primarily serves employees of the large corporation that owns it. Initially, arrangements were made for the van to visit one shelter every other week. A HRSA New Access Points grant enabled the HCH project to extend this service to all shelters in the county." — *Molly Kennedy, San Mateo County Health Services Agency, San Mateo, CA*

"John Muir Health, Inc. provides a mobile clinic vehicle which the HCH Medical Team **staffs** 3 days a week. On the other days of the week, we use our **own mobile clinic** and/or operate a 'suitcase clinic' (bring medical supplies into the shelters and community centers where we provide services)." — *Andrea DuBrow MSW, MPH, Contra Costa County Health Services Department, Martinez, CA*

"We **own** the medical van, but it **hasn't been operational** since Jan 2006; we are trying to get it back on the road within the next several months. The whole structure of our mobile program changed when management of the HCH project shifted from our agency, which owns the medical van, to the Providence CHC. The van was not part of the merger. Our longtime van driver resigned and we had difficulty finding someone to fill that position who had a commercial driver's license and could do outreach. When the van is up and running again, the CHC has agreed to work closely with our mobile program." — *Jennifer Schanck-Bolwell, Providence, Rhode Island*

OUTREACH & MARKETING STRATEGIES

HCH grantees advertise their mobile services to potential clients and community partners more or less aggressively, depending upon the longevity of their program and its capacity to serve more people. They initially spend a good deal of time on outreach to identify regular service sites, set up memoranda of agreement, arrange for referrals by community partners, and publicize mobile services and service schedules. As they become better known among homeless people and the agencies that serve them, mobile health care providers rely more on their reputation to market services; 42 percent of those surveyed said word of mouth is their primary marketing strategy. Nevertheless, outreach remains a necessity for all of them, given the transience and isolation of the populations they serve. Outreach strategies most often reported include advance visits to regular service sites (by 30 percent of respondents), participation in community meetings and trainings (18 percent) or health fairs (15 percent) and the use of currently or formerly homeless people (15 percent) or police (9 percent) to help engage targeted populations. Business groups and hospital case managers were also specified as outreach partners. In addition to word of mouth, a number of programs market their services by means of flyers, pamphlets, posters and signs (39 percent); the appearance of their mobile units (12 percent); and publicity through the media (9 percent), newsletters (6 percent), or service directories and brochures (6 percent).

In cities with numerous services for homeless people, mobile health programs may be challenged to distinguish themselves from complementary programs, while endeavoring to partner with them to facilitate clients' access to more comprehensive services. One respondent called for "stronger collaboration" among local agencies providing mobile services to homeless people. In rural areas where mobile services are the only source of health care, dissemination of service schedules is especially important. A primarily urban program that also visits remote rural areas relies on local community members who know where homeless people are: police, clergy, even mail carriers.

Outreach	**% respondents**
outreach to service sites prior to visits	30%
community meetings, trainings/presentations	18%
health fairs	15%
client input/outreach	15%
police/sheriff's office	9%
business groups	6%
hospital case managers	3%
Marketing	
word of mouth, reputation of program or staff	42%
flyers/ service schedules, pamphlets, posters, signs	39%
appearance/visibility of mobile unit	12%
media: radio, TV, billboards	9%
newsletter	6%
service directory/brochure	6%
marketing department	3%
restrict marketing due to limited capacity	3%

n=33

Community outreach

"We convened several countywide meetings before got our van and asked what community members' concept of a mobile program was. Participants in meetings became part of our marketing structure. They had to buy into service delivery and agree to provide parking space. Each community health worker assigned to a region conducts a **community meeting**. The case manager gets input from clients and does trainings on any issue of interest to the community—e.g., **presentations** in schools about services available to homeless children, **trainings** on television about communicable diseases—so services providers will know who we are." *— G.G. Greenhouse, MSW, Alameda County Public Health Department HCH Program, Oakland, CA*

"When our mobile program began in 2005, we did outreach, met with shelter staff, got Memoranda of Agreement approved and secured permission to park our vans at service sites. As time went on, all **MOAs** were in place and not as much marketing was required. We continue to attend regular **meetings of the homeless coalition** and **visit shelters** in different counties, and we **send our mobile health schedule** to all service sites every 3 months." *— Kimberly Rice, LBSW, New Horizon Family Health Services, Greenville, SC*

"Mobile clinic staff do most of the marketing and outreach themselves. We recently participated in the county's first **Project Homeless Connect Day** (modeled after San Francisco's program), which brought about 500 homeless people under one roof in the Richmond auditorium. We provided services all day outside the auditorium on the mobile clinic and inside at a flu shot clinic, serving homeless people who previously did not know we existed." *— Andrea DuBrow, MSW, MPH, Contra Costa County Health Services Department, Martinez, CA*

"We make presentations at **drop-in centers** and other agencies that serve the same population. We also meet with the **sheriff's office** and a downtown **business group** to educate them about the benefits of our services and try to avoid an adversarial relationship. They want the mobile unit to remove homeless people from the area; we explain the need for housing and health services." *— Michael Cochron, MPH, I.M. Sulzbacher Health Care for the Homeless, Jacksonville, FL*

Consumer participation

"We are developing a strategy to reach more people with input from consumers and former consumers via our **Consumer Advisory Board and focus groups**, which provide input about the whole program, including the mobile unit and shelter-based services." *— Sandra Stephens, Unity Health–Urban and Rural Health Care Services for Homeless Men, Women and Children, Rochester, NY*

"We use **formerly homeless youth** to engage currently homeless youth and let them know where the van will be. We use a group of **volunteer sex workers** who go into lingerie modeling shops and nightclubs to engage other sex workers and hand out flyers. We use community partners to do marketing for us. *— Wayne Centrone, MD, Outside In, Portland, OR*

Word of mouth

"We transport mobile dental equipment (an X-ray unit and a folding dental chair) in a van. When the program started, we called it "**theatre dentistry**" and set up the equipment in shelter waiting rooms where folks could watch others receiving care. This encouraged people to seek care themselves. Now we have a waiting list at area shelters; people don't avoid dental care any more. Former clients are our best advertisement." *— Fran White, DDS, Grace Hill Neighborhood Health Centers, Inc., St. Louis, MO*

"Our services are advertised primarily by word of mouth, based on the **reliability and safety of the program**. It's about trust; this is not a group of people who trust easily." *— Molly Kennedy, San Mateo County Health Services Agency, San Mateo, CA*

Publicity

"At the very beginning, we did **leaflets and brochures** to advertise the mobile program. After a year or two, when we were established and able to maintain a stable schedule, we shifted to using patients as our most effective source of advertising. Today, about 50 percent of our clients come to us through word of mouth and 50 percent through referrals from other programs (mainly other homeless service providers, hospitals, and CHCs). We still distribute the "**quad-fold,**" a wallet-sized packet of phone numbers and addresses of service sites and agencies that are of importance to folks living on the street. We print and distribute these cards on outreach, in the clinic, to other agencies, ERs, volunteers, and medical students. They are still in great demand." *— Matias Vega, MD, Albuquerque Health Care for the Homeless, Inc., Albuquerque, NM*

"We use **radio, flyers, and billboards** as well as word of mouth. **Outreach workers** help to publicize our program: a homeless outreach team and a Latino outreach team. (Alabama has one of the fastest growing Latino populations due to farming and chicken plants.) We participate in one **health fair** each quarter, and distribute a **newsletter** to hospitals, substance abuse treatment providers, and a group of clergy who meet at the HCH center. The Chair of this group has had a radio show for 50 years; he advertises our mobile health services every Sunday and Wednesday. We received a grant from the University of Alabama-Birmingham School of Public Health to provide advertising and outreach through that ministry." *— Jonathan Dunning, MEd, CCS, Birmingham Health Care, Inc., Birmingham, AL*

"We put out **flyers** after identifying and assessing a service site. We post signs and a picture of the van to announce its coming. The dental van coordinator does **dental education and applications** before the van even goes there (collects medical histories)." *— Marion Scott, MSN, RN, Harris County Hospital District–Health Care for the Homeless, Houston, TX*

"We use our HCH Program service directory (**Yellow Pages**) as a marketing strategy. **Hygiene kits** distributed on the van have the HCH phone number and logo on them. The design for our **brochure** was reviewed by homeless people living in parks and shelters, who provided input on the graphics." *— G.G. Greenhouse, MSW, MSW, Alameda County Health Care for the Homeless Program, Oakland, CA*

"Our biggest challenge is **media coverage** – getting the word out there, since Las Vegas is such a transitional community. Outreach workers go to **health fairs**. The Mammovan travels to many different locations; we try to keep the same schedule each year. The dental van goes regularly to schools." *— Vivian Hanson, Nevada Health Centers, Inc., HCH, Las Vegas, NV*

Appearance/visibility of mobile unit

"The van itself is a marketing device; we put the logo for Alameda County on it and **avoided using the word 'homeless'**. We didn't want clients to shy away from the van for fear of being identified as homeless." *— G.G. Greenhouse, MSW, Alameda County Public Health Department HCH Program, Oakland, CA*

"The mobile units are kid friendly, with soft colors and happy scenes. All units have different **graphic designs** on them: a picture of parade, outdoor scenes in the city or beach, underwater graphics. They are designed to be attractive to the public and look clean. Generally, we have had no negative reactions from the public; the vans also provide services to young people who are not homeless." *— Antonio de los Santos, Family Health Center of San Diego, San Diego, CA*

PROGRAM OBSTACLES

Mobile health programs are not easy to initiate or maintain, and a number of them fold after a few or even many years. A majority of mobile service providers interviewed for this report (58 percent) identified **lack of financial capacity** as the most significant obstacle they encounter. With more resources, these programs would: purchase, maintain, or upgrade their mobile unit(s); pay for more clinician hours or employ additional staff to provide more needed services; dispense more medications to indigent patients; and/or invest in more efficient information technology. Nearly half (48 percent) of respondents identified **vehicle or equipment problems** as a serious obstacle; 39 percent said they struggle with data collection and **clinical information management** (charting, medical records, tracking clinical outcomes); and 33 percent mentioned **staffing** issues (recruitment and retention, balancing clinic and outreach staff). Other obstacles noted were: **insufficient space** (by 21 percent of respondents), **patient follow-up** (18 percent), problems with **parking or plug-ins** (12 percent), **community access barriers** (9 percent), and difficulties obtaining, storing or dispensing **medications** (9 percent).

Mobile health programs use the following strategies to address the obstacles most frequently mentioned: cross-training of staff (e.g., drivers who double as outreach workers) and collaboration with community partners (public health departments, academic medical centers, corporate sponsors) to ***increase service capacity***; regular maintenance and repair schedules to ***prevent breakdowns*** (often futile for 10–15-year-old vehicles); electronic medical records, database management systems, and wireless Internet connections (not always reliable in the field) to ***facilitate information management***; and regular opportunities for staff communications and professional growth to ***promote staff retention and help prevent burnout***. Strategies to overcome other obstacles mentioned are listed below and described in respondents' own words:

Program obstacles		**Strategies to overcome obstacles**	
lack of financial capacity	58%	multi-tasking/cross-training staff, corporate sponsorship, collaboration with community partners	45%
breakdowns, equipment problems, technical issues	48%	maintenance/repair schedule, fuel plan	6%
data collection/info management: charting/med records, tracking	39%	laptop, DBMS, EMR, broadband, wireless, VPN	33%
Staffing: clinic versus outreach, recruitment/retention, expertise	33%	regular staff meetings, training, burnout prevention	3%
insufficient space	21%	purchasing larger mobile unit	12%
patient follow up/tracking, outcomes assessment	18%	cell phones to coordinate follow-up appointments	3%
parking/plug-in	12%	Preview/assess service sites.	3%
community access/NIMBY, police run clients out of area	9%	Inform community partners; work with police.	9%
medication storage, refrigeration, limits on dispensing	9%	Be aware of state regulations; use pre-packaged meds.	6%
rugged terrain	6%	Assure adequate undercarriage clearance.	3%
rural areas more expensive to serve	3%	providing more urban/suburban care	3%
inconsistent procedures	3%	population-based protocols, policies & procedures	3%
part-time clinical licensure of providers (60 day limit)	3%	license mobile units to extend time spent in the field	3%

n=33

Lack of financial capacity

"Our dedicated homeless health van died in Hurricane Katrina. Since then, we have received 2 pediatric units provided by the Children's Health Fund that serve all children, including homeless children; but there are **no mobile services for adults**. We're serving a new set of homeless people now on Tuesday nights at a fixed site close to the former HCH clinic – workers rebuilding the city who have no health insurance due to day labor and no place to live. These individuals often have co-occurring mental health and substance use disorders, lose their job, and become homeless." — *Cathy Dumal, RN, Coastal Family Health Center, Biloxi, MS*

"**Funding for outreach** is the biggest problem. Our HRSA grant hasn't been cut, but there have been cuts in the other grants that help fund our mobile outreaches, which makes it hard to maintain enough personnel to have the flexibility to continue to provide outreach. — *Matias Vega, MD, Albuquerque Health Care for the Homeless, Inc., Albuquerque, NM*

"If we had more resources, we could provide more needed services: **dental care**, more **mental health services** for clients who don't have a severe and persistent mental illness, more **substance abuse recovery programs**, and more direct care for chronically homeless persons who live outside in encampments or on the street. — *Andrea DuBrow, MSW, MPH, Contra Costa County Health Services Department, Martinez, CA*

Equipment breakdowns/technical problems

"Our biggest obstacle is the vehicle, a 27-foot retrofitted RV that was used when we got it, 5 years ago. We have **continual breakdowns and power problems**. The generator wasn't working for 5 months; we provided services without heat and power at some sites for most of the winter, one of the worst in memory. We don't have a refrigerator that meets temperature requirements to carry vaccines. We are having a 40 foot mobile unit manufactured that will enable us to do more prenatal care exams and STD screening. "
— *Darcie Meierbachtol, ANP, FNP, Colorado Coalition for the Homeless–Stout Street Clinic, Denver, CO*

"Our van was out of commission 22 days during the first 9 months of operation, despite the fact that it is a fairly new vehicle. We had problems with electrical systems: difficulty getting **shore plugs** installed so we don't have to run off generator." — *Kim Tierney, MPH, Multnomah County Health Dept., Portland, OR*

"Our **generator** is a big problem; it is so loud that it interferes with auscultation [listening to the heart and lungs using a stethoscope]. We got an electric blood pressure monitor so that we don't have to listen as carefully." — *Marie Aylward-Wall, MS, RN, Clinica Sierra Vista Homeless Mobile and Respite Services, Bakersfield, CA*

"Patient registration is difficult because we can't get an **Internet connection** in the field; we have to do registration by hand." — *Molly Kennedy, San Mateo County Health Services Agency, San Mateo, CA*

Clinical information management

"**Storage of medical records** is a huge problem. Our number one need is an electronic medical record. We talked about retrofitting the [11-year-old] van to enable an EMR, but the cost would be prohibitive ($90,000) and the generator would create an energy field that would interfere with wireless communications. So we do **data entry** on a laptop, download it into the clinic server, then input data into a homeless management information system (a triple data entry process)." — *Marie Aylward-Wall, MS, RN, Clinica Sierra Vista Homeless Mobile and Respite Services, Bakersfield, CA*

"We've had challenges **managing medical records**; currently we keep records in the conference room. We have a modern database management system and a .4 FTE data evaluator. But an electronic medical record would facilitate **data collection and access** in the field; we hope to get an EMR by October 2007."
— *Kim Tierney, MPH, Multnomah County Health Department, Portland, OR*

"Grace Hill has an electronic medical record, but **no electronic dental record** yet; we are working on that to overcome paperwork obstacles. Recording encounters online from various sites would be a real help."
— *Villie Appoo, MA, MSW, Grace Hill Neighborhood Health Centers, Inc, St. Louis, MO*

Staffing challenges

"Staffing is tough; **balancing geography with acuity** while trying to expand hours for availability with only 3 providers is challenging. We try to balance coverage of a huge geographic area with the fact that the sickest people come to our clinic. Two providers are in the clinic and one is on outreach all the time. The outreach provider covers soup lines in the evenings, serving large numbers of people not seen in the clinic. We could put all 3 providers in clinic and be busy all the time; but we wouldn't engage new people who also need our services." — *Adele O'Sullivan, MD, Maricopa County Dept. of Public Health, Phoenix, AZ*

"Nurse practitioners are our primary providers; it's difficult to hire FNPs with the **nursing shortage**. Moreover, our county program can only hire when somebody leaves. One thing we do to retain personnel and prevent burnout is to make sure there are lots of **opportunities for communication** (staff meetings, sufficient "down time" so staff can be supportive of each other) and **professional growth** (training for all staff, encouraging them to attend conferences). "— *G.G. Greenhouse, MSW, Alameda County Health Care for the Homeless Program, Oakland, CA*

"It takes a unique medical provider to be able to work on a mobile unit. **Providers must be autonomous** because they have less opportunity to collaborate with peers. Areas they serve may be threatening; it's not as comfortable as working in a fixed-site clinic. Every day is different on a mobile clinic; there is little consistency. They may see 20 patients or 2, depending on the weather and the time of day. **Culturally competent staff** are key in convincing homeless clients that the mobile clinic is a safe place to go." — *Molly Kennedy, San Mateo County Health Services Agency, San Mateo, CA*

Community & service access barriers

"We have encountered community obstacles (**NIMBY)** — for example, in trying to set up a syringe exchange program that is separately funded from the HCH project. The community was initially very resistant to this idea. We sent e-mails, joined discussions, went to a **community forum** to meet with neighborhood association leaders, and were eventually able to set up the program." — *Wayne Centrone, MD, Outside In, Portland, OR*

"In response to complaints from people living or working in locations where homeless people gather, police come and tell them to leave. As a result, our clients get pushed from area to area. Care-a-van staff try to find them, but inevitably lose clients for a certain period, which interferes with **continuity of care**. To address this problem, we are **working with city and county police**. We asked police to let us know when they will be moving homeless people out of a given area. The mobile team tries to alert clients to service options elsewhere before they are moved out. We also talk to service providers in surrounding communities to find out what services are available there." — *Darlene Hein, Waikiki Health Center, Honolulu, HI*

Parking & plug-ins

"Our 40 foot vehicle is getting old, and we're looking at ways to replace it. We'll probably get a smaller unit that is more accessible and easier to park, especially in winter. The current unit has good visibility, but is sometimes **too large to park** on the street or in parking lots. The environment we serve is urban now; we discontinued our rural service sites, which required too much gas." — *Sandra Stephens, Unity Health–Urban and Rural Health Care Services for Homeless Men, Women and Children, Rochester, NY*

"**Shore plugs** require 50 amps and must not be more than 50 feet away from the van. Some service sites are moving their location and can't install shore plugs. Another site in an unsafe area required parking closer to the facility so they can keep an eye on the van. Finding a place to park a 40 foot van in a safe and **secure area** is a challenge." — *Kim Tierney, MPH, Multnomah County Health Department, Portland, OR*

Medications

"Pharmaceuticals are a major financial barrier. **Obtaining medications** from outside pharmacies at regular prices posed a problem for us last year. We decided to refer clients back to the HCH clinic to get prescriptions filled. We don't dispense medications from the mobile unit; we set up clinic appointments for clients to get meds there. This was required to get the reduced rate [available to FQHCs through the 340B drug program]." — *Kimberly Rice, LBSW, New Horizon Family Health Services, Greenville, SC*

"State Board of Pharmacy laws differ; the California Board "black bags" **dispensing medications** inside buildings at some of our mobile service sites; rules are more lenient in rural areas. It's very important for mobile health programs to completely understand their state's laws and policies, and how they affect what is going to be done on the mobile unit." — *Kathy Proctor, MPH, Northeast Valley Health Corporation, San Fernando, CA*

"According to Arizona's pharmacy regulations, physician assistants may dispense but not break and re-label a package of medications; so we **buy medications pre-packaged** with a prescription label and just fill in the patient's name, date, and directions – which is convenient in the field. Our mobile OTC formulary includes cold meds, ointments, stomach & diarrhea meds, and lice shampoo. We dispense 20 prescription medications, 1 drug from each basic category, all pre-packaged. We take vaccines (tetanus, flu) in an ice chest when needed; we're out only a short time. We transport medications from the passenger van to service sites in backpacks or a large suitcase with a pull-up handle and wheels." — *Adele O'Sullivan, MD, Maricopa County Department of Public Health, Phoenix, AZ*

"We can't keep the temperature on our van within a safe range to **keep vaccines refrigerated** at required levels. — *Kim Tierney, MPH, Multnomah County Health Department, Portland, OR*

REASONS FOR PROGRAM SUCCESS

Health Care for the Homeless providers interviewed had several opportunities to explain how and why their mobile outreach efforts work or do not, in response to a number of open-ended questions. "To what do you attribute the success of your mobile health program?" was asked at the outset, and most respondents gave explicit answers. Yet they came back to this question again and again in their responses to subsequent questions. The reasons they specified for program success are listed in the table below in order of frequency. Most respondents gave more than one reason. Several attribute success to elements of the HCH model of care which are common to both fixed-site and mobile clinics.

Two factors identified as fundamental to the success of mobile health outreach by 82 percent of persons interviewed were: **selection of service sites** where homeless people congregate and **collaboration with community partners** (for referrals, space to park the mobile unit or provide services inside, help reaching targeted populations, and/or funding). **Staff effectiveness** at building trusting relationships with homeless clients was a close second (79 percent). Several respondents emphasized the importance of an individual clinician or outreach worker who had worked with their mobile program for many years. Nearly half (45 percent) thought **outreach** ("going where homeless people are") and the **appearance of the mobile unit** (attractive and easily identifiable) were key in making health services more accessible to underserved populations; and 39 percent attributed success to their **program's strong reputation** among homeless people and other community service providers, over many years. **Information technology** to facilitate outcomes monitoring, **consistency and continuity of care**, and **linkage to comprehensive services** were also stressed as important elements of program success by a number of respondents.

Reasons for program success	% respondents
Selection of service sites/ collaboration with community partners	82%
Staff rapport with homeless clients, responsiveness to needs, length of service	79%
Outreach – increase in service availability and accessibility	45%
Appearance/ visibility of mobile unit	45%
Program reputation and longevity (yrs): 15-22(7), 9-10(2), 5-7(3), 1-2(2)	39%
Information technology/ outcomes monitoring	27%
Continuity and consistency	21%
Linkage to comprehensive services	21%
Only source of care	12%
Gateway to clinic/ medical home	9%
Better service delivery to severely mentally ill	9%
Flexibility	9%
Interdisciplinary team	9%
Cost-effective service model	9%
Security/ safety	9%
Incentives for engagement (snacks, supplies)	9%
Integration of services	6%
Harm reduction	6%

n=33

Service sites & community partners

"We **go where homeless people are**. That is the main reason why we are successful at reaching our target population. We have many significant **partners**, both within CCHS and in the community, which makes it easier for our clients to gain access to comprehensive services." — *Andrea DuBrow, MSW, MPH, Contra Costa County Health Services Department, Martinez, CA*

Staff effectiveness

"Three main factors contribute to the success of our mobile health program: providing a **hospitable, accepting environment** in and around the van; delivering **professional, high quality services**; and placing **outreach workers** in the field who encourage reclusive, chronically homeless individuals to visit the van for care." — *Linda Sheets, MPM, Mercy Hospital/Operation Safety Net, Pittsburgh, PA*

"Unsheltered homeless people don't have many places that welcome them. Program staff feel comfortable with these clients and know them personally, see them regularly and remember them. We send the same team to the same site, so staff and clients can get to know each other. We attribute our success to the fact that **services are consistent**, the van is there reliably, **service providers are competent**, and **treat clients in a professional manner**." — *Darlene Hein, Waikiki Health Center, Honolulu, HI*

"We try to **match the needs of the community with the skills and talents of the providers** by assigning them to sites where clients with whom they are most comfortable tend to seek services. Every provider has a different skill set and a subset of the homeless population he or she particularly enjoys and is good working with — e.g., youth, individuals with substance use disorders." — *Darcie Meierbachtol, ANP, FNP, Colorado Coalition for the Homeless–Stout Street Clinic, Denver, CO*

"Focus groups comment on the fact that unlike other providers, our **staff don't stigmatize or judge** clients. We **send the same team to particular areas on a regular basis** to promote continuity of care and increase clients' comfort level." — *Sharon Joseph, MD, New York, NY*

"Staff **dress casually** to avoid "white coat syndrome": in jeans and smocks. If going to a site with a large immigrant population, they bring someone with them who **speaks the language** to help with translation." — *Michelle Madison, Unity Health Care, Inc., Washington, DC*

"Our program's most compelling feature is the **support staff** — the medical assistant, driver, and office manager work well as a team. It's a close unit, which makes patients feel safer, particularly in rough areas. Staff are "street wise" and nonjudgmental (not "preachy"). They **do what people want at the time** and don't lecture or expect change — just do what they can to help that day." — *Marie Aylward-Wall, MS, RN, Clinica Sierra Vista Homeless Mobile and Respite Services, Bakersfield, CA*

Outreach

"We **provide outreach and help in austere environments**, primarily in rural areas that are mountainous and heavily wooded, with very scattered populations. There are lots of homeless people living in the woods. We are recognized and welcomed in any encampment; word is out that we are there to help. — *Clyde Drury, Metropolitan Development Council, Tacoma, WA*

"Our HCH project began in 1985 as a mobile program using an Airstream RV. In 1991, we finally got a fixed-site clinic and let go of the RV. The organization has evolved through different phases, but still understands that outreach is a critical component. We can be very efficient and medically sophisticated in our fixed-site clinic, but we need to be even more concerned about those who don't reach our clinic doors. The acuity of health problems seen in our homeless patients, both in the clinic and on outreach, has increased dramatically over last 20 years. Some of the sickest people can't get to the clinic. **Outreach and case management** are the heart and soul of Health Care for the Homeless." — *Matias Vega, MD, Albuquerque Health Care for the Homeless, Inc., Albuquerque, NM*

Program reputation

"The success of our mobile homeless unit is associated with the name of our HCH project, which is **well-known in the community**. We're the only organization that specifically serves homeless people in DC. Homeless people flag down the vehicle." — *Michelle Madison, Unity Health Care, Inc., Washington, DC*

"Our program's success is attributable to 2 things: The agency has a significant amount of **name recognition** in the community; and we **work closely with community partners**." — *Wayne Centrone, MD, Outside In, Portland, OR*

Information technology/ outcomes monitoring

"We use **wireless Internet access** via HealthPro to download medical information or enter intake data on laptop computers that are carried on the van. We're working toward developing an EMR." — *Kimberly Rice, LBSW, New Horizon Family Health Services, Greenville, SC*

"We use an **electronic practice management system** that enables us to check patient information in real time; we can see who is being checked in at various sites. We use **wireless devices** on the mobile unit that don't always work as well as we would like, but they enable us to monitor medication use and misuse by clients at different sites." — *Rod Stuldivant, Saint Joseph's Mercy Care Services, Inc., Atlanta, GA*

"Our **EMR** makes data collection and tracking easier. We use a **virtual private network** (VPN) to collect data via a cellular modem and transmit data from a laptop computer. We can get lab results and X rays this way from the HCH clinic. An IT team helps us run data queries using a number of variables."
— *Wayne Centrone, MD, Outside In, Portland, OR*

Continuity & consistency

"The most important thing about mobile services is continuity and consistency — when you will show up and where." — *G.G. Greenhouse, MSW, Alameda County Public Health Department HCH Program, Oakland, CA*

"Be at a certain place at the same time. Folks stop looking for you if you don't have that consistency, and it's harder to find them." — *Matias Vega, MD, Albuquerque Health Care for the Homeless, Inc., Albuquerque, NM*

Recommendations from HCH Mobile Health Care Providers

The individuals interviewed for this project were given the opportunity to specify any other information which they considered important for health centers that are involved in or seeking to initiate mobile health programs for homeless people. Here are their recommendations:

- Assess the need for a mobile health program and specify target populations.
- Assess your financial and service capacity and space requirements before selecting a mobile unit; be aware of the variety of mobile units in use.
- Capitalize the mobile program prior to implementation; identify funding sources and in-kind services. Recognize that a long-term investment is necessary.
- Choose providers who can work independently and enjoy working with homeless people.
- Identify and build strong relationships with community partners to meet service needs that you can't — seek affiliations with medical teaching programs; develop referral contracts with specialty services.
- Understand state laws and regulations regarding service provision. Notify police about services to be provided and service sites.
- Select service sites where homeless people congregate.
- Plan where to park the mobile unit; consider road surface, space to turn around, access to plug-ins, distance from power lines, traffic patterns, and safe exit from the vehicle for patients.
- Communicate with potential clients; seek client input in developing and evaluating the mobile program.
- Establish and adhere to a reliable service schedule; be where you say you are going to be when you say you'll be there.
- Schedule sufficient preparation time before and after mobile outreach.
- Make a plan to ensure client and staff safety and security of the mobile unit.
- Let the program evolve; be flexible and adapt to change.
- Share knowledge; learn from programs working in similar environments, geographical and political.
- Groom younger people to replace yourself.

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OTHER RESOURCES ON MOBILE HEALTH CARE:

Mobile Health Clinics Network (MHCN): http://www.mobilehealthclinicsnetwork.org

Nuts & Bolts of Mobile Medical Service Delivery. PowerPoint presentation by G.G. Greenhouse, MSW, Alameda County Public Health Department HCH Program: gg.greenhouse@acgov.org

Service Directory ("Yellow Pages") for the Alameda County Health Care for the Homeless Program: gg.greenhouse@acgov.org

Strategic Plan for a Mobile Medical Program – San Mateo County Health Services Agency, San Mateo, California, available from Molly Kennedy: mkennedy@co.sanmateo.ca.us

APPENDICES

A. Survey questionnaire

B. Mobile health program description & marketing materials

C. Mobile health vehicle: equipment & inventories

D. Mobile clinical encounter & referral forms

E. Job descriptions for mobile health programs

Appendix A: Survey Questions

Questions to which mobile health program representatives responded during telephone interviews or in writing, September 2006 – April 2007:

1. Within what **environment**(s) does your program provide mobile services (e.g., urban, suburban, rural)?

2. What has contributed to the **success** of your mobile program, and what you would do to make service delivery **more effective**?

3. What **services** are provided via your mobile program, and where are they provided?

4. What **other agencies** participate in or partner with your mobile service program?

5. What **type of mobile unit**(s) does your program use? Please describe the **physical space** on your mobile unit(s) and how the **design** contributes to success of your program (or does not).

6. What p**hysical and other characteristics** of your program (e.g., location of sites, appearance of van, dress or manner of personnel) help you reach your targeted population**?**

7. What are the main **barriers to health care** experienced by the population(s) served by your mobile outreach program, and how does the program address those barriers?

8. What **obstacles** has your mobile service program experienced (e.g., funding, equipment, liability, staffing, information management issues)**,** and what strategies has the program used to overcome them?

9. What **marketing and outreach strategies** (if any) does your mobile service program use?

10. Do you have any **materials that you are willing to share** which other mobile service programs might find helpful (e.g., manual, data collection forms, job descriptions, strategic plan)?

11. What **other information** do you think Health Care for the Homeless providers need to know about mobile health programs?

Appendix B: Mobile Health Program Description & Marketing Materials

- Brochure
- Target Populations
- Flyer
- Newsletter

SOURCES:

Outside In – Healthcare for the Homeless Medical Outreach, Portland, Oregon

San Mateo Medical Center Health Care for the Homeless Program, San Mateo, California

Healthcare for the Homeless Medical Outreach

Building Community One Person at a Time

OUTSIDE IN

Community Medical Outreach

MISSION STATEMENT –

The OUTSIDE IN Healthcare for the Homeless medical outreach program is a project dedicated to providing for the needs of underrepresented groups and peoples. Developing, organizing and representing peoples of all races, colors, gender identities and sexual preferences through service to the dignity of all human kind.

The Outside In Healthcare for the Homeless Medical Outreach Program is a project dedicated to providing for the needs of underrepresented groups. The Outside In Medical Outreach Program brings medical and healthcare services directly to the streets serving the hardest to reach communities. The Outreach Program works to build bridges for patients without resources or advocates.

The outreach program currently operates out of a 38 foot mobile medical vehicle. The van provides 3 fully stocked consultation rooms, an electronic medical record system, a laboratory, and pharmacy area.

Working to contribute preventive and life enhancing medical services to communities that do not routinely access primary health care is the primary goal of the Medical Outreach Program. Outside In strives to do this through:

- Creating equal opportunity to contact basic needs through the sharing of community resources and organizations
- Offering health education services that create vehicles for personal change and empowerment
- Helping everyone to have the opportunity to live a basic existence without worries for survival

"Survival with dignity is one of the basic rights of life"

OUTREACH OPPORTUNTIES –

1. Medical outreach clinics to targeted populations – homeless youth and adolescents, homeless single women and marginalized and underserved families

2. Urban "mission" teams designed to educate and enhance health through preventative medical services

3. Community awareness through planning volunteer cooperation between medical professionals and social assistance agencies

4. Helping people help themselves by providing for basic health care needs

VOLUNTEER POSITIONS AVAILABLE – positions are available for volunteer providers in primary care, medical assistants, ancillary healthcare professionals, and mental health professionals; volunteer positions that include direct patient contact and require credentialing with MCHD and a background check with Outside In.

PROGRAM MODELS:

PROGRAM #1: **Dignity Village** - Portland, Oregon's "houseless" community. Providing medical services and health education outreach, the OUTSIDE IN Community Outreach is bringing medical professionals to the people who need their services and skills the most. Multnomah County has an estimated homeless and transient population of over *4,000 people; the social programs developed to help them do not serve over 40% of these people*. Some are the victims of poor self-advocacy; others are beyond the mission statements of the provider networks. By uniting medical professionals with public health and social assistance organizations, the underserved of the greater Portland area are afforded health care that meets their needs where they need it the most, on the streets.

PROGRAM #2: Rose Haven Catholic Charities – Providing medical and social service intervention to woman at the Old Town Portland domestic violence and commercial sex worker advocacy center. OUTSIDE IN works to ensure adequate access to family planning and acute care medical services to women experiencing homelessness and violence.

PROGRAM #3: Goose Hollow Family Shelter - Providing medical services and health education outreach, the Goose Hollow Shelter/First United Methodist Church project is bringing medical professionals to the people who need their services and skills the most. The program will provide Shelter guests with access to preventive medical examinations, acute medical care, and healthcare advocacy.

PROGRAM #4: "After Hours" Clinics - Many medical professionals are driven by the altruistic need to "help" and "provide." All too often, the demands of a busy work schedule far outweigh the available hours in a professional week or the energy levels of a caring compassionate soul. OUTSIDE IN offers the opportunity for a multi-disciplinary team of healthcare providers to donate their medical expertise to helping uninsured and underinsured clients. The clinics, operating on Monday and Wednesday evenings from 6 until 10 p.m., provide urgent care medical services and social assistance advocacy.

PROGRAM #5: Street Outreach – Reaching clients who fall outside of the programs and projects available in "mainstream" public health requires creativity. Outside In is in the early stages of developing a program to send physicians and healthcare professionals into the streets. This outreach project is supported in conjunction with the Outside In Syringe Exchange Program and the medical clinic, and works to educate and triage clients to continuity of care environments. Paramount to the delivery of effective healthcare outreach programs is defining the needs of the target population. The street outreach program is designed to collect, analyze and interpret healthcare statistics for homeless youth and underrepresented Portland populations. This data will be used to develop new outreach programs and create pilot research studies.

PROGRAM #6: Road Warrior – Reaching the hardest to serve homeless youth requires a flexible approach. Outside In has created a model of healthcare that allows youth and young adults to access acute care medical services in a non-threatening manner. Road Warrior is run in conjunction with a youth drop-in event (often a pizza and movie sponsored by the Outside In Youth Program) and is conducted every Monday night from 10 p.m. until 12 a.m. Engagement and relationship development are the hallmarks of the program.

PROGRAM #7: Cascade AIDS Project/VOZ Outreach Clinic – Once per week, a physician from O/I and a medical assistant/health advocate join forces with Cascade Aids Project and VOZ to provide street level healthcare services to Latino day workers. The program, a collaborative project designed at reaching

highly underserved laborers, is oriented toward STI testing and acute healthcare services.

PROGRAM #8: Cascade AIDS Project/Outside In 82nd Avenue Clinic – One of the hardest to reach and serve segments of the homeless and uninsured populations is commercial sex workers. Every 2nd and 4th Wednesday of the month Outside In, in collaboration with Cascade AIDS Project, sends a team of providers and support staff to Southeast 82nd Avenue in Portland to bring desperately needed clinical care services to sex workers. The primary goal of this project is connecting clients with resources.

PROGRAM #9: Cascade AIDS Project/Outside In Outreach Testing Program– Collaborating on a Centers for Disease Control grant to provide counseling, testing and referral based services to high-risk populations, OI and CAP have develop cutting edge outreach to bath houses and night clubs. Four times monthly, the collaboration team works to provide testing, medical and social services to populations at greatest risk to HIV infection.

PROGRAM #10: Cascade AIDS Project/Outside In Men's Wellness Center – Collaborating on a Centers for Disease Control grant to provide counseling, testing, treatment and referral based services to high-risk men who have sex with men (MSM), OI and CAP have develop a Wellness Center for MSM that incorporates prevention, testing and treatment for STI's and medical conditions/concerns relevant to the MSM community.

PROGRAM #11: North Clackamas Services Center/Outside In – Developing collaborative moderate level care clinic sites outside of the "downtown core" area of Portland has been a programmatic goal for Outside In for a few years now. Working with the Oregon Food Bank and the North Clackamas Service Center, Outside In brings health and social service care to chronically homeless population in one of the most underserved neighborhoods of the tri-county area.

PROGRAM #12: Flavel Street Outreach – Working in conjunction with the Portland Women's Crisis Line, Outside In has developed a clinic on the 82nd Avenue corridor to expand the service delivery to commercial sex workers. The clinic is designed to provide broad medical services and case management through the unique collaboration of our two agencies.

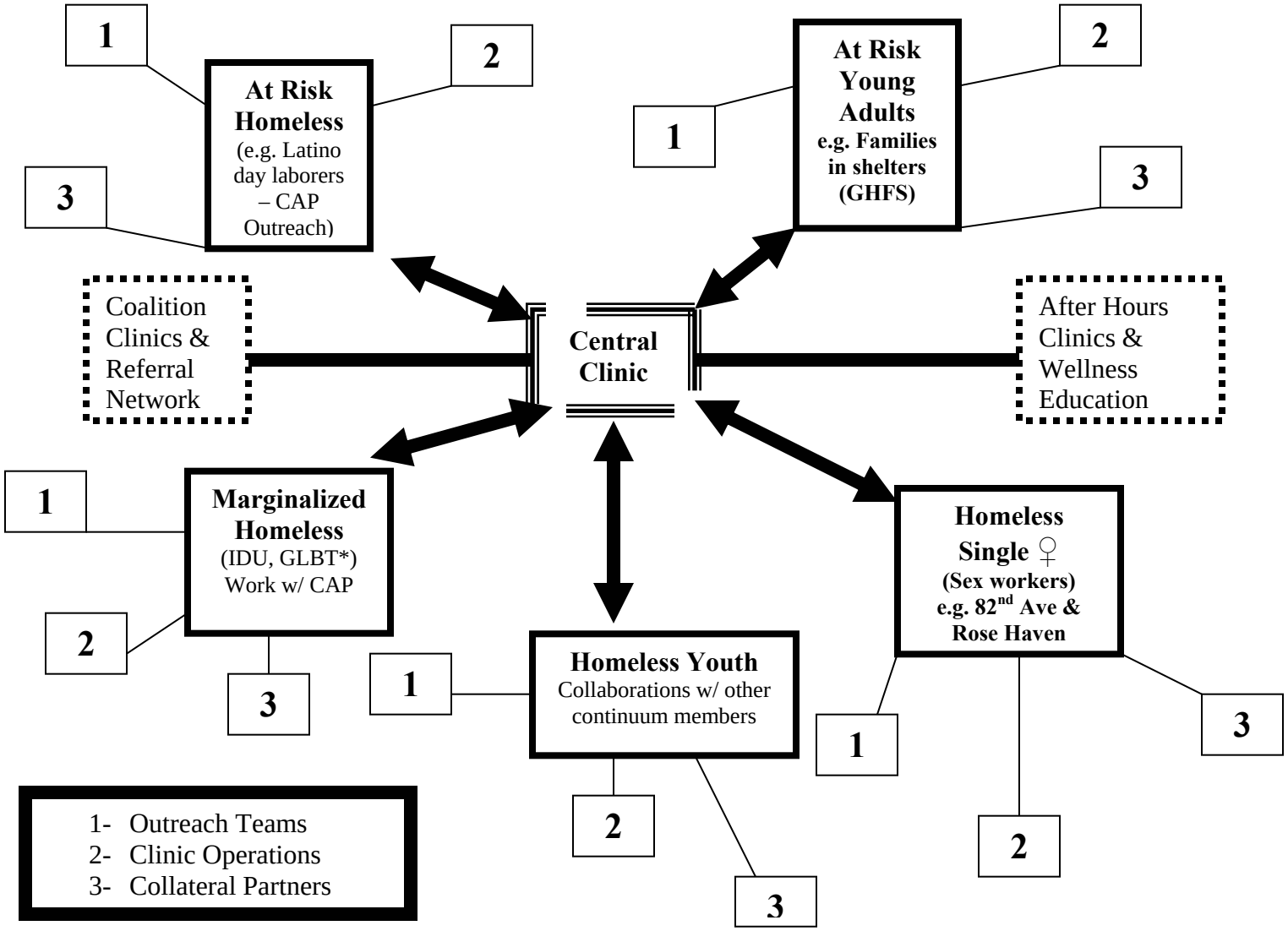
PROGRAM #13: Portland Community College Sylvania Campus – Working in conjunction with the PCC administration, Outside In has partnered to develop a reproductive healthcare clinic to meet the needs of this thriving college campus in the Southwest Portland area. The clinic focuses on bringing services to uninsured young adults through a focused clinic format.

PROGRAM GUIDELINES: Staffing is provided by Outside In medical clinic. Dr. Wayne Centrone, Outreach Medical Director and Dr. Tanya Page, Family Medicine Physician work along with Mr. Jaisen Glowgowski, Ms. Laura Paz, and Mr. Liam Pervisky, Outreach Program Coordinators, to lead a team of volunteer providers. Support services and ancillary healthcare are provided through medical assistant volunteers and registered nurses. Medical malpractice insurance for v volunteer professionals is provided through the Multnomah County Volunteer provider network.

Program volunteer physicians and providers are required to register with Multnomah County as a volunteer physician/provider and with Outside In Clinic Volunteer Coordinator (Contact Ms. Stacy Hall at (503) 535-3815). This program represents a coordinated effort between independent volunteer medical providers, Outside In Medical Clinic, and the Coalition of Community Clinics.

Health Care for the Homeless
Mobile Medical Outreach Plan

Phase I: Develop understanding and working knowledge of target population (i.e. needs assessment)
Phase II: Create Model Program – Develop outreach around four focused homeless youth populations (at-risk, marginalized, street kids and homeless single females) (i.e. systems assessment)
Phase III: Recruit, train and implement (volunteer providers working in conjunction with central agency team) (i.e. Implementation)
Phase IV: Develop a method of measuring outcomes, evaluating quality of care, sustaining programs (i.e. programming and action planning)
Phase V: Document and present model program at conferences (i.e. evaluation of outcomes and recycling of data)



***IDU** – Intravenous drug use populations
GLBT – Gay, lesbian, bisexual and transgender youth

OUTSIDE IN
TOGETHER ON THE EDGE

Medical
Outreach Program

Services Provided:

Screening Physical Examinations
Well Child Examinations
Urgent/Acute Care Medical Encounters
Assessment & Triage
Cough & Cold Examinations/Treatment
Birth Control Options
Pregnancy Testing
Nutritional Counseling
Wellness Counseling
Immunizations (Flu Shots, Td, HAV, HBV)
Strep Testing & Treatment
Health Education & Advocacy
Sexually Transmitted Infection Testing (gonorrhea, Chlamydia, syphilis, HIV (rapid and conventional))
Rapid HIV Testing
Blood Sugar Testing
Urine Testing
Social Services Enrollment

OUTSIDE IN MEDICAL CLINIC

1132 SW 13th Ave
Portland, OR 97205-1703
(503) 535-3800

San Mateo Medical Center
A County System of Healthcare

HCH News
From the Health Care for the Homeless

Vol I Issue 4 September/October 2006

How to Quit Smoking

Do you smoke and want to quit or have a loved one who is finding it difficult to quit smoking? There are FREE classes available in all areas of San Mateo County to help you quit. Not only are the classes free but you are also supplied FREE patches, also known as Nicotine Replacement Therapy. If you were to buy these patches for yourself they would cost $90.00 or more. At forty two years old Roberto had been smoking for 30 years. He began when he was twelve years old by sneaking a few of his mother's Winston's out of her purse from time to time. By the time Roberto was 16 he was smoking every day and when he turned 18 he was a pack a day man, Marlboro's. At age 30 Roberto was feeling a little like an outcast when he was told to go outside, 20 feet away the doorway of his job in order to take a smoke break. His medical doctor had been on his case also but worst of all were his kids, they were constantly telling him that smoking was bad for him.

Continues on page 2

Medical Care Being Provided to Homeless Shelters
San Mateo County Public Health Mobile Clinic

The Public Health Mobile Health Clinic provides the following services to homeless shelters throughout San Mateo County:

~health, illness & injury treatments ~blood pressure screening ~diabetes screening ~adult, adolescent and children vaccinations ~hepatitis A&B vaccinations ~TB screening ~HIV testing ~STD screening & testing ~birth control ~health advice and referrals to local medical centers

'The Mobile Health Clinic provides these services to the following shelters and other locations:

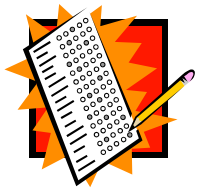
Day	Location	Time
Monday	**Maple & Grand, SSF**	**11:00 am— 5:00 pm**
Tuesday	**Fair Oaks Community Center, RWC**	**10:00 am—2:00 pm**
Wednesday	**5th & Spring Street, RWC** **Maple Street Shelter, RWC**	**10:00 am—3:00 pm** **5:00 pm—7:-00 pm**
Thursday	**5th & Railroad, SM*** **Safe Harbor Shelter**** **King's Community Center*****	**8:30 am—3:30 pm** **5:00 pm—7:00 pm** **5:00 pm—7:00 pm**
Friday	**San Bruno & Green Street**	
*** 1st, 2nd, 3rd Thursday, **1st & 3rd Thursday, *** 2nd Thursday**		

Continue from page 1

Life had been hard for Roberto, he had been introduced to meth and it didn't take long for him to get into trouble with it. In a couple of years of intermittent drug use he had lost his job and, even though he had found some temporary work from time to time, he eventually lost his place to live.
Roberto had gotten into recovery from his drug abuse. Through a treatment program and Narcotics Anonymous he had quit methamphetamine and alcohol. He became clean and sober. Now, every time he saw his kids they nagged him constantly about quitting smoking.
Roberto was someone who had tried quitting smoking many times and had even been successful for almost seven months before he began smoking again when he heard about San Mateo County's program. He called the local number 573-3989 and found out that there was a class near where he lived. He signed up for the free class and learned much about his smoking that he hadn't known before. The classes were great for him because they used many of the same principals that he had used to quit u sing drugs. He also really appreciated how much the patches worked in cutting down on his craving. Roberto learned to build on the lessons and successes that he had from previous attempts when he had quit smoking on his own. At the end of the seven week class Roberto was smoke free and had several new non-smoking friends. He was convinced that he could quit for good this time.

If you know someone like Roberto. Call the quit smoking line in San Mateo County or give them this number: (650) 573-3989 to find the time and location of a class, there is likely to be one close to where the smoker lives. Classes are available in Spanish. You can't quit if you don't try. Give yourself a chance. Call now. 573-3989.

Written by: Mark Korward
HCH Advisory Committee Member



Satisfaction Survey
Health Care for the Care for the Homeless Program

The Heath Care for the Homeless is currently disseminating a satisfaction for homeless individuals who have been seen by the Public Health Mobile Health Clinic, Onsite Dental Mobile Dental Clinic, Ravenswood Family Health Center, Innvision Clara-Mateo Alliance. To assure that the HCH Program is providing quality services that meet their needs of homeless individuals we need to hear their feedback on their services that

If an homeless individual that you work with has received services at one or more of the programs and has not had a chance to completed a satisfaction survey please give them (see next page for copy of survey) a copy of the survey. Completed surveys need to submitted to Molly Kennedy by October 20, 2006 either by fax 650-573-2030 or mail at 222 W 39th Ave, San Mateo, Ca 94403

Have Questions about the HCH Program or needs assistance accessing health care, dental care, or other socials services for a homeless individual please call Molly Kennedy @ 650-573-2966 or email mkennedy@co.sanmateo.ca.us.

San Mateo Medical Center
Health Care for the Homeless Program

2006 Client Satisfaction Survey

Site_____ **Date**_____

Were you satisfied with the services you received?	Yes	No
Were the services that you received what you expected?	Yes	No
Was the visit helpful?	Yes	No
Would you use these services again?	Yes	No
Was staff helpful?	Yes	No
Did you feel free to ask questions?	Yes	No
Were your questions answered to your satisfaction?	Yes	No
Were you given enough privacy?	Yes	No
Would you recommend a friend to use these services?	Yes	No
If you saw a doctor and/or nurse were you given enough information on your health problem including how to take your medication if prescribed?	Yes	No

Overall, how would you rate the services you received?					
Excellent Good Fair Poor					
How many times have you received services at this location?	1	2	3	4	5

Other Comments:

_____

_____

_____

_____

_____

_____

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_____

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Appendix C: Mobile Health Vehicle: Equipment & Inventories

- Operations Check List
- Equipment for the Mobile Medical Vehicle
- Inventory of an Exam Room
- Van Closing Check List

SOURCE:

Outside In, Healthcare for the Homeless Medical Outreach, Portland, Oregon

Mobile Medical Outreach Vehicle

Operations Check List
ADI Van # 34162

Important Contact Numbers:

- General vehicle questions: ADI, Dan LaFleur (19425 SW 89th Ave, 503/885-0886, call # 503/819-3081) When calling ADI, please reference van # 34162
- Maintenance questions: Northside Ford (503/282-7777)
- Operational questions: Wayne Centrone (503/535-3846 pager)
- Driver: Ben Hellerstein (503/535-3834)
- IT questions: Colin Bondi (503/535-3903)
- QA questions: Angie Hurley (503/535-3908)
- Outreach questions: Rebecca Adler (503/535-3832) or Jaisen Glogowski (503/535-3808)
- Insurance questions: Bill Aronson (503/535-3827)
- Billing questions: Shirene Iesalnieks (503/535-3863)
- Outreach mobile phone: 503/970-1852

Before each Outreach

- Acquire the vehicle keys from the Outreach Clinic Coordinator who was last responsible for the van
- Review the check list created by the previous shift coordinator; acquire supplies and inventory as listed on the "Check Out/In" sheet
- Keep in mind that the vehicle will either be parked on 13th Avenue in front of the agency or in the First United Methodist Church annex parking lot on 18th Avenue
- Perform a complete exterior and interior walk around/through – take special note of the vehicles tires, exterior compartment doors and interior "tie down" equipment
- Check the vehicle "fill" levels by using the panel located above the electric box
- Review the pharmacy supplies and take a minor inventory – re-stock as needed
- Ensure that the "float" lap top computer is locked in the lab/pharmacy cabinet above the autoclave
- Before starting the vehicle – check to ensure that the external mirrors are best positioned for the operator of the vehicle
- Activate the rear view monitor if operating in congested city traffic or backing out of a parking/storage space
- Allow time for the defroster fans to diminish the condensation on the windshield
- When moving the van in heavy traffic or congestion – always utilize two people: the driver and a spotter
- The key to safe driving of the Mobile Medical Vehicle is to always use the external mirrors and when in doubt . . . drive slowly!

At the Outreach Site:

- Park the vehicle in an area that allows for the proper use of the jacks

- Always aim to park in an area that will provide the jacks with a rather firm foundation to stabilize and level the vehicle – therefore, avoid parking on grass, muddy fields, etc. (when parking on an unstable terrain [e.g. grass field] – use wood blocks under the leveling jacks)
- Before lowering the jacks perform an exterior walk around
- **STARTING THE JACKS:**
    - Power-up the vehicle to the "accessory position" on the steering column
    - Fully engage the parking brake
    - On the panel located left of the steering wheel, press the top right hand corner button marked "power"
    - Repress the power button a second time to initiate the jacks
    - The jacks will automatically sequence to the proper level in a four point configuration
- **RAISING THE JACKS:**
    - Power-up the vehicle to the "accessory position" on the steering column
    - Press the "store" button on the panel located left of the steering wheel; allow 10-15 minutes for the system to fully turn "off" the jacks
- Power up the generator to prepare for clinic operations: The generator is located on the drivers side of the vehicle in the furthest external storage panel
    - STARTING – before starting the generator, ensure that the "land line" cord is connected to the outlet unit of the generator (the "land line" and the outlet can be found in the storage compartment immediately to the left of the generator)
    - Before starting the generator – ensure that the fan is operational in both directions; This may be accomplished by toggling the fan switch (located on the right side of the generator control box) up and down – holding each position for 5-7 seconds (**NB:** "up" for one fan and "down" for the second fan)
    - The switch to "power" the generator is located in the top left hand corner of the control panel
    - The "starter" switch for the generator is located immediately to the right of the "power" switch
    - After both switches have been engage(d) the 50 amp circuit breaker flip must be moved into the upward direction; once operational – two yellow lights will illuminate in the lower right hand corner of the control panel
    - It is important to power down the generator before moving clinic outreach sites – this may be accomplished from the dash board of the drivers seat; This is a temporary "power" switch and will not provide the degree of attention necessary to turn off the generator in preparation for storing the vehicle overnight
- After the generator has been started prepare the examination rooms:
    - Walk through the "clinic" and unlock all the cabinets
    - Start and log into all computers
    - Ensure that power is available for the refrigerators, centrifuge, autoclave and specimen incubator

- Ensure that power is available for the Welch Allyn oto/opthalmascopes and the exam table light
- Place the illuminator heads onto the Welch Allyn units – these units can be located in the storage drawer of each examination room
- Remove all necessary equipment from the cabinets (i.e. tongue blades, cotton balls, etc.) and place on counter tops
- Remove all of the lab equipment and place on the counter tops in the lab area
- Ensure that the autoclave is "powered" and held in the temperature range of 20-30 degrees Celsius
- Restock the equipment and supplies
- Extend the awning –
    - Be certain that the awning has proper clearance before extending the unit
    - ALWAYS utilize the "wind smart" setting while using the awning
    - Set the default "wind smart" power selection at "low"
    - To extend the unit – depress the extend button
- Lock out the vehicle steps
- Invite patients

Basics

- The vehicle operates on regular unleaded gasoline (the least expensive at the pumps); the gas tank is located on the drivers side of the vehicle; the Liquid Propane Gas (LPG) tank is located on the passengers side behind the rear tire
- Oregon law requires that only ***TWO*** passengers are in the vehicle while driving; It is important to sign-up for Flex Car services (or agency van when available) for every clinic outreach that involves more than two people
- Before starting the vehicle a general "walk around and through" (that includes checking the external and internal compartment doors of the van, tires, generator, levelers, etc.) should be performed
- **Be careful when engaging the Emergency Brake** – the brake release handle is in close proximity to the brake foot pedal. If you push the brake and the handle together you will break the handle and inactivate the leveling jacks system.
- Servicing of the vehicle should be accomplished by the following vendors:
    - **Every 3,000 miles:** Oil and general maintenance - Northside Ford (6221 NE Columbia Blvd, 503/282-7777); Call for an appointment
    - **As needed:** Tire repair and replacement – Les Schwab Tires (2952 NE Sandy Blvd, 503- 231-8290) (NOTE: Before phoning Les Schwab for a tire repair – reference the tire size that is delineated on the sticker located on the bottom of the drivers side door)
    - **As needed:** Equipment repair – ADI, Dan LaFleur (19425 SW 89th Ave, 503-885-0886, call # 503/819-3081) When calling ADI, please reference van # 34162
    - **As needed:** Graphics repair – Kolorwerx, Kevin Mead (725 SE 9th, Suite 1, 503-702-1294)

- **As needed:** Liquid Propane Gas (LPG) – Ladd's Shell 1525 SE Ladd Ave Portland, OR 97214 (503/233-4249)
- **Monthly:** The generator oil must be changed every 200 hours (clock counter can be found on the front of generator); this may be accomplished through Camping World (26875 SW Boones Ferry Rd. Portland, OR 97070 1-503-682-0752); Call for an appointment
- **Weekly:** The water level in the generator must be checked every week; The water reservoir is clearly visible from the front of the generator and displays demarcation lines for levels of fluid contents (DO NOT OVER FILL); This should be accomplished by an Outreach Clinic Coordinator
- **Weekly:** The van waste water should be dumped by an Outreach Clinic Coordinator; Waste water disposal – Flying J (I-84 at Exit 17, 400 NW Frontage), Town & Country (9911 SE 82nd (503)771-1040)
- **Weekly:** The engine oil, coolant and transmission fluid should be checked by an Outreach Clinic Coordinator
- **As needed:** Towing – call insurance broker (Dick Newland 503/2956374)
- **As needed:** General equipment and parts – Camping World, (503) 682-0752, 26875 SW Boones Ferry Rd, Wilsonville, OR; www.campingworld.com/

- "Hidden" keys are located in the following locations:
  - Door Key – in the LPG compartment on the far right side
  - Ignition Key – in the overhead compartment located on the passenger side of the vehicle above the side window

Electric Panel

- Check the battery level by turning off the battery charger and utilizing the monitor on the wall above the electric panel (the charger must be "OFF" or you will receive false readings)
- Check the "green" light for electric/power to the panel: the lights will remain illuminated if there is adequate power to the panel.
- The electric/power panel has two components: Grey box – AC electric for the entire coach and Black box – DC electric for the vehicle.
- Check the battery function by turning on the lights in the vehicle
- Check the water heater – Two 240V circuits in the electric panel (DO NOT leave on overnight) – to ensure that the power is off
- If the vehicle has not been running off of an external power source (i.e. plugged into a building or power source) – the auxiliary battery will automatically operate to keep the refrigerator operational for a period not to exceed 24 hours

Electric Source

- It is very important to check the voltage (by using the volt meter located in the storage compartment on the dash board of the vehicle) before connecting to any new power source
- When checking the AC voltage of a new power source – every item in the vehicle should be shut off (with the exception of the battery charger)

- An extension cord for a standard 120V AC power outlet is located in the external compartment of the vehicle immediately adjacent to the generator hold; the connection requires that an adaptor is placed on the end of the extension cord
- It is important to remember that this is a 110v-15 amp power source and can not be used to run the entire vehicle; ONLY a 50 amp, 120/240v power source (as per the generator or a specific power converter) can be used to power the entire vehicle
- A note about power for the vehicle - When you power on the generator during the day, the top right column breaker is the battery charger. If you are charging during the day the batteries will last between 24-60 hours (with the refrigerators running); it is very important to be mindful of the power resources of the vehicle and utilize an external power source whenever possible

Water

- Check the water level of the monitor control panel located above the electric panel
- Always ensure that the water tanks are full on Monday before a clinic outreach to Rose Haven; use the water spout at OI to fill the tanks; NEVER fill the *fresh* water tanks before first emptying the *gray* water tanks; the tanks will require filling every week during the summer months and approximately every 10 days during the winter.
- Turn "on" the water pump as located on the monitor control panel above the electric panel
- Turn "on" the water heater at the circuit breaker on the electric panel
- Turn "on" the red switch labeled "Water Heater" adjacent to the electric panel

Generator

- The generator is located on the drivers side of the vehicle in the furthest external storage panel
- Once per week the oil in the generator should be checked
- The oil/filter must be changed in the generator every 200 hours; This may be accomplished at Camper World in Wilsonville or ADI. The generator hours are tracked via a small "counter" located on the front of the generator motor.
- The water level in the generator must be checked every week; The water reservoir is clearly visible from the front of the generator and displays demarcation lines for levels of fluid contents (DO NOT OVER FILL)
- Please review the maintenance manual (located in the glove box of the vehicle) for further recommendations
- STARTING – before starting the generator, ensure that the "land line" cord is connected to the outlet unit of the generator (the "land line" and the outlet can be found in the storage compartment immediately to the left of the generator)
- Before starting the generator – ensure that the fan is operational in both directions; This may be accomplished by toggling the fan switch (located on the right side of the generator control box) up and down – holding each position for 5-7 seconds (**NB:** "up" for one fan and "down" for the second fan)

- The switch to “power” the generator is located in the top left hand corner of the control panel
- The “starter” switch for the generator is located immediately to the right of the “power” switch
- After both switches have been engage(d) the 50 amp circuit breaker flip must be moved into the upward direction; once operational – two yellow lights will illuminate in the lower right hand corner of the control panel
- It is important to power down the generator before moving clinic outreach sites – this may be accomplished from the dash board of the drivers seat; This is a temporary “power” switch and will not provide the degree of attention necessary to turn off the generator in preparation for storing the vehicle overnight
- To turn “off” the generator – please follow the above steps in reverse order
- The generator will burn approximately 1.0-1.3 gallons of gasoline per hour of operation

Sewage

- The sewage compartment is located on the drivers side of the vehicle
- Dumping the “gray” or “black” water on the vehicle requires a visit to one of the following disposal sites: Town & Country RV Park (located at 9911 Southeast 82nd Avenue), Flying J Travel (Exit 17 on I-84 Eastbound) The sewage water should be dumped every week
- Dumping the “gray” or sink water requires two people – one to spot and another to drive
- Remove the hose (located in the external storage compartment marked *sewage*), place the hose in the dump hole, connect the hose to the outlet valve, release the damper
- ALWAYS wear rubber gloves **AND** safety glasses (found in the sewage compartment) while dumping the waste water **AND** always rinse the hose after dumping

Engine

- Oil, coolant and transmission fluid should be checked every month (the dip sticks are clearly marked in the engine compartment of the vehicle)
- The oil must be changed every 3,000 miles
- Northside Ford is the service center that we utilize for oil changes and engine related repairs

Leveling Jacks

- Always aim to park in an area that will provide the jacks with a rather firm foundation to stabilize and level the vehicle – therefore, avoid parking on grass, muddy fields, etc. (when parking on an unstable terrain [e.g. grass field] – use wood blocks under the leveling jacks; the wood blocks are located in the external storage compartment of the vehicle on the passenger side)
- Before lowering the jacks perform an exterior walk around

- First thing before heading home after completing a clinic is to start the jacks AND ensure that you complete an external walk around before leaving the site – looking for any hazards or obstructions to moving the vehicle
- **STARTING THE JACKS:**
    - Power-up the vehicle to the "accessory position" on the steering column
    - Fully engage the parking brake
    - On the panel located left of the steering wheel, press the top right hand corner button marked "power"
    - Repress the power button a second time to initiate the jacks
    - The jacks will automatically sequence to the proper level in a four point configuration (four point configuration means that all four corners of the vehicle – under the vehicle wheels – will be securely positioned in a level position)
- **RAISING THE JAKCS:**
    - Power-up the vehicle to the "accessory position" on the steering column
    - Press the "store" button on the panel located left of the steering wheel; allow 10-15 minutes for the system to fully turn "off" the jacks

Heating

- Three forms of heat are accessible in the vehicle: electric "toe kick" heaters, ceiling heat pump and LPG/base heaters
- Thermostats are located in the front and rear exam spaces; the front thermostat controls will allow you to run both gas and electric heat (but do not control, for the "toe kick" heaters)
- Use the electric "toe kick" heaters for the front of the vehicle and LPG heat for the back (it will accommodate a larger space in a quicker time frame)
- NOTE: Always set the storage heat at 40 degrees Fahrenheit to prevent freezing the external storage compartments

Liquid Propane Gas (LPG)

- LPG levels can be checked with the
- The LPG tanks are a reservoir of fuel that can be used to heat the vehicle
- The LPG tanks burn at a rate of approximately 1.2 gallons per hour of operation (the holding tank has approximately 25 gallons of fuel)
- The responsibility for physically filling the tanks is the gas stations; the compartment for the LGP is located on the drivers side of the vehicle
- It is Oregon state law that all passengers must exit the vehicle when the LPG tanks are being filled
- LPG Tanks can be filled at the Shell gas station located at: 1525 SE Ladd Ave Portland, OR 97214 (503/233-4249)
- In the Fall/Winter – weekly filling of the LPG gas take should take place on Friday mornings; in the Spring/Summer – monthly checks of the levels will dictate fill schedules.

ADA Wheelchair Lift

- *Operating the lift:*

    - Close side entry van door on the passenger side of the vehicle
    - Turn on lift at the top of the control panel located in the compartment immediately to the right of the van entrance
    - Remove the remote control from the compartment
    - Open the ADA lift door from the interior of the vehicle (the door is opened just like any passenger vehicle door)
    - Follow control switches
    - Raise the guard rails on the lift platform – pull up side rails and push in lock pin to stabilize
    - Lower lift to ground
    - Extend ramp
    - Position patient on lift and lock wheels of chair
    - Push the "up" button and the patient will be elevated into the vehicle
- *Storing the lift:*
    - Lower lift to ground
    - Lower the guard rails – left rail first
    - Push "store" button on remote control

Retractable Awning

- Control panels for the awning are located to the right of the electric panel inside the van
- Be certain that the awning has proper clearance before extending the unit
- ALWAYS utilize the "wind smart" setting while using the awning
- Set the default "wind smart" power selection at "low" (Wind Smart is a power setting that electronically adjusts the awning in accordance to the wind; if the wind is too strong (as dictated by the setting of the "Wind Smart" unit) the awning will automatically retract)
- To extend the unit – depress the extend button
- To retract the unit – depress the retract button
- Be sure to power down the unit after fully retracting the awning

Vehicle Steps

- The vehicle steps are on an automatic retract setting – this is set to reposition the steps in store mode when the door is closed; this function may be overridden by selecting the "lock-out" mode on the control panel; the control panel is located above the awning controls to the right of the electric panel.
- The doors will automatically retract – regardless of the "lock-out" function when the vehicle is placed into drive, if the door is closed

Maintenance Schedule (maintenance should be facilitated by the Outreach Coordinator designated for the weeks maintenance)

WEEKLY

- Check engine oil, transmission, and fluids (Refer to Ford F53 owners manual)
- Check generator engine oil – DO NOT OVERFILL (ADI 12.5 Gen-Set uses 3 to 3.25 quarts 10w-30w Mobile One motor oil, add slowly)

- The van waste water should be dumped by an Outreach Clinic Coordinator
- The engine oil, coolant and transmission fluid should be checked by an Outreach Clinic Coordinator
- The van should be inspected for damage and equipment failure; this should include a thorough "walk through" the vehicle and examination of the external storage compartments.
- Always ensure that the water tanks are full on Monday before a clinic outreach to Rose Haven; use the water spout at OI to fill the tanks; NEVER fill the *fresh* water tanks before first emptying the *gray* water tanks; the tanks will require filling every week during the summer months and approximately every 10 days during the winter.
- Assure that the agency van is reserved for outreach clinic sites that require the transport of more than two persons in the mobile medical vehicle. The agency van can be reserved through Bill Aronson at 503/535-3827.
- In the Fall/Winter – weekly filling of the LPG gas take should take place on Friday mornings; in the Spring/Summer – monthly checks of the levels will dictate fill schedules.

MONTHLY

- Have tires checked
- Check main engine battery fluid levels (Use only distilled water or electrolyte, use Hydrometer to check battery cells)
- Check auxiliary battery fluid levels
- Check generator coolant when cold.
- Lubricate Kwikee automatic folding step joints with Kwikee lube.
- Wash van and check for roof damage or leaks

OTHER

- Change oil and filter on generator engine (every 100 hours – this is equivalent to 6000 miles)
- Maintain Ford components as per manufacturing requirement outline in your owner's manual.

Equipment for the Mobile Medical Vehicle

EXAM ROOM EQUIPMENT
Wall mounted ENT scope kit (include speculum tray) (3 rooms)
Wall mount BP cuff (3 rooms)
Wall mount pelvic exam light scope (pelvic speculum lights) (2 rooms)
Wall mounted thermometer (3 rooms)
Wall mounted sharps container (3 rooms)
Durable supplies for each room (as per clinic set-up) (3 rooms)

EMERGENCY EQUIPMENT
AED
Oxygen – portable kit (talk with Angie for equipment dimensions)

LABORATORY
Centrifuge
Incubator
Urinalysis unit
Hemoglobin
Glucometer
Microscope
Refrigerator for vaccines

MISC. EQUIPMENT
Pulse oximeter
Computers for each of the rooms
Central printer
Supplies to wall mount computers
QA log
Med log

EQUIPMENT PROVIDED by vendor
Exam tables
Autoclave

SAFTEY EQUIPMENT
Goggles
Gowns
Face masks
Eye shields
A medical dry razor for the AED
Spill kit materials (a small spill kit comes with the Exposure Control Kit that our handy Health and Safety Coordinator will pick up for them, but they should probably have a jug of absorbent material).

Additional Equipment
Diag set all-in-one 767 76791-2mp welch allyn
Jar sundry unlabeled 6/cs 2086 pss select
Light exam ls150 w/floor std 44500 welch allyn
Sharps cabinet locking 2/3gl 305420 becton dickinso
Stand mayo side base 34in-53in 312 pss select
Stool exam pneu *color* 304 pss select
Table exam rh no top w/heat 404007 midmark-ritter

SOURCE: Outside In, Portland, Oregon

Inventory of an Exam Room

Examination table (Ritter 104 by Midmark)
Sphygomanometer (Welch Allyn)
Opthalmascope Wall Unit with Sure Temp electronic Welch Allyn Thermometer
Wooden dowel With Exam Bench Paper Covering
Plastic Wall Container for Disposable Gloves and gloves
Sharps Container
Computer
Sani Cloth Plus
Saline, Fixative, Vinegar, KOH
Rolling Stool/Chair
Privacy Curtain
Speculum Optic Lamp

5 Glass Containers:
1) Tongue Blades
2) Scopettes and Wooden Handled Cotton Tipped Applicators
3) 1x1s
4) Cotton Balls
5) Bandaids

Biohazard and Garbage Container
Kleenex
Soap
Paper Towels
In drawers: paper sheets, gowns, chucks, booties
Ammonia Inhalants
KY Jelly
Alcohol Preps
Test Tubes
Ear Syringes
2x2s and 4x4s
Natural Air Freshener
1 bottle Citriguard

Van Closing Checklist

Date:_____ **Staff Initials:**_____

Lab

completed

- o Medications put away/organized _____
- o Medications inventoried for next shift and restock list prepared _____
- o Paperwork in shred file or locked in secure location _____
- o Lab logs double-checked and returned to clinic lab _____
- o Verify all cabinets/fridge doors are shut/locked _____
- o Counters wiped down with spray _____
- o All lab specimens correctly labeled and paperwork completed _____
- o Check O2 bottle psi: _____ _____
- o Check AED (black X blinking in upper left hand corner) _____
- o Adequate supply of saline, fixative, vinegar, KOH for next shift _____
- o Verify there are no specimens left in the centrifuge/incubator _____

Coordinators

- o Separate Stat Sheets and Health Histories _____
- o Health History forms/other paperwork into "To Be Scanned" box in Clinic _____
- o Shred documents in shred bin _____
- o Check Millbrook and be sure all patients not seen are marked Walk Out _____
- o Personal papers picked up and in appropriate place _____
- o Log off your computer _____
- o ***ALL*** patient materials, names, numbers, papers locked up or shredded _____

Exam Rooms

- o Exam tables wiped down with spray or bleach wipes _____
- o All supplies restocked or restocking list (back of form) prepared _____
- o Sharps containers checked. If >/= 2/3 full change out _____
- o Paper towels and soap adequately stocked _____
- o Gowns, paper sheets, chucks stocked for next shift _____

Van

- o All doors locked _____
- o Cabinets secured _____
- o Tank levels checked (report to Jaisen when close to full) level: _____ _____
- o Gas levels checked (report to Jaisen when low) level: _____ _____
- o Orange clean dropped in toilet (Thursday only) _____
- o Trash removed _____
- o Biohazard removed _____

Note: _____

_____

_____

Please note: this form to be completed at the end of every day Outreach is conducted and returned to clinic manager

OUTSIDE IN MEDICAL OUTREACH

Mobile Medical Vehicle "Check Out/In"

Date: _____

Name: _____

Location of Outreach: _____

Supplies needed: **[ ]** None **[ ]** See below **[ ]** See attached page

Medication	Strength	Amount

Supplies	Amount/Number

Issues/Problems from last outreach:

_____

_____

_____

_____

Parking: **[ ]** Goose Hollow **[ ]** Outside of agency **[ ]** Other: _____

_____

Please note: This form is to be completed after every outreach clinic

Appendix D: Mobile Clinical Encounter & Referral Forms

- Clinical Encounter Form
- Immunization Certificate
- Preventative Health Screening Forms
- Referral Form
- HIPAA Authorization Release Form

SOURCES:

Maricopa County Dept. of Public Health HCH project, Phoenix, Arizona

Kentucky River Foothills Development Council, Inc., Richmond, Kentucky

San Mateo Medical Center Health Care for the Homeless Program, San Mateo, California

MCDPHS HCH OUTREACH – CLINIC ONLY

- ☐ **Dr. O'Sullivan**
- ☐ **Dr. Ellert**
- ☐ **Janne Croll P.A.C**
- ☐ **Keith Williamson, P.A.C.**
- ☐ Eureka King
- ☐ Cathy Hollis
- ☐ Linda Looker
- ☐ Tresa Floyd
- ☐ Isabel May
- ☐ Tex Uvalle
- ☐ Allan Gange
- ☐ Jeff Jirak

- ☐ **MCHP** _____
- ☐ **APIPA** _____
- ☐ **Grant**_____
- ☐ **Mercy Care**_____
- ☐ **Care First**_____
- ☐ **Health Choice** _____
- ☐ **PHP** _____

LAST NAME:_____
FIRST NAME:_____
DOB:_____
SOC. SEC. # _____

DATE HOMELESS_____

Marital Status: Single Married
Circle One: Male Female
Limited English: Y N
Ethnicity: W B H NA O

Substance Abuse History: Y N
SAC Offered: Y N / Referred: Y N
Mental Health Issues: Y N

SITE:_____ **DOS:**_____

Housing Status			SMI			Referred To		
001	Shelter		X1856	YES		AHC	AHCCCS	
002	Transitional		X1857	NO		DEN	Dental	
003	Doubling Up		Case Management			ADV	Advocates for the Disabled	
004	Unknown		W2052	Triage Screening (1/4 Hour)		SHE	Shelter	
005	Street		W2030	Case Management 1/4		VLO	Value Options	
006	Other		Levels - Outreach			DES	DES – Food Stamps	
007	Migrant		X1953	Level 1 - Approached		SOC	Social Security	
008	Seasonal		X1954	Level 2 - Engagement		SAT	Substance Abuse Treatment	
Income/Poverty Level			X1955	Level 3 - Referral		TRN	Transitional Housing	
IP001	< 100%		Immunizations			PER	Permanent Housing	
IP002	100% ($650 per month)		90658	Influenza (Adult)		MDL	Medical	
IP003	101-150% ($850 per month)		Treatments			PSY	Psychiatric	
IP004	151-200% ($1300 per month)		94664	SVN - Initial		**Providers**		
IP005	Over 200		94665	SVN - Subsequent			Levels Of Service	
IP006	Unknown					**Level**	**1 2 3 4 5**	

Diagnostic Code			Diagnostic Code			Diagnostic Code		
789.0	Abdominal Pain		525.9	Dental Disorder, Unsp		684	Impetigo	
919.0	Abrasion		**311**	**Depression**		719.40	Joint Pain	
303.90	**Alcholism**		110.9	Dermatophytosis-Unsp		729.0	Limb Pain	
300.00	**Anxiety Disorder**		**250.00**	**Diabetes NIDDM**		724.2	Low Back Pain	
493.90	**Asthma**		**250.01**	**Diabetes IDDM**		V68.1	Medication Refill	
917.2	Blister, Foot		304.90	Drug Addiction		**382.9**	**Otitis Media**	
466.0	Bronchitis, Acute		536.8	Dyspepsia		132.9	Pediculosis	
682.9	Cellulites / Abscess		388.9	Ear Disorder		462	Pharygitis, Acute	
786.52	Chest Wall Pain		**692.9**	**Eczema**		V22.2	Pregnancy	
372.00	Conjunctivis, Acute		782.9	Edema		569.3	Rectal Bleeding	
564.0	Constipation		780.79	Fatigue		110.3	Tinea Cruris	
V25.41	Contraceptive, Oral		829.0	Fracture		110.4	Tinea Pedis	
V25.09	Contraceptive, Other		784.0	Headache		465.9	URI	
780.39	Convulsive Disorder		070.51	Hepatitis C		599.0	UTI	
496	**COPD**		**401.9**	**Hypertension**		879.8	Wound, Open / Laceration	

Social Service

In person _____ Phone _____ Collateral Contact _____
15 Minutes: _____ 30 Minutes: _____ 45 Minutes: _____ 60 Minutes:_____ ( )Minutes _____

Social Service: _____

_____

_____

Case Manager's Signature:_____

☐ I have been given a copy and had the opportunity to, or have had explained to me, the information in the "Vaccine Information Pamphlet(s)" or the "Important information Statement(s)" for Influenza Vaccine.
I agree to the health care provider placing the **FLU Shot**, releasing the Flu Shot results to other health care providers for continuity of care.

☐ I give my consent for routine medical care to be provided by the Health Care for the Homeless Program

Signature Of Recipient/Parent/Guardian or Adult _____ Date_____

S: _____ ***Allergies:*** _____

_____

_____

O: VS _____ P _____ R _____ BP _____ O2SAT _____

Gen'l _____

	Normal	**Abnormal**
HEENT	☐	_____
Heart	☐	_____
Chest	☐	_____
Abd	☐	_____
Ext	☐	_____
Skin	☐	_____
Other	☐	_____

A: _____

_____

_____

Plan:
- ☐ **Hydrocortisone Cream 1%** 1oz Apply BID PRN
- ☐ **A&D Ointment** Apply to AA P.R.N
- ☐ **Antacid Tabs** Chew 2 up to TID P.R.N
- ☐ **Antibiotic Ointment** Apply to AA B.I.D P.R.N
- ☐ **Antifungal Ointment/Cream** Apply as directed
- ☐ **Acetaminophen Tabs** 2 tabs 4 hrs P.R.N
- ☐ **Cough Syrup DM** 2tsp 4 hrs P.R.N
- ☐ **Lice Shampoo** 1 bottle externally as dir.
- ☐ **MultiVitamins** take 1 daily
- ☐ **Sudafed 30mg** TID ÷
- ☐ **Amoxil 500mg Cap** ____ Take 1 capsule T.I.D. until gone
- ☐ **Cephalexin 500mg** ____ Take 1 capsule Q.I.D.
- ☐ **Cyclobenzaprine 10mg** ____ Take 1 tablet T.I.D. P.R.N
- ☐ **Cipro 500mg** ____ Take 1 tablet B.I.D. until gone
- ☐ **Colace 100mg** ____ Take 1 capsule B.I.D. PRN
- ☐ **Dilantin 100mg** ____ Take __ capsule daily
- ☐ **Benadryl 25mg** ____ Take 1 tablet q6h P.R.N.
- ☐ **Ibuprofen 600mg** _1_ T.I.D with Food
- ☐ **Ibuprofen 800mg** _1_ T.I.D with Food
- ☐ **Imodium 2mg** ____ Take 2 tabs now and 1 after each loose stool
- ☐ **Lisinopril 10mg** ____ Take___tablets___times daily
- ☐ **Septra DS** ____ Take 1 tablet B.I.D until gone
- ☐ **Zantac 150mg** ____ Take 1 tablet B.I.D
- ☐ **Prednisone 10mg** ____ Take 4 tablets daily until gone
- ☐ **Zithromax 250mg** ____ Take 2 tabs now and 1 daily for the next 4 days
- ☐ **Naprosyn 500mg ____ Take 1 tablet B.I.D with food**

Medical Provider: _____ **Date:** _____

COMMONWEALTH OF KENTUCKY

IMMUNIZATION CERTIFICATE

(Required of each child enrolled in a public or private school, preschool program, day care center, certified family child care home, or other licensed facility which cares for children.)

Name of Child_____ **Birthdate**_____
(Last) (First) (Middle)

Name of Parent or Guardian_____

Address_____
(Street) (City) (State) (Zip Code)

DATES ADMINISTERED (month/day/year)

DIPHTHERIA, TETANUS, PERTUSSIS* **#1**____/____/____ **#2**____/____/____ **#3**____/____/____ **#4**____/____/____ **#5**____/____/____

POLIO VACCINES **#1**____/____/____ **#2**____/____/____ **#3**____/____/____ **#4**____/____/____

MMR (Measles, Mumps, Rubella)** **#1**____/____/____ **#2**____/____/____ _____ ____/____/____ _____ ____/____/____
Other **Other**

Hib*** **#1**____/____/____ **#2**____/____/____ **#3**____/____/____ **#4**____/____/____

Hepatitis B** **#1**____/____/____ **#2**____/____/____ **#3**____/___/___ **or #1**____/____/____ **#2**____/____/____ **(adult dose)**
Varicella *** #1**____/____/____ **or child has had chickenpox disease (X)** _____**.**

---

*DTaP, DTP, DT, Td **MMR for one dose, measles-containing for second. ***Hib not required at age 5 years or more. **** Alternative two dose series of approved adult hepatitis B vaccine for children 11-15 years of age. *****Varicella required for children 19 months to 7 years unless a parent, guardian or physician states that the child has had chickenpox disease.

This child is current for immunizations until ____/____/____, (two weeks after the next shot is due) after which this certificate is no longer valid and a new certificate must be obtained.

I CERTIFY THAT THE ABOVE NAMED CHILD HAS RECEIVED IMMUNIZATIONS AS STIPULATED ABOVE.
Signature of physician, Health Dept., or their designee_____**Date**_____

This Certificate should be presented to the school or facility in which the child intends to enroll and should be retained by the school or facility and filed with the child's health record. **EPID-230 (Rev 8/2002)**

PREVENTATIVE HEALTH CARE EXAMINATION FORM - INITIAL ENTRY [headstart - fourth (4) grade]

All local boards of education shall require a preventative health care examination of each child first entering a Kentucky public school within a period of twelve (12) months prior to initial admission to school. Local school boards may extend this time not to exceed two (2) months. The administration shall have an approved program of continuous health supervision which shall include evidence of having been screened for vision and hearing.

PLEASE COMPLETE THE IDENTIFYING INFORMATION AND RECORDS

IDENTIFYING INFORMATION

Student Name: _____

Social Security Number: _____ **Date of Birth:** _____

Parent or Guardian Name: _____

RECORD OF IMMUNIZATIONS TO BE REPORTED ON IMMUNIZATION CERTIFICATE FORM, EPID 230.

MEDICAL HISTORY

Seizures: _____

Chronic Illness: _____

Allergies: _____

Medications: _____

Significant Historical Information: _____

_____

Physical Exam:

N.	Abn.		
_____	_____	General Appearance	Hgt:_____ Wgt:_____ BP:_____/_____
_____	_____	HEENT	Hearing: R_____ L_____
_____	_____	Skin	Vision: R_____/ _____ L _____/_____
_____	_____	Neck	STRABISMUS/AMBLYOPIA SCREEN ☐ ABNORMAL
_____	_____	Chest	Optional---------HCT/HGB: _____(required for headstart)
_____	_____	Heart	Optional----------UA: _____
_____	_____	Abd - Genitalia	
_____	_____	Extremities-Back	
_____	_____	Neuro	

Explain Abnormal Exam: _____

_____

Recommendations:

_____ **No Restrictions: Normal Exam**

_____ **RESTRICTIONS AND SUGGESTIONS TO SCHOOL:** _____

_____

_____

Age appropriate and suggested anticipatory guidance *(health assessments)*

☐ **Discuss injury prevention with parents**

☐ **Bicycle Safety** ☐ **Car Seat Belts** ☐ **Memorization of Name, Address and Phone Number**

☐ **Advise the child not to go with or accept anything from strangers and feel free to say "NO" to strangers.**

☐ **Emphasize the importance of dental care.**

☐ **Discuss mental health issues.**

Signed: _____ **Date:** _____

Physician/ARNP/PA/EPSDT Provider

Address: _____ **Telephone:** _____

Kentucky Department of Education

PREVENTATIVE HEALTH CARE EXAMINATION FORM - Sixth (6th) Grade Form (for grades 5-12)

All local boards of education shall require a second and third preventative health care examination of each child within one (1) year prior to entry into the sixth (6th) grade or subsequent grades. Each board shall have an approved program of continuous health supervision in accordance with current statutes and regulations, vision, hearing and scoliosis scheduled screening tests. Local school districts shall establish a plan for implementation and compliance with the sixth (6th) grade examination.
PLEASE COMPLETE THE IDENTIFYING INFORMATION AND RECORDS

IDENTIFYING INFORMATION Grade: 5th 6th 7th 8th 9th 10th 11th 12th *(Circle appropriate grade)*

Student Name: _____

Social Security Number: _____ **Date of Birth:** _____

Parent or Guardian Name: _____

RECORD OF IMMUNIZATIONS TO BE REPORTED ON IMMUNIZATION CERTIFICATE FORM, EPID 230.

MEDICAL HISTORY

Seizures: _____

Chronic Illness: _____

Allergies: _____

Medications: _____

Significant Historical Information _____

_____

Physical Exam:

N.	Abn.		
_____	_____	General Appearance	Hgt:_____ Wgt:_____ BP: _____ / _____
_____	_____	HEENT	Hearing: R _____ L _____
_____	_____	Skin	Vision: R_____/ _____ L _____/_____
_____	_____	Neck	Optional---------HCT/HGB: _____
_____	_____	Chest	Optional----------UA: _____
_____	_____	Heart	
_____	_____	Abd-Genitalia	
_____	_____	Extremities-Back (including scoliosis screen for 6th grade)	
_____	_____	Neuro	

Explain Abnormal Exam: _____

_____

Recommendations:

_____ **No Restrictions: Normal Exam**

_____ **RESTRICTIONS AND SUGGESTIONS TO SCHOOL:** _____

_____

_____

Age Appropriate and Suggested Anticipatory Guidance *(Health Assessments)*

1. **How have things been going for you at school? With your peers?**
2. **How do you rate your own health?**
3. **What concerns do you have about your own development?**

Advise adolescents about the following good health habits and self-care. – See sample reference on back of form.

☐ **Risk behaviors were discussed and addressed**

☐ **Risk behaviors were not addressed today**

Signed: _____ **Date** _____
Physician/ARNP/PA/EPSDT Provider

Address: _____ **Telephone:** _____

San Mateo Medical Center
Health Care for the Homeless Program

Fair Oaks Same Day Clinic
Referral Form

Patient Name:_____

Date of referral:_____ _____

Date of Birth: Month _____ Day _____ Year _____

Gender:_____ SSN:_____ - _____ - _____

Person making referral:_____

Referring organization:_____

Phone:_____

Preferred language:_____

Phone number:_____

Ethnicity _____ Health Insurance _____

Family Members _____ Monthly Income _____

Individual is living at the following: (please check one)

□ Homeless Shelters
□ Transitional Housing (i.e. hotel, rehab center, transitional shelter programs etc)
□ On the Streets (i.e. car, park, abandon building)
□ Temporality with friends or extend family

REASON FOR REFERRAL (Describe in one or two sentences):

_____
_____
_____
_____
_____
_____

If you have questions regarding referring a homeless person into the Fair Oaks Same Day Clinic please call 650-573-2966 or send an email to mkennedy@co.sanmateo,ca.us

If possible please fax a copy of the referral form to the HCH Program (650) 573-2966 or an email to mkennedy@co.sanmateo,ca.us so the HCH Program can assure that the individual received service.

Guidelines Only - Please do not mark risk factors on this form.

	Low Risk	**Moderate Risk**	**High Risk**
Body Mass Index	Between 15-85% Normal weight/ height per the growth chart	Between 5-15%/85-95% (Just over or just under the normal range)	<5%/>95% (Much over or much under normal weight)
Weight perception	Feels good about weight	Feels "fat" even though weight is normal on the chart	Skips meals, vomits, takes medicine, or exercises too much to control weight
Nutrition	Eats 3 meals/day; and eats fruits, vegetables, and foods with fiber	Eats less than 3 meals/day; or vegetarian without milk or eggs	Eats a lot of snacks with fat and sugar, eats few regular meals
Exercise	5 times/week for at least 20 min each, with increased heart rate and sweating	Exercises less than 5 times/week, not strenuously	No regular exercise to increase heart rate
Tobacco use	No smoke or chew	Smoke or chew less than daily; or Stopped less than 6 weeks ago	Smoke or chew regularly
Drug use	Never used	Previously used; not in the past 3 months	Recently used or currently uses marijuana, huffing, LSD, cocaine, heroin, etc.
Alcohol use	Has only tasted it, or used for religious purpose	Social only, not more than once/week; less than 3 beers or 2 liquor drinks at a time	Drunkenness, blackouts; drinking interferes w/school, family, etc.; 4 or more drinks at a time
Sexual activity	Never, or is married and faithful	Not in last 6 months; safe sex with condoms	Sex without regular use of condoms; first intercourse before age 16
School	B/C average or better, steady improvement in grades	Grades slipping; detention problem	Failing grades; suspension; often skips school
Depression	Usually happy	Often feels discouraged or down; cries a lot	Unhappy most of the time; feels hopeless; thought of suicide
Abuse	No physical or sexual abuse	Abuse reported and counseling received	Abuse still occurring or not treated with counseling
Safety	Uses seat belt/helmet, never rides with drunk driver	Usually uses seat belt/helmet; rarely rides with drunk driver	Does not use seat belt/helmet; has driven drink; sometimes rides with drunk driver
Violence	No fights, no threats, does not carry a knife, gun, or rifle, no legal troubles	Threatens others; previous illegal acts (stealing, etc.) but not in past 3 months	Damages own or others' property; carries a gun, knife, or rifle; physical fights with peers; has had contact with police
Family relationships and responsibility	Gets along with family, completes chores or work duties	Often argues with family; does not complete chores or work duties	Physical and/or intense verbal fights with family
Friends and Recreation	Has male and female friends; involved in clubs, activities, or hobbies	Has few friends; does things alone; has friends who often get into trouble	Has no friends; or belongs to gang or cult
Good qualities and Future plans	Can name 3 good qualities about self; has plans for the future	Hard to think of good qualities about self; has few interests; does not have future	No good qualities about self; no interests or activities
Immunizations	Second MMR; tetanus within ten years; hepatitis series; had varicella or been vaccinated	Lacks any one item	Lacks two or more items

Cowell Student Health Center, One Shields Avenue, University of California, Davis, CA 956l6
Phone: 530-752-2300 Fax: 530-752-5587

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient Name:_____ DOB:_____ Chart#_____

SID #_____ Phone #_____

Address_____
Street City, State Zip

I authorize: _____
(Name of person/facility which has information)

_____
Street address, City, State, Zip Code

Phone _____ Fax_____

to release health information to:

_____
(Name of person/facility to receive information)

_____
Street address, City, State, Zip Code

Phone _____ Fax_____

TYPE OF DISCLOSURE: (check) ☐Copies ☐Verbal ☐Inspection ☐Summary

PLEASE SPECIFY THE HEALTH INFORMATION YOU AUTHORIZE TO BE RELEASED:

☐ **MEDICAL** (may include drug/alcohol /mental health info documented by a primary care provider.)
☐ **MENTAL HEALTH** (include psychiatric/mental health notes documented in the CSHC medical record)

DATE(s) of treatment or time period:_____

TYPE(s) of health information**:**

☐Immunizations/vaccinations
☐ other (specify)_____
_____

If applicable please check:

☐ I specifically authorize the release of **HIV/AIDS test results** (Health and Safety Code 120980(g)).
☐ I specifically authorize the release of information pertaining to **drug and alcohol abuse, diagnosis or treatment** (42 C.F.R. 2.34 and 2.35).
☐ I specifically authorize the release of **genetic testing** information (Health and Safety Code 124980(j)).

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION – page 2 of 2…

The purpose of this release is for (check one or more)

☐ At the request of the patient or patient representative

☐ Other (state reason)_____

PERSONAL COPIES: _____ (initial) I understand I may be charged a reasonable fee for copies

NOTICE

UCD CSHC and many other organizations and individuals such as physicians, hospitals and health plans are required by law to keep your health information confidential. If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, it may no longer be protected by state or federal confidentiality laws.

YOUR RIGHTS

This authorization to release health information is voluntary. Treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this Authorization except in the following cases: (l) to conduct research-related treatment, (2) to obtain information in connection with eligibility or enrollment in a health plan, (3) to determine an entity's obligation to pay a claim, or (4) to create health information to provide to a third party.

This authorization may be revoked at any time. The revocation must be in writing, signed by you or your patient representative, and delivered to: Medical Record Supervisor, CSHC, UCD, One Shields Avenue, Davis, CA 956l6.

The revocation will take effect when UCD CSHC receives it, except to the extent UCD CSHC or others have already relied on it.

You are entitled to receive a copy of this Authorization.

EXPIRATION OF AUTHORIZATION

Unless otherwise revoked, this Authorization expires _____ (insert actual date or event). If no date is indicated, the Authorization will expire 12 months after the date of my signing this form.

_____ _____

Print Name Signature (Patient/Patient representative)

_____ _____ _____

Date Time Witness

Appendix E: Job Descriptions for Mobile Health Programs

- Director of Outreach Services
- Outreach Worker
- Mobile Certified Medical Assistant

SOURCES:

Unity Health Care, Inc., Washington, DC

Saint Joseph's Mercy Care Services, Atlanta, Georgia

Job Description: Director of Outreach Services
Unity Health Care, Inc.

INTRODUCTION

The Director of Outreach Services is responsible for the supervision, coordination, communication and problem solving related to Project Orion as well as Homeless Outreach (Excludes Christ House, CCNV). The Director of Outreach Services works under the direction and guidance of the Chief Clinical Officer.

MAJOR DUTIES

- Assist in the development, implementation and monitoring of Project Orion and Homeless outreach service policies.
- Develops the budget for Orion and Homeless outreach Services in conjunction with the CCO.
- Coordinates the hiring, orientation and evaluation of Orion and Homeless Outreach Staff
- Coordinates the data collection/reporting activities associated with outreach services provided via the Orion and Homeless Outreach sites, such as Orasure/Oraquick testing data, provider utilization of Orion and Homeless Outreach, annual analysis of appropriate sites/stops etc.
- Develops and coordinates Provider (in collaboration with the office of the CMO) and staff scheduling for Orion and homeless outreach Services to assure adequate provider, nursing and testing/counseling services.
- Develops and coordinates substance abuse training programs for staff to assure appropriate level of care is maintained
- Promotes customer services by resolving client concerns in a timely manner
- Promotes occupational health and safety within Unity Health Care
- Collaborates with other departments within UHC, such as clinical support and facilities to assure that the homeless sites are routinely cleaned and stock for client care
- Participates in the ongoing evaluation of the clinical support staff, such as Coordinators for Homeless services, Van drivers, case managers and counselors
- Develops linkages with city wide agencies that provide services to substance abuse and/or homeless clients to ensure continuity of care for all clients.
- Represents Unity Health Care at meetings as designated by the Chief Medical Officer, Chief Executive Director or Chief Clinical Officer.
- Coordinates the schedules and directly supervises the Cargo Van/Medical Van drivers
- Assures that the Orion Van and Homeless Van is routinely maintained, cleaned, stocked And available for client care as scheduled.
- Other duties as assigned.

KNOWLEDGE REQUIRED BY THE POSITION

1. Bachelor's degree required in counseling and/or health related field, Master's degree preferred.
2. At least 5 years of experience working with outreach services such as HIV/Homeless
3. At least 2 years supervisory experience and or program management and oversight..
4. Experience in working with homeless and/or underserved populations preferred.
5. Ability to articulate the mission of Unity Health Care through his/her works.
6. Experience in working in a multi-site agency helpful.

Job Description: Outreach Worker
Unity Health Care, Inc.

INTRODUCTION

Outreach workers for Unity health Care / Project Orion work with diverse populations with multifaceted needs. Primary responsibilities include, but not limited to, engaging and assisting clients in following through on established treatment plans; enhancing social functioning; and improving the client's quality of life. The outreach worker serves as a culturally sensitive liaison between the client and services and/or service providers to insure that the services and service providers present treatment plans that are culturally palliative.

MAJOR DUTIES

1. Establish and develop working relationships with clients; initiate outreach to the target population using telephone, mail, and visits in the community.
2. Communicate with other staff members regarding the status of client social, mental and physical health needs using oral and written communication skills to include electronic media.
3. Develop effective incentives to encourage clients to seek care/treatment for HIV, substance abuse, chronic illness, and/or mental illness.
4. Dispense, in accordance with Unity Health Care policy, incentives such as vouchers, tokens, etc.
5. Maintain accurate and current records.
6. Assist in production of required weekly/monthly/quarterly data collection reports.
7. Attend staff team meetings as required.
8. Drive outreach mobile as required.
9. Maintain outreach mobile (i.e., maintenance records, fuel, routine care, cleanliness, stocking, etc.).
10. Other duties as assigned.

KNOWLEDGE REQUIRED BY THE POSITION

- A minimum of 2 years experience in substance abuse and HIV/AIDS prevention and intervention programming including substance abuse treatment.
- A minimum of one-year experience in mobile HIV and/or substance abuse outreach.
- Knowledge of and documented experience with intake and service placement systems.
- Preferable experience as addictions Counselor in the District of Columbia.
- Proven cultural competency in the target client population.
- Current District of Columbia driver's license.
- Bilingual in English and Spanish (Optional).
- Ability to pass an English language competency test.

Saint Joseph's Health System
(Saint Joseph's Mercy Care Services)
Staff Position Description

POSITION TITLE: Mobile Certified Medical Assistant	**POSITION CODE:** 21722 **Exempt θ Non-exempt X**
DEPARTMENT: Mobile Clinical Services **DEPARTMENT NUMBER:** _____	**DATE PREPARED: 04/29/02**
REPORTS TO: Multi-site Clinic Manager	**DATE REVIEWED: 1/1/2005**

POSITION SUMMARY: Coordinates target populations access to healthcare, health education, and preventive services. Independently develops and staffs clinics and coordinates all clinic function, including supportive linkage services and specialized clinical programs. Advocates for specific needs of client populations.

**Provides patient care and/ or support activities appropriate to ages served; primarily adults ages 18-65 or geriatric patients ages over 65. May also include care for infant age 0-1 year, child ages 1-12 years or adolescent ages 13-17 years.*

EDUCATION REQUIREMENTS: High School diploma required, college graduate or professional/technical school preferred. CPR Certification required. CMA required.

EXPERIENCE REQUIREMENTS: Five years experience in a health related field. Experience in the training and supervision of new employees and volunteers preferred. Experience with both front and back office operations preferred. A second language desirable. A safe driving record and current Georgia driver's license required. CDL Driver's Permit preferred. A second language is desirable and may be required.

JOB KNOWLEDGE: Must be able to provide leadership among peers. Must be able to work independently. Have good understanding of medical terminology. Must demonstrate expertise in clinical areas of laboratory, radiology, and other primary care procedures. Possesses good verbal and written communication skills, good listening skills, compassionate attitude and demeanor. Has sufficient computer literacy to enter and retrieve office and patient data.

PHYSICAL REQUIREMENTS: See attached Working Conditions and Physical Requirements Sheet

SUPERVISORY RESPONSIBILITY FOR: May supervise Certified Medical Assistants/Health Advocates/ Volunteers

Working Conditions and Physical Requirements

(Note: Needs to be customized to each position)

Please check the appropriate level for each section.

Working Conditions and Physical Requirements	Level of Physical Effort Normally Required For This Position			
	Never	**<20 % of time Occasionally**	**20-80% Frequently**	**>80% of time Constantly**
1. Close Eye Work (computers, typing, reading, writing)			**X**	
2. Sedentary (continuous sitting)		**X**		
3. Light Work (standing, walking, lifting < 15 pounds)				**X**
4. Moderate Work (lifting, moving, loading 15-30 pounds, prolonged use of small hand tools, climbing ladders)			**X**	
5. Moderately Heavy Work (lifting, moving, loading 31-50 pounds)		**X**		
6. Heavy/Hard Work (above average strength and stamina, lifting > 51 pounds, constant shoveling, etc.)	**X**			

_____ _____

Signature, Director Date