Medicaid Division

Mobile Health Unit Pilot Program

OREGON HEALTH AUTHORITY

Mobile Health Unit Pilot Program Feasibility Study **Interim Report**

HB 4052 (2022)

December 2025

Acknowledgments

This report was produced on behalf of the Oregon Health Authority, Medicaid Division, by Rede Group. Rede would like to sincerely thank the many people who contributed to this study, including the Oregon Health Authority and the Mobile Health Advisory Committee.

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Introduction

The Oregon Health Authority (OHA), Medicaid Division, commissioned Rede Group in 2025 to evaluate the Mobile Health Unit (MHU) Pilot Program and to conduct a statewide needs assessment and feasibility study as directed by House Bill (HB) 4052 (2022).

HB 4052 mandates that OHA establish a culturally and linguistically responsive mobile health pilot program to reduce health disparities experienced by priority populations disproportionately affected by racism. Through two funding cycles (2023 and 2025), OHA has awarded grants to 10 unique mobile health operators. Grantees vary in operational readiness, scope, and geographic reach.

The purpose of this interim report is to summarize progress to date, present preliminary findings from the evaluation and environmental scan, and outline ongoing methods supporting the final feasibility study to be submitted to the Oregon State Legislature in June 2026. This work utilizes a mixed-methods approach incorporating document review, environmental scan, and engagement with OHA, the Mobile Health Advisory Committee (MHAC), and grantees.

Discussion

- **Evaluation Planning and Engagement:** Rede Group collaborated closely with the MHAC and Mobile Health Unit Pilot Program grantees to finalize an evaluation plan and program logic model. Engagement activities included presentations, structured review and feedback sessions, and opportunities for confirming shared evaluation priorities.
- **Environmental Scan:** A comprehensive mobile health unit scan identified 40 organizations operating 50 mobile health units statewide as of October 2025. Services offered include chronic disease management,

wound care, behavioral health, dentistry, optometry, maternal health, communicable disease prevention, and wraparound support. Most MHUs serve communities of color and low-income individuals. Geographically, operators are concentrated in the Portland tri-county area and along the I-5 corridor, with fewer units based in rural or frontier areas despite significant unmet health care needs. A review of Community Health and Health Needs Assessments and Community Health Improvement Plans revealed limited reference to mobile health services and widespread concerns regarding lack of culturally and linguistically responsive care, distrust of health systems, and barriers experienced by priority populations.

- **Needs Assessment:** Analysis of Areas of Unmet Health Care Need using data from the Oregon Office of Rural Health indicates substantial variation in access to primary, dental, and mental health care across the state. Several rural regions (see map on page 42) exhibit the highest unmet need, while current mobile service availability is disproportionately located in areas with lower unmet need but with larger populations.
- **Ongoing Feasibility and Evaluation Activities:** Between November 2025 and May 2026, Rede will continue conducting feasibility study and evaluation activities to develop an evidence-based, culturally and linguistically responsive statewide mobile health model.

Summary

Initial findings indicate that Oregon has a diverse but unevenly distributed mobile health landscape. The Mobile Health Unit Pilot Program is contributing to expanded access for priority populations; however, significant needs remain, particularly in rural and frontier regions. Community feedback highlights ongoing issues related to cultural and linguistic responsiveness, trust, and systemic barriers to care. The evaluation and feasibility study are progressing as planned and will yield comprehensive recommendations.

Terminology

Acronyms

Acronym	Term
AUHCN	Areas of Unmet Health Care Need
CBO	Community-Based Organization
CHA	Community Health Assessment
CHIP	Community Health Improvement Plan
CHNA	Community Health Needs Assessment
CP	Community Paramedicine
HRSA	Health Resources and Services Administration
KEQ(s)	Key Evaluation Question(s)
LGBTQIA2S+	Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, Asexual, Two-spirit
LPHA	Local Public Health Authority
MA	Medical Assistants
MHAC	Mobile Health Advisory Committee
MHU(s)	Mobile Health Unit(s)
MIH	Mobile Integrated Healthcare
OHA	Oregon Health Authority
ORH	Oregon Office of Rural Health
PCP(s)	Primary Care Physician(s)
RHT	Rural Health Transformation

Definitions

Health Equity: "Oregon will have established a health system that creates health equity when all people can reach their full health potential and well-being and are not disadvantaged by their race, ethnicity, language, disability, age, gender, gender identity, sexual orientation, social class, intersections among these communities or identities, or other socially determined circumstances. Achieving health equity requires the ongoing collaboration of all regions and sectors of the state, including tribal governments to address:

- The equitable distribution or redistribution of resources and power; and
- Recognizing, reconciling, and rectifying historical and contemporary injustices."[1]

Mobile Health Operators: An organization mobilizing, equipping, staffing, and managing all other required capacity needs of a mobile health unit.

Mobile Health Advisory Committee: A group of individuals convened by OHA with a special interest, expertise, or lived experience in mobile health or health care access of priority populations in Oregon. This committee, established in House Bill 4052 (2022), consists of 10-12 members. The Mobile Health Advisory Committee is chartered to provide guidance to the Oregon Health Authority on establishing, funding, and operating a pilot program to improve the health outcomes of Oregonians impacted by racism by providing grants to one or more entities to operate culturally and linguistically responsive mobile health units in this state.

OHA Mobile Health Unit Pilot Program: Housed at OHA, Medicaid Division, the Mobile Health Unit Pilot Program is a strategic action identified in Oregon HB 4052 (2022). The program grants funds to select Oregon mobile health operators to establish culturally and linguistically specific mobile health units to remove barriers and increase access to and the quality of health care for priority populations, thereby addressing healthcare disparities caused by

[1] Oregon Health Policy Board - Health Equity Committee

racism. (See priority populations outlined in HB 4052 (2022) on the following page.)

OHA Mobile Health Unit Pilot Program Grantees: Mobile health operators that receive funding from OHA to participate in the OHA Mobile Health Unit Pilot Program.

Mobile Health Unit: Any combination of people and equipment that delivers health care directly into communities to help individuals overcome common barriers they experience when attempting to access health care in traditional settings, including time, geography, and trust.

Introduction

Oregon is engaged in a longstanding effort to transform its health care system to achieve health equity, expand access to care, improve population health outcomes, and ensure a financially sustainable, high-quality system. Recognizing that bolstering mobile health is one way to improve health care delivery, the Legislature passed Oregon House Bill (HB) 4052 in 2022. The bill called upon the Oregon Health Authority to create a mobile health pilot program to improve the health outcomes of Oregonians impacted by racism. In collaboration with the Mobile Health Advisory Committee, OHA developed the pilot program and began funding mobile health units to provide culturally and linguistically responsive care in 2023.

HB 4052 further directed OHA to study the feasibility of a statewide mobile health program.

Purpose

This interim report describes progress toward evaluating the Mobile Health Unit Pilot Program and outlines methods currently underway to complete a needs assessment and feasibility study for mobile health in Oregon.

Background

Mobile Health Unit Pilot Program Description

Substantial evidence indicates that mobile health can help underserved communities overcome common barriers to accessing health care, including time, culture, geography, and trust.[2] HB 4052 directed OHA to coordinate a Mobile Health Advisory Committee (MHAC) and collaborate with them to develop a Mobile Health Unit Pilot Program. The Mobile Health Unit Pilot Program's goal is to reduce barriers to health care access by bringing care

[2] de Peralta, A. M., Gillispie, M., Mobley, C., & Gibson, L. M. (2019). It's All About Trust and Respect: Cultural Competence and Cultural Humility in Mobile Health Clinic Services for Underserved Minority Populations. *Journal of health care for the poor and underserved,* 30(3), 1103–1118. https://doi.org/10.1353/hpu.2019.0076

directly into communities, leveraging existing community assets, and providing culturally and linguistically responsive services. OHA's Medicaid Division is responsible for establishing the pilot program to fund organizations seeking to establish or expand existing mobile health units. The pilot program centers on health equity and community by emphasizing community engagement and focusing on priority populations (as defined in OAR 950-020-0010(7)), which are groups that disproportionately experience avoidable illness, death, or other poor health or social outcomes attributable directly or indirectly to racism, including:

- Communities of color, including members of the following racial or ethnic communities: American Indian; Alaska Native; Hispanic or Latino; Asian; Native Hawaiian; Pacific Islander; Black or African American; Middle Eastern; North African; Mixed race; or Other racial or ethnic minorities.
- The Nine Federally Recognized Tribes in Oregon and the descendants of the members of the Tribes;
- Immigrants;
- Refugees;
- Migrant and seasonal farmworkers;
- Low-income individuals and families;
- Persons with disabilities; and
- Individuals who identify as lesbian, gay, bisexual, transgender, or queer or who question their sexual or gender identity.

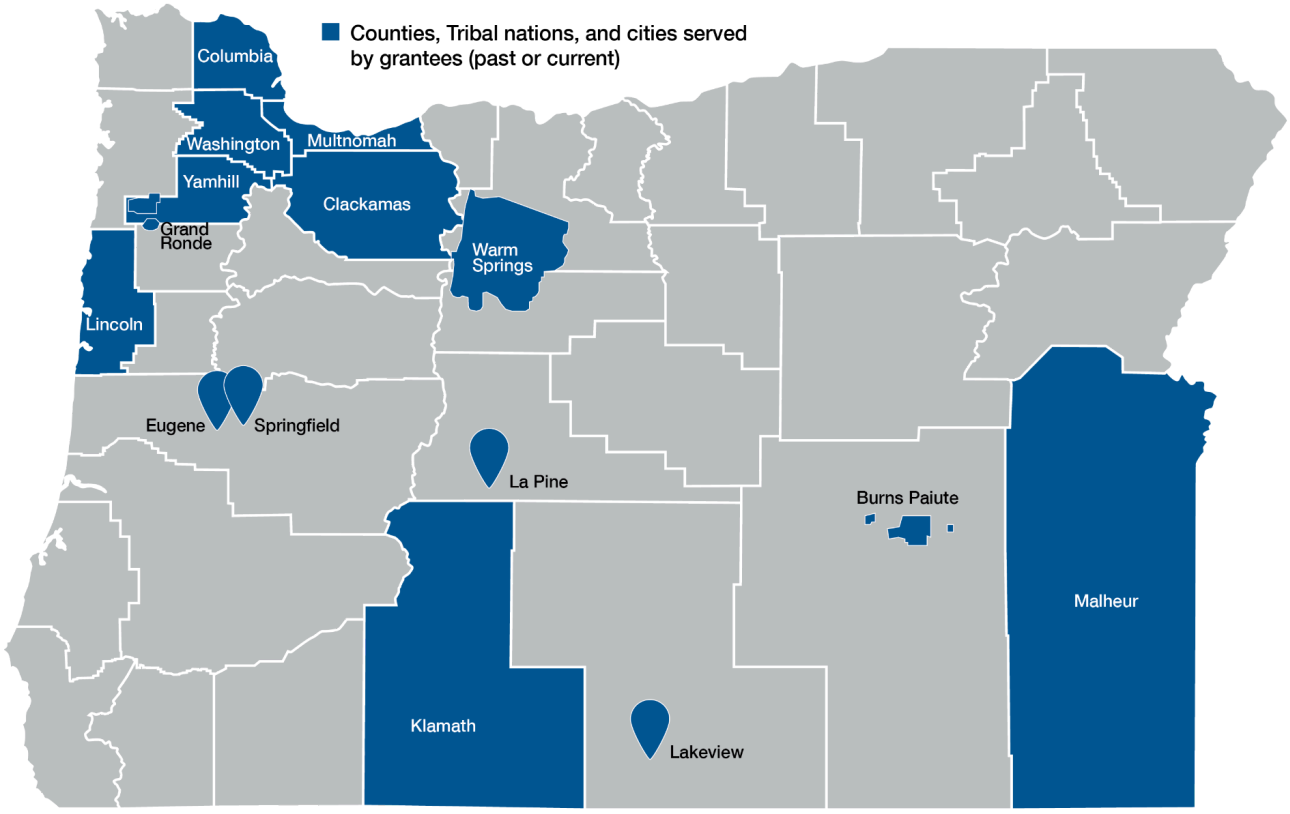
OHA's budget for the pilot program was $1,275,000 for the 2021-2023 biennium, $1,700,000 for the 2023-2025 biennium, and $1,600,000 for the 2025-2027 biennium.

In May 2023, OHA selected three Mobile Health Unit Pilot Program grantees for funding (Cohort 1) based on a competitive application process. In 2025, OHA published a request for grantee proposals (RFGP 6119) to fund additional mobile health unit grantees. In the 2025 application cycle, eight organizations received funding (Cohort 2). One organization from Cohort 1 was also funded in Cohort 2. Therefore, a total of 10 unique OHA Mobile Health Unit Pilot

Program grantees were funded across the two program cycles. Grantees are at various stages of implementing their OHA Mobile Health Unit Pilot Program grants, with some launching and establishing new mobile health operations, procuring supplies, or hiring staff, while others are engaging in long-term service delivery.

Figure 1 (below) shows the counties, Tribal nations, and cities where each of the 10 OHA Mobile Health Unit Pilot Program grantees provide or intend to provide services to Oregonians.

Figure 1: Counties, Tribal nations, and cities where grantees provide or intend to provide select services



Mobile Health Unit Pilot Program Grantees

MHU Pilot Program Grantee Cohort 1

Central City Concern: Central City Concern (CCC) delivers services to vulnerable populations on the streets of Portland. They provide wellness

checks, general medical wound care, and other various services for those who need them. CCC operates in Multnomah County. Funded from June 2023 to July 2025.

Great Circle Recovery Opioid Treatment Program: The program is operated by the Confederated Tribes of Grand Ronde. Services included opioid treatment and recovery, and the mobile health unit operates in Yamhill and Polk Counties. Funded from June 2023 to July 2024.

Raíces de Bienestar: Raíces de Bienestar's services include mental health services for populations across most of the North Central counties in Oregon, from Yamhill to Clackamas. Funded from June 2023 to January 2026

MHU Pilot Program Grantee Cohort 2 (August 2025 - August 2026)

Central City Concern: Continuation of services provided in the previous grant cycle.

Daisy C.H.A.I.N.: Daisy C.H.A.I.N. plans to provide full-spectrum doula and peer support services, including lactation education and consulting. Daisy C.H.A.I.N. provides services in Lane County, primarily in the Eugene-Springfield area.

El Programa Hispano Católico: El Programa Hispano Católico (EPHC) provides services and plans to offer more consistent services. EPHC provides health education on chronic disease and mental health, wellness checks, full one-hour therapy sessions, prenatal care, and preventive screenings. EPHC serves people in the Portland tri-county area.

Lincoln County Public Health: Lincoln County plans to provide vaccinations, STI screenings, wound care, medication access, referrals, and OHP enrollment. Lincoln County Public Health’s van will operate in Lincoln County.

Medical Teams International: Medical Teams International (MTI) is an organization that has been operating mobile health units internationally for decades. They will provide oral health care services with four different MHUs to patients who are members of the Confederated Tribes of Warm Springs and the Burns Paiute Tribe.

St. Alphonsus: St. Alphonsus will provide primary care services. They have a fleet of 2 MHUs and one utility vehicle in Malheur County.

Tayas Yawks: Tayas Yawks operates an MHU that provides preventive screenings, opioid services, and health education sessions for tribal communities in Klamath County. They plan to expand community partnerships throughout Klamath county as well as in LaPine (Deschutes county) and Lakeview (Lane County).

Urban League of Portland: Urban League aims to provide blood pressure and glucose screening, wound care, STD testing, pregnancy testing, and other culturally specific services.

Pilot Program Evaluation

In consultation with the Rede Group, OHA developed a formal evaluation plan to study the implementation of the Mobile Health Unit Pilot Program (see Appendix A for the complete evaluation plan). The evaluation plan outlines methods for systematically assessing the quality and effectiveness of the pilot. The evaluation is underway and will be completed by May 2026.

Engagement in Evaluation Planning

Engagement of interest holders is a key piece of conducting a well-rounded, equity-centered evaluation. Rede engaged two main groups—MHAC and Mobile Health Unit Pilot Program Grantees—to gather feedback on the evaluation plan before conducting evaluation activities. The engagement process with both groups is described below.

MHAC Engagement in Evaluation Planning

In August 2025, Rede attended an MHAC meeting to give a brief presentation on the evaluation process and to invite MHAC members to provide feedback or ask questions about the co-created logic model developed with the Mobile Health Unit Pilot Program grantees as part of the 2023 Evaluation Plan (pg. 14). The window for comments was left open for a month and distributed to MHAC members who were not in attendance. At this engagement, Rede also garnered interest from MHAC members in serving in a more significant advisory role throughout the evaluation. Two members of MHAC volunteered for this role and have since served as reviewers on a multitude of evaluation and/or feasibility study activities, including an in-depth review of the evaluation plan to provide feedback on evaluation activities and key evaluation questions.

Mobile Health Unit Pilot Program Grantees Engagement

Rede also engaged the eight Mobile Health Unit Pilot Program grantees in providing feedback on the evaluation plan and key evaluation questions. After integrating feedback from MHAC and OHA on the evaluation plan, Rede sent

the complete evaluation plan, a short “one-pager” with key evaluation activities in English and Spanish, and guiding review questions to the eight grantees. These questions were:

- Do you feel like this evaluation will gather credible evidence about the mobile health program?
- Do you think this evaluation, as described, will tell the story of the program?
- As you understand it, is your participation in the evaluation feasible given your availability and time constraints?
- What questions do you have?
- Does anything stick out to you, or is there anything else Rede should consider in the evaluation?

Grantees could provide feedback via email or verbally during a virtual meeting. Seven grantees elected to provide their feedback via email, and one grantee provided feedback via Zoom. Feedback was integrated into the evaluation plan and shared with OHA for further consideration.

Program Logic Model

The logic model on page 14 was co-created with grantees and reviewed by OHA MHU Pilot Program staff and MHAC. The logic model is a visual diagram that illustrates how the program's resources, activities, and outputs are connected to its intended short-term and long-term outcomes. It is intended to show the causal link between the program's activities and its intended outcomes.

Evaluation Plan Methods (*in brief*)

Rede will use a combination of qualitative and quantitative data collection methods to evaluate the Mobile Health Unit Pilot Program based on a set of key evaluation questions. All methods for data collection, analysis, and interpretation are outlined in the evaluation plan in Appendix A.

Logic Model

OHA Mobile Health Unit Pilot Program

Situation Statement: Following HB 4052 (2022), OHA funds mobile health units (MHUs) in a pilot program focused on health equity.

Inputs	Activities	Outputs	Outcomes – Impacts		
			Short-term Result (1-3 years)	*Medium-term Result (3-5 years)*	*Long-term Result (5+ years)*
• Funding for pilot program • OHA grant and program evaluation support • Medicaid or other insurance	• Launch pilot program • Plan for evaluation and feasibility study	• Completed grant-making process • Staff retention policies • Continuous needs assessment	• Successful launch of MHU and start of services with community engagement	• Clients are receiving services from MHU or PCPs (if referred) • Clients are satisfied with the care they receive from MHUs	• Increased client network, allowing for a self-sustaining economic model for the MHU • Established long term relationships with patients • Decreases morbidity among MHU clients • Decreased mortality among MHU clients • Decreased healthcare costs
• Mobile Health Unit operators/ clinicians/drivers • MHU equipment + materials • MHU Organization's support • Community partnerships • Consumers/clients	• Build MHU staff capacity, including training/education for MHU clinicians/ operators • Procure materials and supplies for services • Plan culturally specific client services • Plan bridge medical services to help clients feel safe with PCPs	• MHU staff training occurs • MHU equipment and materials secured • Plans for culturally specific services developed and staff training to provide those services • Plans for bridge medical services developed • Referral program for primary provider & specialist	• Increased services provided for clients and those in crisis • Improved culturally specific services • Successful bridge services to primary care providers • MHUs can track and monitor patient data	• Specific-population clients connect consistently with primary care and other prevention services at MHUs	**Note:** Long term results will **only** be achieved with sustained funding beyond the pilot project timeframe.
Assumptions: - Stable funding for MHU operations - Contingency plan for consolidating to essential services, if necessary, due to funding shifts - Community partners will remain invested in MHU activities, outputs, and outcomes	• Conduct community outreach • Provide services (e.g., primary care, urgent care, mental health, substance use) • Collect information about services provided	• Services provided and documented at a level appropriate to the level of service provided	• Increased substance/opioid use disorder services, mental health services, infectious disease prevention, primary care, urgent care, wound care, vaccinations, and medication management.	• Specific improved health outcomes for MHU clients in Pilot Service Areas (overdose, advanced infection, depression, anxiety, etc.) • Decrease in unnecessary utilization of high-cost emergency services	

Pilot Program Evaluation Limitations

As visualized in the logic model, an effective mobile health program—one that operates consistently and at scale to provide reliable, culturally and linguistically responsive care—will improve community health outcomes (e.g., lower disease rates and fewer premature deaths). Measuring the health outcome effects of the Mobile Health Unit Pilot Program in the evaluation described above is restricted by several factors:

1. **Scale** - To create population-level changes in disease and death, a larger number of mobile health units would be necessary. This is not the intent of a pilot program or a pilot study. Instead, this pilot program relies on published science to replicate a program with an established evidence base and identify necessary modifications to develop it in a new setting.
2. **Time** - Measurable improvements for many health conditions, especially chronic ones, can take years, if not decades, to manifest. For example, the effects of a healthy eating program focused on youth, aimed at reducing the risk of Type 2 diabetes later in life, may take a decade or more to be seen. At the same time, there are some health services, especially in communicable disease control, where mobile health units may have a more immediate effect. For example, early detection of a sexually transmitted infection (e.g., syphilis or gonorrhea) can prevent its spread to others and allow for quick treatment. Thus, tracking of *specific* health outcome measures may be possible within the evaluation period, but the evaluation does not allow for longitudinal tracking by the patient, which is costly and beyond the ethical scope of the current program evaluation. The evaluation team could collect process data about the number of people served by mobile health units and general descriptions of services provided. While these process measures do not directly demonstrate health outcomes, they are important indicators of program reach and service delivery.
3. **Service readiness level of grantees** - As noted, grantees are at different stages in their development toward providing health care

services, meaning that some of them have had less time to create inroads into communities and build trusting relationships with community members/patients/clients. This limits the amount of data the evaluation team can collect from these grantees, potentially weakening the evaluation results, especially in terms of generalizability.

Environmental Scan

Rede conducted an environmental scan to examine current conditions, trends, and factors that can impact mobile health in Oregon.

Identifying mobile health operators in Oregon

As a first step in conducting an environmental scan, Rede attempted to identify all “current” (as of October 2025) mobile health operations in Oregon. The **mobile health operators scan** captured over 50 mobile health units (MHUs) that met the assessment’s definition, operated by 40 organizations (including 8 Mobile Health Unit Pilot Program grantees).

The number and service areas of mobile health operators and units must be considered through the lens of limitations to finding and documenting mobile health operations. For the purposes of this report, it is essential to note that this mobile health operator scan is a point-in-time snapshot of mobile health operations in Oregon. The mobile health landscape is constantly shifting as operators' capacity and priorities change; moreover, current national changes in health care and health equity policy create a volatile environment for mobile health.

Mobile health operators included Local Public Health Authorities (LPHAs) and county health departments, Federally Qualified Health Centers (FQHCs), Community-Based Organizations (CBOs), universities, and other private-sector organizations such as hospitals. The mobile health operator scan includes eight OHA Mobile Health Unit Pilot Program grantees, with short-term funding through HB 4052 (2022), who are operating a total of 13 mobile health units. However, the grantees have been separated in this report to reflect the mixed state of their mobile health operations (i.e., from fully operational to just starting).

Engagement

Rede consulted mobile health experts in Oregon and nationwide, including those at Oregon Health and Science University, Harvard University, and the Oregon Health Authority, Public Health Division, to determine the best methods for identifying mobile health operators and units.

Methods

Rede scanned for mobile health operators and units by collecting primary data from mobile health operators and utilizing several secondary data sources (see list below). Rede included mobile health programs in the scan using the exclusion and inclusion criteria described on page 19. Below is a list of all the methods used to produce the findings in the scan.

Primary Data Collection

- A survey was sent to CBOs, FQHCs, universities, and other public or private-sector organizations identified as possibly having a mobile health operation on their websites or other online sources.
- Directly contacting LPHAs, CBOs, FQHCs, universities, and other public or private sector organizations to verify their MHUs via email and/or telephone.
- Collaborative meetings, including interviews and discussions with mobile health leaders in Oregon.

Secondary Data Collection

- Harvard Mobile Health Map[3]
- Oregon Primary Care Association's Mobile Clinic Map
- Internet desk research results
- Previous environmental scan conducted by Rede in 2023[4]
- Journal articles, peer-reviewed research, and university research on MHUs in Oregon

[3] Harvard Mobile Health Map. https://www.mobilehealthmap.org/
[4] Rede Group & OHA's Mobile Health Pilot Program Evaluation Plan and Environmental Scan

- Systematic review of Community Health Assessments and Community Health Needs Assessments (CHAs/CHNAs) and Community Health Improvement Plans (CHIPs), described below

Exclusion Criteria

MHUs were excluded from the scan results if they did not align with the following operational definition:

For the purpose of the mobile health operators scan, a mobile health unit refers to any vehicle-based platform—such as a van, bus, or trailer—staffed to deliver health care services directly into the community. These criteria emphasize the vehicle's functional role in enabling and delivering care.[5] Specifically, units were excluded if they:

- Did not utilize specialized vehicles as the primary means of delivering or transporting care;[6]
- Operated solely from fixed locations, rather than being mobile and community-integrated;
- Functioned primarily as transportation services or medicine delivery models (e.g., patient shuttles, meds on wheels programs) rather than platforms for direct care delivery or chartering patients; or
- They were not designed to bring health care services to underserved or remote areas, thereby failing to meet the community-based outreach intent of mobile health (e.g., a pop-up immunization van for a corporate event, serving as an on-site, mobile clinic that provides vaccinations to employees as part of a seasonal wellness program).

Inclusion Criteria

Any vehicle-based platform—such as a van, bus, or trailer—staffed to deliver health care services (physical, mental, oral, or vision) directly into the community. MHUs that were currently operational or would be operational by the summer of 2026 and that did not meet the exclusion criteria listed above.

[5] Georgetown University. (n.d.). *Beyond the clinic walls: Exploring the potential of mobile health*. https://chir.georgetown.edu/wp-content/uploads/Beyond-the-Clinic-Walls.pdf

[6] The exclusion criteria in the mobile health operators scan may differ from general definitions of mobile health, particularly regarding specialized vehicles.

Data Collected

Across all primary and secondary data collection methods, Rede attempted to capture the following variables for each MHU in the scan.

- Focus population served:
    - Communities of Color
    - The Nine Federally Recognized Tribes in Oregon and their members (Tribal Communities)
    - Low-income
    - Person(s) with disabilities
    - LGBTQIA2S+ populations
- The number of MHUs the organization currently operates
- Services the MHU(s) offer
- Geographic service areas

To gather this information, Rede utilized a mix of primary and secondary research. A limitation of this secondary research is explained in the limitations section.

Results

Below is a comprehensive list (as of 10/31/2025) of mobile health operations identified in the scan and meeting the inclusion criteria. The scan found that 40 mobile health operators (including the 10 Mobile Health Unit Pilot Program grantees, past and current) are operating 50 mobile health units across the state. The full range of services offered by mobile health units includes:

- Blood testing
- Chronic disease management
- Communicable disease
- Dentistry
- Food & water provision
- General medical attention/wound care
- Insurance enrollment
- Language services

- Mental health/ wellness checks
- Mother & infant care
- Opioid treatment and prevention
- Optometry
- Referrals
- Showers
- Sports physicals
- Sexually transmitted disease (STD) testing and prevention
- Vaccinations
- Wraparound services

Mobile Clinic Name/ Organization	Population served	Number of MHUs	Geographic service location	Services of MHU
ADAPT Mobile Medical Clinic	Communities(y) of color, low-income	1 MHU	Douglas County	• Chronic disease management • General medical attention/wound care • Mother & infant care • STD testing and prevention
Aviva Health Mobile Clinic	Communities(y) of color, low-income	2 MHUs	Douglas County	• Blood testing (and donation) • Chronic disease management • Vaccinations
Cascadia Mobile Health Unit	Communities(y) of color, low-income	1 MHU	Multnomah County	• Mental health/wellness checks
Clatsop County Mobile Health/Clinic	Communities(y) of color	1 MHU	Clatsop County	• Referrals • STD testing and prevention • Vaccinations
Central City Concern*	Communities(y) of color, LGBTQIA2S+, low-income, persons with disabilities	2 MHUs	Multnomah County	• Wound care • Mental health/wellness checks
Columbia County Health Services Mobile Health Van	Communities(y) of color, low-income	1 MHU	Columbia County	• Mental health/wellness checks
Cultivate Initiatives Shower Unit	Communities(y) of color, LGBTQIA2S+, low-income, persons with disabilities	1 MHU	Multnomah County	• Showers
Daisy C.H.A.I.N*	Communities(y) of color, LGBTQIA2S+, low-income, persons with disabilities	1 MHU	Lane County	• Mother & infant care • Mental health/wellness checks
Envision Eye Care	Communities(y) of color, LGBTQIA2S+, low-income, persons with disabilities, tribal communities(y)	1 MHU	Gilliam, Hood River, Sherman, Wasco Counties	• Chronic disease management • Language services • Optometry • Referrals

Mobile Clinic Name/ Organization	Population served	Number of MHUs	Geographic service location	Services of MHU
Fem Forward Health	Communities(y) of color, low-income	1 MHU	Multnomah County	• Mother & infant care
Greater New HOPE Charities	Communities(y) of color, low-income	1 MHU	Multnomah County	• Chronic disease management • General medical attention/wound care
Lincoln County Mobile Van*	Communities(y) of color, low-income	1 MHU	Lincoln County	• Vaccinations • STD testing and prevention • General medical attention/wound care • Referrals • Insurance enrollment (OHP)
Marion County Health & Human Services Van	Communities(y) of color, LGBTQIA2S+, low-income, persons with disabilities	1 MHU	Marion County	• STD Testing and Prevention
Medical Teams International*	Communities(y) of color, LGBTQIA2S+, low-income, persons with disabilities, tribal communities(y)	4 MHUs	Statewide	• Dentistry
Mobile Mammography/ Breast Health Clinic/Hillsboro Medical Center	Communities(y) of color, LGBTQIA2S+, low-income	1 MHU	Within a 75-mile radius of the Forest Grove area (Washington, Multnomah, Clatsop, Marion, Clackamas counties)	• Mother & infant care • Referrals
Morrow County/Boardman Mobile Clinic	Communities(y) of color, LGBTQIA2S+, low-income, persons with disabilities	1 MHU	Morrow County	• Chronic disease management • General medical attention/wound care • STD testing and prevention

Mobile Clinic Name/ Organization	Population served	Number of MHUs	Geographic service location	Services of MHU
Mosaic Community Health	Communities(y) of color, low-income	2 MHUs	Central Oregon	• Chronic disease management • Food & water provision • General medical attention/wound care • Language services • Mental health/wellness checks • Opioid treatment and prevention • STD testing and prevention • Vaccinations • Wraparound services
Multnomah County Mobile Clinic	Communities(y) of color, LGBTQIA2S+, low-income, persons with disabilities, tribal communities(y)	1 MHU	Multnomah County	• Blood testing (and donation) • Chronic disease management • Communicable disease testing and prevention • Dentistry • General medical attention/wound care • Mother & infant care • Opioid treatment and prevention • STD testing and prevention • Referrals • Vaccinations • Wraparound services
New Season Methadone Clinic	Communities(y) of color, LGBTQIA2S+, low-income, persons with disabilities, tribal communities(y)	1 MHU	Multnomah County	• Mental health/wellness checks • Opioid treatment and prevention
OHSU Casey Eye Institute	Communities(y) of color, LGBTQIA2S+, low-income, persons with disabilities, tribal communities(y)	1 MHU	Statewide	• Optometry
OHSU Knight Cancer Institute	Communities(y) of color, LGBTQIA2S+, low-income, persons with disabilities, tribal communities(y)	1 MHU	Statewide	• Chronic disease management

Mobile Clinic Name/ Organization	Population served	Number of MHUs	Geographic service location	Services of MHU
One Community Health/La Clinica Mobile Clinic	Communities(y) of color, low-income	1 MHU	Gilliam, Hood River, Sherman, Wasco County	• Chronic disease management • Communicable disease testing and prevention • General medical attention/wound care • Mental health/wellness checks • Opioid treatment and prevention • Optometry • Referrals • Wraparound Services
Pacific Eye Van	Communities(y) of color	1 MHU	Clark, Gillam, Hood River, Multnomah, Polk, Wasco, Washington, Yamhill Counties	• Optometry
Portland Street Medicine	Communities(y) of color, low-income	1 MHU	Multnomah County	• Chronic disease management • General medical attention/wound care • Food & water provision • Mental Health/wellness checks • Vaccinations • Wraparound services
Raíces De Bienestar*	Communities(y) of color, low-income	1 MHU	Columbia, Multnomah, Washington, and Yamhill Counties	• Mental health/wellness checks

Mobile Clinic Name/ Organization	Population served	Number of MHUs	Geographic service location	Services of MHU
Salud! Covid-19 Clinic	Communities(y) of color, low-income	2 MHUs and 1 utility vehicle	Willamette Valley	• Chronic disease management • Communicable disease testing and prevention • Dentistry • General medical attention/wound care • Optometry • Referrals • Wraparound services • Vaccinations
Sky Lakes Mobile Clinic	Communities(y) of color, low-income	1 MHU	Klamath County	• Chronic disease management • Communicable disease testing and prevention • General medical attention/wound care • Mental Health/wellness checks • Referrals • Vaccinations
Smile Care Everywhere	Communities(y) of color, LGBTQIA2S+, low-income, persons with disabilities, tribal communities(y)	1 MHU	Clark, Gilliam, Hood River, Multnomah, Polk, Wasco, Washington, and Yamhill Counties	• Dentistry
St. Alphonsus Mobile Fleet*	Communities(y) of color, low-income	2 MHUs	Malheur County	• Chronic disease management • General medical attention/wound care
Tayas Yawks*	Tribal communities(y)	1 MHU	Klamath County	• Chronic disease management
The Confederated Tribes of Grand Ronde (Great Circle Recovery Opioid Treatment	Tribal communities(y)	1 MHU	Grand Ronde Tribal Area	• Opioid treatment and prevention

Mobile Clinic Name/ Organization	Population served	Number of MHUs	Geographic service location	Services of MHU
Program)*				
The Dental Foundation of Oregon/The Tooth Taxi	Communities(y) of color, LGBTQIA2S+, low-income	1 MHU	Statewide	• Dentistry
Tillamook County Community Mobile Clinic	Communities(y) of color, LGBTQIA2S+, low-income, persons with disabilities	1 MHU	Tillamook County (School Districts)	• Dentistry
Urban League of Portland*	Communities(y) of color, low-income,	1 MHU	Multnomah County	• Chronic disease management • General medical attention/wound care • STD testing and prevention
Virginia Garcia Mobile Health Unit	Communities(y) of color, low-income	2 MHUs	Washington, Yamhill Counties	• Dentistry • General medical attention/wound care • STD testing and prevention • Sports Physicals • Vaccinations
Vision To Learn (Portland's Van)	Communities(y) of color, LGBTQIA2S+, low-income, persons with disabilities	1 MHU	Multnomah County	• Optometry • Referrals
Washington County Health and Human Services Division of Public Health/Harm Reduction Mobile Vans	Communities(y) of color, LGBTQIA2S+, low-income, persons with disabilities, tribal communities(y)	2 MHUs	Washington County	• Chronic disease management • Food & water provision • General medical attention/wound care • Insurance enrollment • Referrals • STD testing and prevention • Vaccinations
Waterfall Clinic/Waterfall Mobile Unit	Communities(y) of color, LGBTQIA2S+, low-income	1 MHU	OSU Extension Center/Coos County	• Chronic disease management • Dentistry • Food & water provision • General medical attention/wound care

Mobile Clinic Name/ Organization	Population served	Number of MHUs	Geographic service location	Services of MHU
				• Language services • Mental health/wellness checks • STD testing and prevention • Referrals • Vaccinations • Wraparound services
White Bird/CAHOOTS	Communities(y) of color, low-income	1 MHU	Lane county	• General medical attention/wound care • Mental health/wellness checks • Opioid treatment and prevention • Referrals
Wy-Kan-Ush-Pum	Communities(y) of color, low-income, tribal communities(y)	1 MHU	Columbia River and Surrounding Communities	• Dentistry • General medical attention/wound care • Insurance enrollment

*Mobile Health Unit Pilot Program grantee (past or current).

Geographic Locations of Mobile Health Operators

Figure 2 (below) shows the locations of all mobile health operators identified in the mobile health operators scan; collectively, these operators provide 50 MHUs in Oregon. It is important to note that the mapped locations represent addresses of organizational bases or administrative offices of the MHUs, and do not reflect their geographic service areas, which could, and do, span multiple regions or counties in Oregon.

Figure 2: Point locations of mobile health operators in Oregon

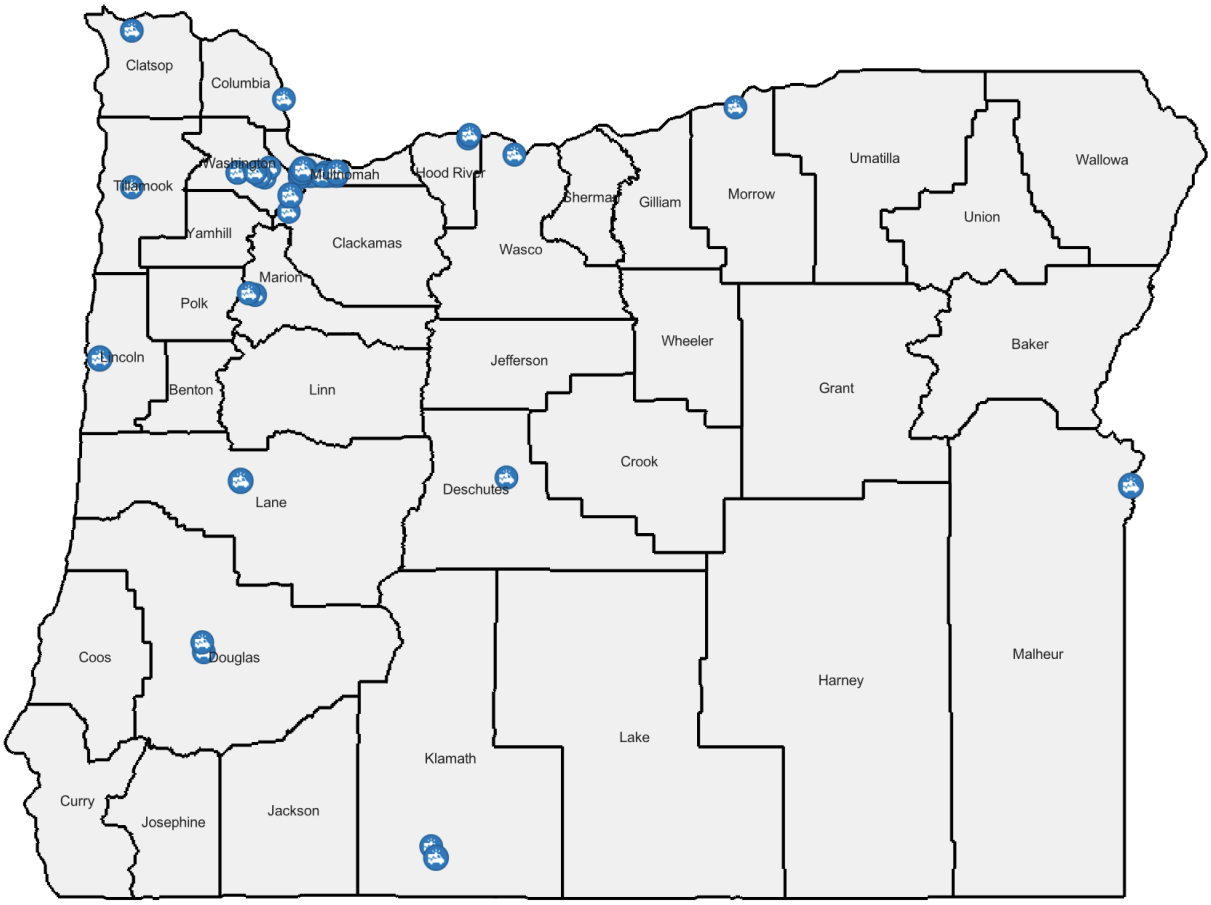
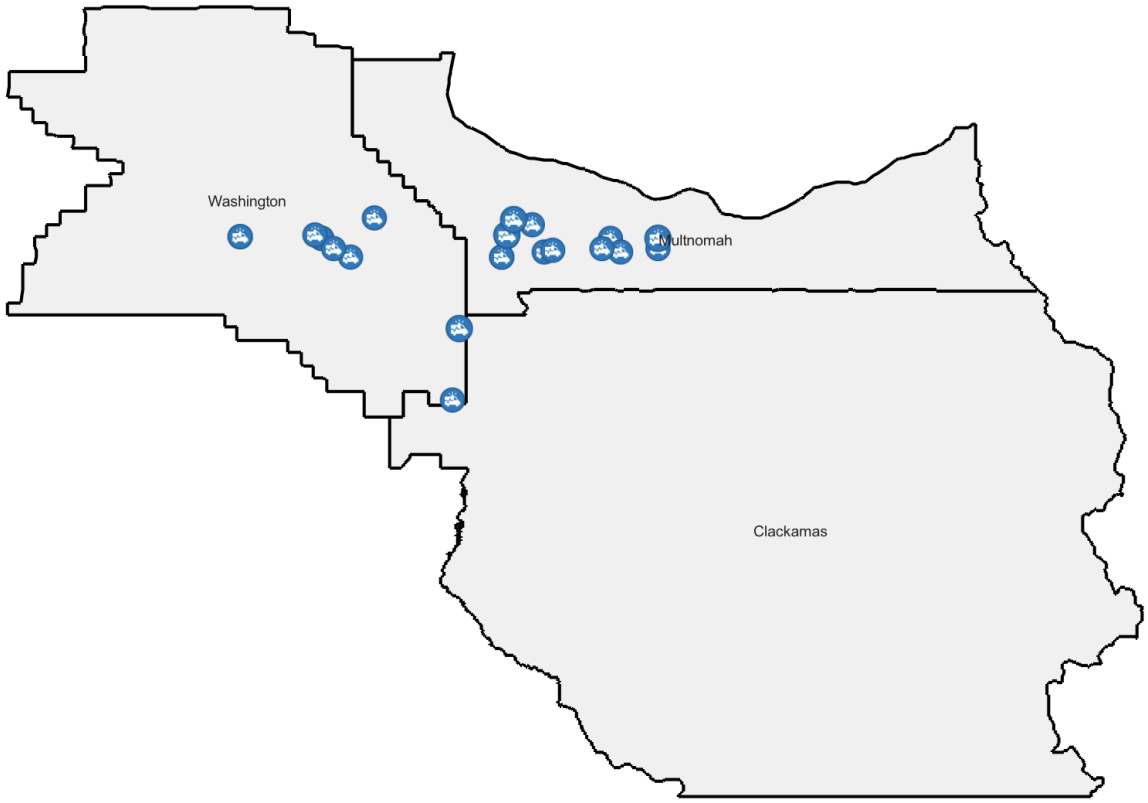


Figure 3: Zoom-in view of mobile health operators in the Portland Metro tri-county area



The table below estimates the number of services delivered by mobile health units in the scan across Oregon.

Service	Count of MHUs delivering service
Chronic disease management	17
General medical attention/wound care	15
Referrals	12
Mental/Behavioral health/wellness checks	12
STD testing and prevention	11
Vaccinations	11
Dentistry	9
Optometry	6
Opioid treatment and prevention	6
Mother and infant care	5

Food & water provision	4
Communicable disease control and prevention	4
Language services	3
Insurance enrollment	3
Blood testing	2
Showers	1
Sports physicals	1

Below is a table of estimated priority populations served by mobile health units in the scan across Oregon.

Priority Population	**Count of MHUs serving the priority population**
Communities(y) of color	38
Low-income	36
LGBTQIA2S+	18
Persons with disabilities	15
Tribal communities(y)	10

Examples of excluded mobile health units:

- Portland Meds on Wheels: Determined to be a van that solely delivers medications to seniors, thus operating primarily as a transportation service, which does not meet the definition of a mobile health van.
- Multnomah Mobile Book Library: Determined not to offer health care services for underserved populations.

Community Health Assessment/Community Health Needs Assessments and Community Health Improvement Plans Review

As a part of the environmental scan, Rede analyzed 20 community health assessments (CHAs) and 9 community health needs assessments (CHNAs) across all 36 counties in Oregon. Rede also reviewed 16 community health

improvement plans (CHIPs) to identify mentions of mobile health as a priority and model of care to address health care access and unmet needs of Oregonians.

The systematic review process included scanning all CHA, CHNA, and CHIP documents for the mention of a mobile health unit/clinic/van/vehicle/motor. Rede then assessed the method by which CHAs and CHNAs engaged and/or sought feedback from the community, and which populations were identified and prioritized in the assessments. Additionally, Rede assessed content related to lack of trust, discrimination, and the need for culturally and linguistically responsive health care within these assessments and plans. This approach supports the legislatively mandated feasibility study, which includes identifying and developing a mobile health unit or model of care that is culturally and linguistically responsive and meets the needs of the priority populations outlined in HB 4052 (2022). Through this review, the goal was to help understand the need and urgency for providing health care that is mindful and sensitive to cultural and racial differences.

Results

Six counties mentioned mobile health services in their CHAs/CHNAs, three of which—Clatsop, Morrow, and Tillamook—had operational mobile health units at the time of the review; these have been included in the mobile health operators scan, above. One county (Columbia) had recently acquired a new mobile health van; however, it was not yet operational during the review period. Two counties (Malheur and Umatilla) noted the presence of mobile health units in their assessments, but Rede was unable to verify their current operation or obtain additional information, despite contacting them.

Six counties referenced mobile health services in their CHIPs in various capacities. One county (Tillamook) mentioned its mobile health unit as a relevant program and an asset in the community; three counties (Columbia, Hood River, and Yamhill) included expanding mobile health services as strategies in their CHIPs; one county (Marion) noted the presence of a mobile health crisis unit; and one county (Washington) highlighted a successful COVID-19 testing mobile van initiative in their CHIP.

Populations engaged and prioritized in the CHAs, CHNAs, and CHIPs were similar to priority populations identified in HB 4052 (2022). These included, but were not limited to, communities of color, farmworkers, immigrants, the LGBTQIA2S+ community, people experiencing homelessness, caregivers, older adults, people with disabilities, etc.

CHA/CHNAs' engagement methods with priority populations included: focus groups, community health surveys, key informant interviews, panel discussions, listening sessions, and telephone interviews.

Of the 29 CHAs and CHNAs assessed, 12 community assessments reported a lack of culturally and linguistically responsive care, with community members voicing a need for more diverse and bi/multicultural (i.e., providers with two or more cultural identities) service providers. Eleven assessments highlighted distrust of the health care system and fear among community members in accessing services. In the CHAs/CHNAs, community members also brought up feeling discriminated against, shamed, embarrassed, and anxious while seeking health services. These findings highlight a critical gap in culturally responsive, trusted care that could be addressed by mobile health units staffed with providers who reflect the communities they serve and are trained in culturally and linguistically responsive care.

Efforts to Improve Mobile Health Care in Oregon

The environmental scan methods surfaced areas of interest and momentum toward increasing access to mobile health.

Efforts to improve or increase mobile health in Oregon are happening outside of efforts driven by the state government. For example, a regional mobile health collaborative (Clackamas, Columbia, Multnomah, and Washington counties) led by the Multnomah County Health Department meets regularly to share resources and lessons learned and assist in mobile health operations. In addition, Multnomah County is developing a mobile health map web-based application to increase visibility and accessibility of mobile health units in the region.

Nationally, the philanthropically funded Driving Health Forward initiative is advocating for a mobile health set-aside within Rural Health Transformation (RHT) Program funds. While it is unclear if policymakers in Oregon will determine that mobile health is an appropriate use of RHT funds, the tools and resources developed by Driving Health Forward can be used in Oregon to support the sustainability and scalability of mobile health.

The Oregon Mobile Integrated Healthcare Coalition, a non-profit organization dedicated to supporting and advancing Mobile Integrated Healthcare (MIH), organizes initiatives throughout the state to bring together healthcare providers, emergency services, and community interest holders to improve access to quality care, reduce healthcare costs, and enhance patient outcomes. MIH, also called Community Paramedicine (CP), is a mobile care delivery model that brings resources to patients in a home or community-based setting, frequently using specially trained EMTs, paramedics, nurses, Medical Assistants (MAs), and CHWs to support patients with chronic disease management, preventative care, and wraparound, health-related services. According to the MIH Coalition, MIH programs have been shown to reduce 911 call volume, emergency department utilization, and 30-day hospital readmissions, all while increasing cost savings for healthcare and EMS organizations and, importantly, bringing critical health services to people who otherwise may lack access.[7]

Finally, in 2025, ORH received a mobile health care grant from the federal Health Resources and Services Administration (HRSA) to support mobile integrated health services in rural Oregon.[8] ORH is working with Wheeler County to launch a pilot MIH project and study the potential to scale this program to other rural regions in Oregon.

[7] Oregon Mobile Integrated Healthcare Coalition. (n.d.) *Empowering mobile healthcare in Oregon.* https://oregonmihc.org

[8] Denham, L. (2025, August 19). Wyden, Merkley announce $1 million grant to establish a new mobile integrated health program in Wheeler County. Merkley. https://www.merkley.senate.gov/wyden-merkley-announce-1-million-grant-to-establish-a-new-mobile-integrated-health-program-in-wheeler-county/

This environmental scan revealed efforts by some health care advocates and organizations to expand and improve mobile health in Oregon. In the subsequent phases of the Mobile Health Unit Pilot Program evaluation and feasibility study, Rede will continue to gather information about strategic opportunities and other factors that inform decisions on mobile health in Oregon.

Limitations in Environmental Scan

Shifts in Funding Landscape and Federal Policies

The task of identifying all mobile health units in Oregon revealed environmental factors that must be considered when reviewing the scan. First, mobile health units are not registered or licensed in Oregon. Thus, identifying all mobile health units requires extensive fieldwork and is likely to be incomplete, despite the study team's robust efforts.

Second, shifts in federal policies have affected the funding climate for public health, community-based organizations, and health care. This may cause additional fluctuation in the type and number of mobile health units throughout Oregon. For example, faced with significant budget concerns, Clackamas County Public Health announced in October 2025 the immediate closure of its Mobile Health Services/Van. Other providers may have increased or decreased their mobile health operations since this scan was conducted due to the volatile nature of health care funding.

Federal policies aimed at deporting immigrants who are in the country without permission have a widespread, adverse effect on immigrants and refugees who do not face deportation but fear it nonetheless. MHUs serving these groups face enormous challenges in serving and ensuring the safety of these individuals; to ensure services are culturally competent, MHUs serving immigrant and refugee communities may need to maintain a lower profile.

Determining Priority Populations Served

Rede also encountered challenges collecting information on the “priority population served” by mobile health units. For MHUs in the scan that completed the primary data collection survey, the priority population was clearly reported. However, for MHUs in the scan that did not complete the survey, Rede analysts conducted desk research, reviewing various sections of the organization's website or strategic plan to determine whether the MHU serves one or more of the priority populations. For example, if the website indicated the population served, the analyst would mark that in the scan (e.g., “we serve Black and Latino/a communities," which constituted “communities of color” as a priority population served, or “we use a sliding fee scale,” which constituted a “low income population” being served). In addition, information gathered from both survey responses and secondary research on priority populations served is self-reported and may be based on hypothetical circumstances. For example, an MHU may have indicated that they serve “Tribal communities” because they *would* serve a Tribal member who needed care if they came to the mobile health unit for care. This does not necessarily mean that these units actively travel to Tribal communities to provide services. Thus, the scan may present an overrepresentation of the number of mobile health units that have actually served specific populations.

Needs Assessment (Phase 1)

HB 4052 directed OHA to conduct a statewide mobile health care needs assessment. The first phase of the needs assessment entailed looking at the areas of the state where people have less access to health care, including physical and mental health.

Engagement

Rede reached out to the Oregon Office of Rural Health (ORH) to obtain data on Areas of Unmet Health Care Need (AUHCN) and primary care service areas in Oregon to develop maps as shown in Figures 4 and 5.

Methods

Rede employed the following methods to map the health care needs of priority populations, identify underserved geographic areas, and determine how mobile health could help address those needs:

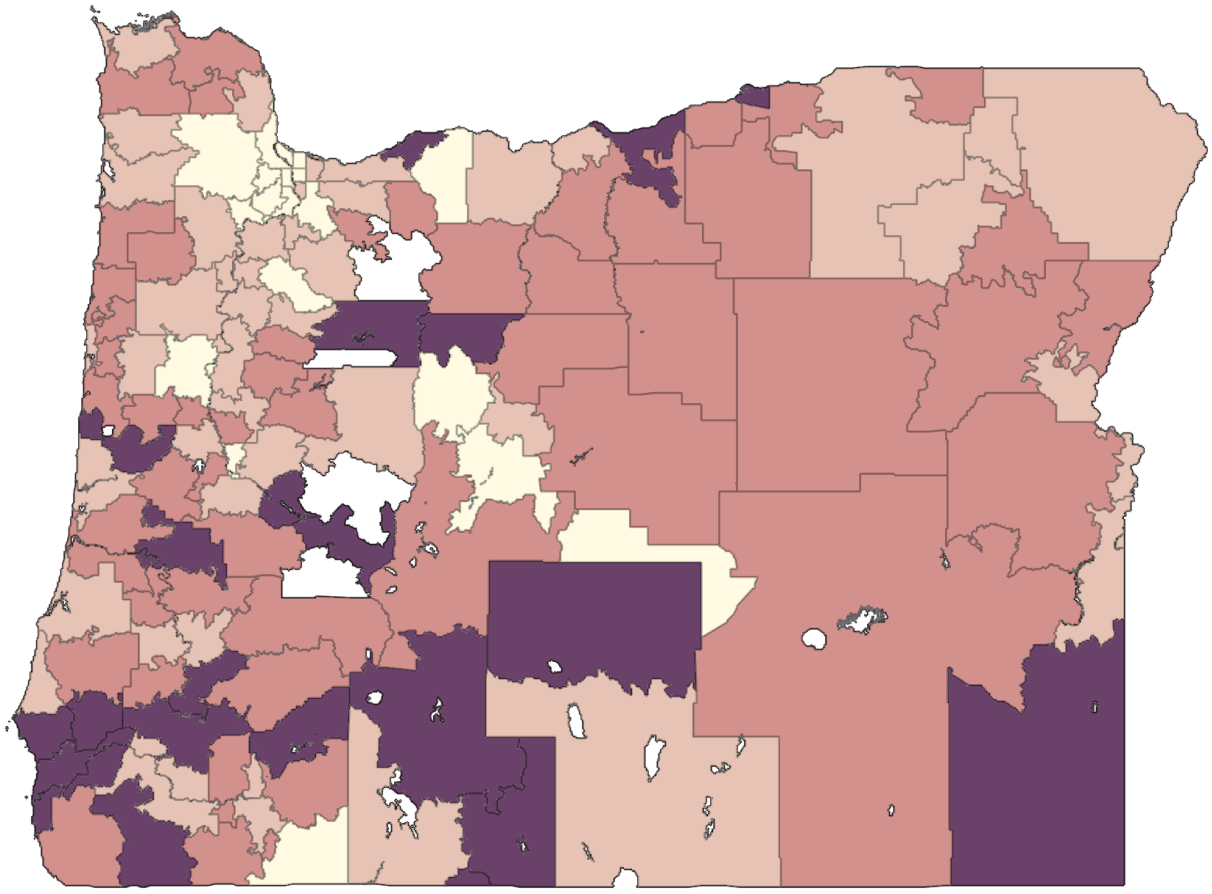
Areas of Unmet Health Care Need

Each year, ORH conducts an assessment of the unmet health care needs of Oregonians. The AUHCN designation uses 9 variables that measure primary, dental, and mental health care availability, affordability, and utilization to calculate a composite Unmet Health Care Need score.[9] Figure 4 shows the Unmet Health Care Need scores for 128 primary care service areas in Oregon as established by ORH with assistance from other state and local agencies. The scores range from 0 to 90, with lower scores indicating higher unmet need. For 2024, scores ranged from 21 (East Klamath - indicating the greatest unmet need) to 78 (Portland SW - indicating the least unmet need)

[9] Oregon Office of Rural Health. (2025). Areas of Unmet Health Care Need. Oregon Health & Science University. https://www.ohsu.edu/sites/default/files/2025-09/AUHCN%20Report_2025%20-%20FINAL.pdf

Results

Figure 4: Areas of Unmet Health Care Need (scores) in Oregon[10]



Map Legend:

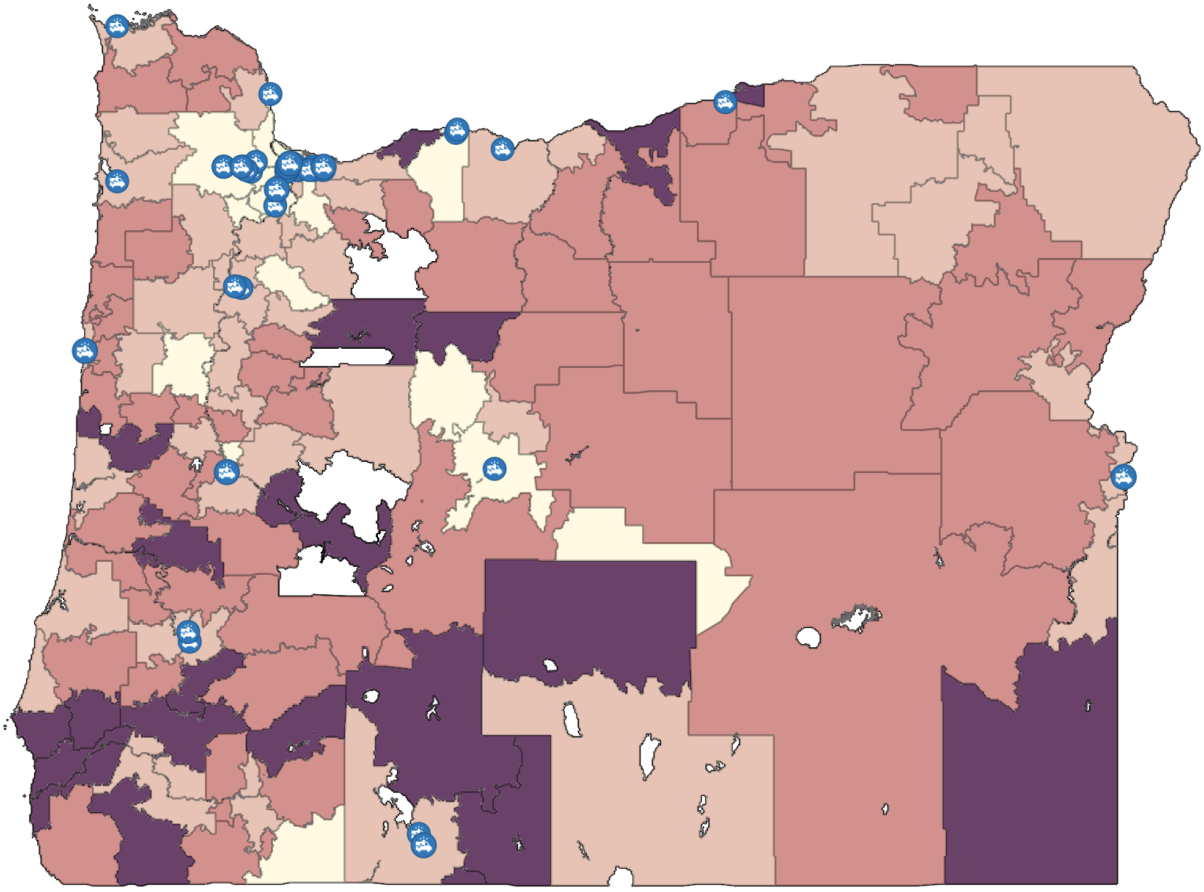
- 64-78 (low unmet need)
- 50-63
- 36-49
- 21-36 (high unmet need)
- No score available

Figure 5 on the following page shows the locations of mobile health operators identified in the mobile health operators scan (on Page 33) superimposed on the AUHCN map. There is a higher concentration of mobile health operators based in the Portland metro tri-county area (Clackamas, Multnomah, and

[10] Data used to create this map was obtained from the ORH website

Washington) and along the I-5 corridor, areas with typically lower unmet health care needs. However, it is important to note that the tri-county area also accounts for 44% of the state's population,[11] and the absolute number of people with unmet health care needs might still be significant.

Figure 5: Mobile Health Operators' locations along with AUHCN[12]



Map Legend:

- 64-78 (low unmet need)
- 50-63
- 36-49
- 21-36 (high unmet need)
- No score available

[11] *Oregon counties by population (2025)*. World Population Review. https://worldpopulationreview.com/us-counties/oregon

[12] Point locations represent addresses of organizational bases or administrative offices of the MHUs, and do not reflect their geographic service areas, which could, and do, span multiple regions or counties in Oregon.

What's next?

Between November 2025 and May 2026, Rede will continue data collection, analysis, and interpretation to finalize the needs assessment and feasibility study and develop recommendations for a statewide mobile health program.

Needs Assessment and Feasibility Study: Methods

To study the feasibility and parameters of statewide implementation of a mobile health program, Rede will conduct the following activities and present findings in the final report due to the Oregon State Legislature by June 30.

1. Interviews with LPHAs and Community-Based Organizations
2. Interviews with mobile health key informants
3. Further analysis of Medically Underserved Areas/Areas of Unmet Health Care Needs
4. Identification of a culturally and linguistically specific mobile health unit model that can meet Oregon's needs for addressing racism as a barrier to quality health care
5. Analysis of Mobile Health Unit Pilot Program grantee activity and expense reports, and client questionnaires
6. Individual structured interviews and site visits with the Mobile Health Unit Pilot Program grantees

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OREGON HEALTH AUTHORITY

Appendix A: Mobile Health Unit Pilot Program Evaluation Plan[13]

Key Evaluation Questions

The following key evaluation questions (KEQs), developed in collaboration with OHA and Cohort 1 Mobile Health Unit Pilot Program grantees, will guide this evaluation[14]:

1. To what extent did OHA Mobile Health Unit Pilot Program grantees provide services for priority populations?
2. To what extent did OHA Mobile Health Unit Pilot Program grantees connect clients with primary care/health care specialists and other health care resources?
3. In what ways, if any, did OHA Mobile Health Unit Pilot Program grantees provide culturally and linguistically specific care?
4. In what ways, if any, did clients of OHA Mobile Health Unit Pilot Program grantees believe the services were safe and trustworthy?
5. How did OHA Mobile Health Unit Pilot Program grantees engage community members in determining and developing services?
6. What elements would be needed to sustain the OHA Mobile Health Unit Pilot Program?
7. What elements would be required to scale the OHA Mobile Health Unit Pilot Program?
8. What were the key lessons learned from the OHA Mobile Health Unit Pilot Program regarding the structuring of services, service models, service delivery, community partnerships, and payment models?

[13] This evaluation draws on an MHU Pilot Program evaluation plan developed in 2023. It has been reviewed and revised in 2025.

[14] This evaluation plan does not include key evaluation questions addressing the long-term objectives in the logic model; rather, it is focused on evaluating the success of OHA Mobile Health Unit Pilot Program grantees in meeting short- and medium-term objectives with the assumption (grounded in the scientific literature) that long-term outcomes will occur if short- and medium-term outcomes are achieved and no unforeseen moderating variables are introduced.

Methods

Rede will employ four processes or methods to gather credible information to answer the key evaluation questions. These are as follows:

Individual Structured Interviews/Site Visit with Mobile Health Unit Pilot Program Grantee Leadership

Rede will arrange and conduct interviews or site visits with key staff from each of the eight Mobile Health Unit Pilot Program grantees funded in 2025. Interviews can be conducted in person or over Zoom and will last approximately one to two hours.

- Recognizing that the eight grantees are at varying stages of implementation, the interview guide will be tailored to reflect the specific stage of implementation for each grantee.
- Rede will develop a structured interview guide with questions focused on community engagement, service provision, sustainability, scalability, lessons learned, and impact stories. A professional interviewer (from the Rede team) will conduct the interviews, and interviewees will be offered anonymity to improve the quality of information gathered.
- There may be a subset of questions that are asked of the OHA Mobile Health Unit Pilot Program grantee who has received two rounds of funding to better understand the process of implementing a longer-running pilot project.
- Interviews will be recorded and transcribed using Rev, a transcription service.

This method will help us answer the following evaluation questions:

- KEQ 1: To what extent did OHA Mobile Health Unit Pilot Program grantees provide services for priority populations?
- KEQ 2: To what extent did OHA Mobile Health Unit Pilot Program grantees connect clients with primary care/health care specialists and other health care resources?

- KEQ 3: In what ways, if any, did OHA Mobile Health Unit Pilot Program grantees provide culturally and linguistically specific care?
- KEQ 4: In what ways, if any, did clients of OHA Mobile Health Unit Pilot Program grantees believe the services were safe and trustworthy?
- KEQ 5: How did OHA Mobile Health Unit Pilot Program grantees engage community members in determining and developing services?
- KEQ 6: What elements would be needed to sustain the OHA Mobile Health Unit Pilot Program?
- KEQ 7: What elements would be required to scale the OHA Mobile Health Unit Pilot Program?
- KEQ 8: What were the key lessons learned from the OHA Mobile Health Unit Pilot Program regarding the structuring of services, service models, service delivery, community partnerships, and payment models?

Survey of OHA Mobile Health Unit Pilot Program Grantees' Staff and Volunteers

Rede will conduct a questionnaire survey of OHA Mobile Health Unit Pilot Program grantees (non-leadership) staff and volunteers to gather insights from their unique perspectives. The survey will include approximately 25 questions and will take no longer than 15 minutes to complete (on average).

- Rede will develop a survey that is sent to all direct service staff, providers, and volunteers of Mobile Health Unit Pilot Program grantees.
- Rede will work with Mobile Health Unit Pilot Program grantees to create a survey distribution list.
- Questions will focus on lessons learned for launching and maintaining a culturally-responsive mobile health unit.
- This survey will be open for around a month, and a gift card drawing for incentives could be integrated if appropriate.
- Rede will analyze these data by conducting descriptive analyses, accompanied by data visualizations, to disseminate the results.

This method will help us answer the following evaluation questions:

- KEQ 1: To what extent did Mobile Health Unit Pilot Program grantees provide services for priority populations?
- KEQ 2: To what extent did OHA Mobile Health Unit Pilot Program grantees connect clients with primary care/health care specialists and other health care resources?
- KEQ 3: In what ways, if any, did OHA Mobile Health Unit Pilot Program grantees provide culturally and linguistically specific care?
- KEQ 4: In what ways, if any, did clients of OHA Mobile Health Unit Pilot Program grantees believe the services were safe and trustworthy?
- KEQ 8: What were the key lessons learned from the OHA Mobile Health Unit Pilot Program regarding the structuring of services, service models, service delivery, community partnerships, and payment models?

Analysis of Quarterly OHA Mobile Health Unit Pilot Program Grantee Activity, Expense Reports, and Client Questionnaires

Rede will synthesize and review information submitted by the Mobile Health Unit Pilot Program to OHA for grant reporting purposes, including:

1. Aggregate the priority population identity of clients;
2. Numbers served, type of service (clinical care, mental health care, and substance use disorder), and connections made to continued care;
3. Additional client, client service, and client outcome reporting requirements were developed in agreement between the OHA staff and grantees (i.e., Public Facing Survey Tool, developed by OHA); and
4. Expenditures

This method will help us answer the following evaluation questions:

- KEQ 1: To what extent did OHA Mobile Health Unit Pilot Program grantees provide services for priority populations?

- KEQ 2: To what extent did OHA Mobile Health Unit Pilot Program grantees connect clients with primary care/health care specialists and other health care resources?
- KEQ 3: In what ways, if any, did OHA Mobile Health Unit Pilot Program grantees provide culturally and linguistically specific care?
- KEQ 5: How did OHA Mobile Health Unit Pilot Program grantees engage community members in determining and developing services?
- KEQ 6: What elements would be needed to sustain the OHA Mobile Health Unit Pilot Program or to sustain the individual mobile health programs of grantees?
- KEQ 7: What elements would be required to scale the OHA Mobile Health Unit Pilot Program or to scale the individual mobile health programs of grantees?
- KEQ 8: What were the key lessons learned from the OHA Mobile Health Unit Pilot Program regarding the structuring of services, service models, service delivery, community partnerships, and payment models?

Analysis & Interpretation

Qualitative data:

- Rede will analyze individual interview transcripts using best practices for qualitative content thematic analysis or inductive analysis. Analysis of transcripts will be conducted using Atlas.ti, a qualitative analysis software. Transcripts will be human-coded.
- Narrative information in grantee reports submitted to OHA will also undergo qualitative analysis.
- Beyond thematic analysis, using the data collected, the evaluation team will focus on “impact narratives” or stories that demonstrate the effect of the Mobile Health Unit Pilot Program grantees’ services on members of the priority populations.

Quantitative data:

- Rede will tabulate numeric data from grantee reports, applying standards for data management and quality control.

- Rede will analyze numeric data from grantee reports using an analysis software and applying industry and best practices for descriptive statistics.
- Interpretation
- Rede will design and conduct a participatory interpretation process (exercise or workshop) with the OHA Mobile Health Unit Pilot Program, program grantees (based on availability), and partners to review preliminary results and inform meaning-making decisions.
- Rede will guide discussions on the effective and appropriate use of descriptive data to inform correlative, causal, or program-effect assessments.

Data Interpretation

Rede will design and conduct a participatory interpretation process (exercise or workshop) with the OHA Mobile Health Unit Pilot Program, program grantees (based on their availability), and partners (MHAC) to review preliminary results and inform meaning-making decisions. Rede will guide discussions about effective and appropriate uses of descriptive data to inform correlative, causal, or program effect assessments.