Medicaid Division

Mobile Health Unit Pilot Program

OREGON HEALTH AUTHORITY

Final Report: Mobile Health Unit Feasibility Study

Prepared by Rede Group in June 2026

Acknowledgments

This report was produced by Rede Group on behalf of the Oregon Health Authority, Medicaid Division, in June 2026. 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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Executive Summary

Background

In 2022, the Oregon Legislature passed House Bill 4052, directing the Oregon Health Authority to establish a mobile health unit pilot program to improve health outcomes for Oregonians impacted by racism.

The legislation also directed OHA to study the feasibility of a statewide Mobile Health Unit program. In response, OHA's Medicaid Division created the Mobile Health Unit Pilot Program, awarding grants totaling approximately $4.6 million across two funding cycles to 10 unique mobile health operators statewide. This report presents findings from both the pilot program evaluation and the statewide feasibility study.

Pilot program evaluation

Rede Group evaluated the pilot program through grantee interviews, a staff and volunteer survey, and the Public Facing Survey Tool (PFST) (which collects demographic data from health care clients). Eight grantees participated in in-depth interviews. Key findings are organized around eight key evaluation questions.

- Serving priority populations. All grantees explicitly served populations named in HB 4052.
- Connecting clients with care. Most grantees had strong referral practices but limited ability to confirm completed referrals.
- Culturally and linguistically responsive care. Every grantee built a care strategy to meet community needs. Approaches included hiring staff from priority populations, using trusted partner organizations as the entry point to services and adapting health education materials to match clients' literacy and cultural backgrounds.
- Safe and trustworthy services. Fear of immigration enforcement was the most cited barrier to building trust. All eight grantees described U.S. Immigration and Customs Enforcement (ICE) response protocols, privacy-protective intake and the use of trusted community partners as core safety practices.
- Sustaining the pilot program. Grantees identified continued, predictable funding as the top sustainability need, followed by Medicaid billing infrastructure, a workforce pipeline for commercial driver's license–qualified drivers and community health workers and statewide coordination among mobile providers.

Feasibility study

The feasibility study drew on an environmental scan of mobile health operations statewide, an analysis of areas of unmet health care need (AUHCN), a review of community health assessments, and structured interviews with 39 health care and public health experts across Oregon.

- Environmental scan. Rede identified 45 mobile health operators running 52 units across Oregon. Operations are concentrated in the Portland metro tri-county area and along the I-5 corridor. Eastern, Southern, and Central Oregon rural and remote communities have the highest unmet need scores and the fewest mobile health resources.
- Community health assessment review. Of 29 community health assessments reviewed, 12 identified a lack of culturally and linguistically responsive care, and 11 highlighted distrust of the health care system as barriers to community health. Mobile health
  staffed by providers who reflect the communities they serve were often identified as a solution.
- Policy and regulatory gaps. Oregon also has no regulatory framework for mobile health nor a central registry for mobile health units. Gaps in Medicaid policy affect mobile health operated by Federally Qualified Health Centers (FQHCs) and mobile integrated health care (MIH).
- Workforce. Community health workers and bilingual and bicultural outreach staff are the irreplaceable foundation of mobile health. Recruiting and retaining clinical providers, especially in rural areas, requires a robust, strategic approach.

Key considerations for the future of mobile health in Oregon

- Consider a statewide dual-model mobile health system that deploys both traditional mobile health units and community paramedicine — also called Mobile Integrated Healthcare in a coordinated, sustainable infrastructure.
- Create a regulatory framework that balances oversight and coordination with minimizing administrative burden, especially for small community-based organizations.
- Develop partner-informed definitions of mobile health, accompanied by clear policy statements on its role within the broader health care system.
- Support mobile health fiscal sustainability through strategic changes to the Oregon Health Plan, including billing rates for mobile health services and billing options for integrated community health workers.
- Provide support for culturally responsive delivery models by disseminating proven strategies used by mobile health operators who are effectively reaching diverse communities throughout Oregon.

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
FQHC	Federally Qualified Health Center
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)
OHA	Oregon Health Authority
ORH	Oregon Office of Rural Health
PCP(s)	Primary Care Physician(s)
PFST	Public Facing Survey Tool
REALD	Race, Ethnicity and Language, Disability
RHT	Rural Health Transformation
SOGI	Sexual Orientation, Gender Identity

Definitions

Health Equity: OHA's definition of health equity is, "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 at least two 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 responsive mobile health units to remove barriers and increase access to

[1] Oregon Health Policy Board - Health Equity Committee

and the quality of health care for priority populations, thereby addressing healthcare disparities caused by racism. (See priority populations outlined in HB 4052 (2022) on page 11.)

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 on the Oregon Health Authority to create a mobile health pilot program to improve health outcomes for priority populations impacted by racism. In collaboration with the Mobile Health Advisory Committee, OHA developed the pilot program and began funding mobile health units (MHUs) 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 report describes the implementation of the mobile health unit pilot program and findings from the feasibility study.

Background

Mobile Health Unit Pilot Program description

Substantial evidence indicates that mobile health can help communities that lack adequate access to health care 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 directly into communities, leveraging existing community assets, and providing culturally and linguistically responsive services. OHA's Medicaid Division was 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 Oregon Administrative Rules (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.

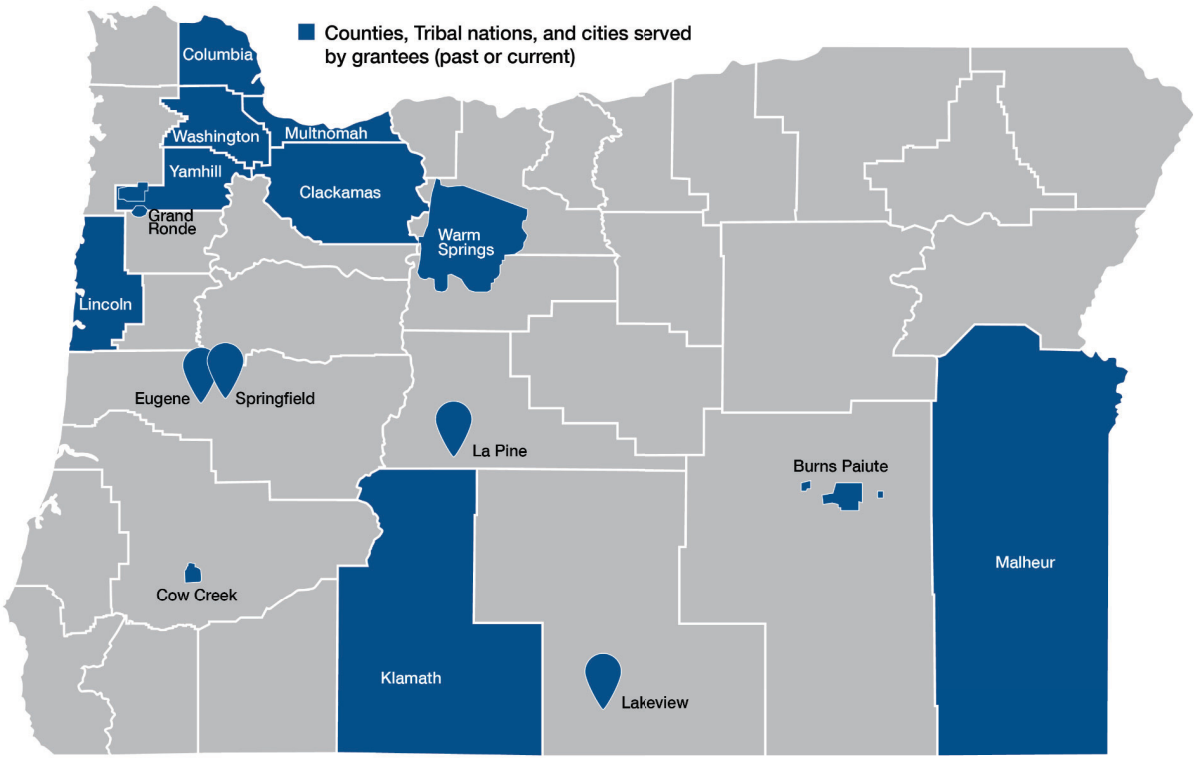
The total dollar amount distributed by OHA for the Mobile Health Pilot Program grants, over the two grant cycles, was $4.6 million.

[2] de Peralta AM, Gillispie M, Mobley C, Gibson LM. It's all about trust and respect: cultural competence and cultural humility in mobile health clinic services for underserved minority populations. J Health Care Poor Underserved. 2019;30(3):1103–18.

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 were 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 provided 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 work plan: Cohort 1

- **Central City Concern:** Central City Concern (CCC) delivers services to populations on the streets of Portland. With grant funding, they planned to 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:** Operated by the Confederated Tribes of Grand Ronde, Great Circle Recovery planned to offer opioid treatment and recovery in Yamhill and Polk Counties. Funded from June 2023 to July 2024.
- **Raíces de Bienestar:** Raíces de Bienestar planned to offer mental health services to populations across most of Oregon's North Central counties, from Yamhill to Clackamas. Funded from June 2023 through December 2025.

Mobile Health Unit Pilot Program grantees: Cohort 2 work plans

- **Central City Concern:** Continuation of services provided in the previous grant cycle.
- **Daisy C.H.A.I.N.:** Daisy C.H.A.I.N. planned to provide full-spectrum doula and peer support services, including lactation education and consulting. Daisy C.H.A.I.N. planned to provide services in Lane County, primarily in the Eugene-Springfield area.
- **El Programa Hispano Católico:** El Programa Hispano Católico (EPHC) planned to offer more consistent services, including health education on chronic disease and mental health, wellness checks, full one-hour therapy sessions, prenatal care and preventive screenings. EPHC planned to serve people in the Portland tri-county area.
- **Lincoln County Public Health:** Lincoln County planned to provide vaccinations, STI screenings, wound care, medication access,

referrals and Oregon Health Plan enrollment. Lincoln County Public Health's van planned to operate in Lincoln County.

- **Medical Teams International:** Medical Teams International (MTI) is an organization that has been operating mobile health units internationally for decades. With grant funding, they planned to provide oral health care services (using four different MHUs) to patients who are members of the Confederated Tribes of Warm Springs and the Burns Paiute Tribe.
- **St. Alphonsus:** St. Alphonsus planned to provide primary care services. They have a fleet of 2 MHUs and one utility vehicle in Malheur County.
- **Tayas Yawks:** Tayas Yawks planned to operate a Mobile Health Unit and provide preventive screenings, opioid services and health education sessions for Tribal communities in Klamath County. They also planned to expand community partnerships throughout Klamath County as well as in La Pine (Deschutes County) and Lakeview (Lane County).
- **Urban League of Portland:** Urban League planned to provide blood pressure and glucose screening, wound care, STI testing, pregnancy testing and other culturally specific services.

Pilot program evaluation engagement and planning

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 program.

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.

Mobile Health Advisory Committee 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. 18). 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 served as reviewers on a multitude of evaluation or feasibility study activities, including an in-depth review of the evaluation plan to provide feedback on evaluation activities and key evaluation questions and reviews of data collection materials, such as the semi-structured interview guide and survey.

Mobile Health Unit Pilot Program grantee 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 for 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 18 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 used 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 (for example, 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.
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 for 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 for communicable disease control, where mobile health units may have a more immediate effect. For example, early detection of a sexually transmitted infection such as syphilis or gonorrhea can prevent its spread to others and allow for quick treatment, but the evaluation did not allow for outcome measure tracking or longitudinal tracking by the patient, which is costly and beyond the ethical scope of the current program evaluation.
3. **Service readiness level of grantees** - As noted, grantees were at different stages in their development toward providing health care services, meaning that some had less time to make inroads into communities and build trusting relationships with community members/patients/clients or purchase medically equipped vehicles. This limits the amount of data the evaluation team was able to collect from these grantees, potentially weakening the evaluation results, especially in terms of generalizability.

4. **Data availability** - Three data sources planned in the original evaluation plan were incomplete due to time or legal constraints. 1) OHA was only able to analyze a small amount of demographic data collected from a small number (five of ten) grantees due to delays in data strategy, planning and deployment. 2) Grantee activity reports were reviewed but not systematically analyzed due to delays in data availability and insufficient data. 3) The evaluators' inability, due to OHA legal restrictions, to gather qualitative information directly from clients who received services at the mobile health programs.

Mobile Health Unit Pilot Program evaluation data collection (in brief)

Data sources

- In-depth interviews with eight OHA Mobile Health Unit Pilot Program Grantees
- Grantee activity and expense reports
- Surveys from OHA Mobile Health Unit Pilot Program staff and volunteers
- PFST

Interviews with OHA Mobile Health Unit Pilot Program grantees

Semi-structured interviews were conducted with eight grantees (one from cohort 1 and seven[3] from cohort 2). Seven of these interviews were conducted virtually via Zoom, and one was conducted in person. Interviews lasted from 37 minutes to 1 hour and 50 minutes, with an average of 1 hour and 15 minutes.

Grantee activity and expenses reports

Grantee activity and expense reports were reviewed before each semi-structured interview and for additional program context, and again

[3] Rede conducted in depth interviews/site visits with OHA Mobile Health Unit Pilot Program grantees in spring 2026. One grantee, DAISY C.H.A.I.N., was not interviewed because the organizations closed in February 2026.

for overall context on grantee activities and spending, but were not systematically analyzed due to time constraints.

OHA Mobile Health Unit Pilot Program staff and volunteer survey

To elicit experiences and opinions from those working in a mobile health environment, Rede launched a 20-question survey with both closed and open-ended questions.

Rede worked with contacts at each of the seven Cohort 2 grantees to distribute the survey to their staff and volunteers. A total of 14 staff across the seven grantees completed the survey. The sampling frame (total number of eligible staff and volunteers) is unknown.

Public Facing Survey Tool

The REALD & SOGI survey is a standardized, self-reported data collection tool used to capture detailed information on race, ethnicity, language, disability, sexual orientation and gender identity in support of health equity and disparity analysis. It features 64 race and ethnicity categories, nine disability questions, three language-related questions and three SOGI questions — all using inclusive, community-vetted response options that go beyond broad federal categories. For the Mobile Health Pilot Project, the survey was administered via the PFST, a secure, multilingual web-based platform that automatically reports data to the Oregon Health Authority.

Mobile Health Unit Pilot Program evaluation results

Key evaluation questions (KEQs)

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 or 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 responsive 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?

Table 1. Data sources for key evaluation questions

Data Sources	KEQ 1	KEQ 2	KEQ 3	KEQ 4	KEQ 5	KEQ 6	KEQ 7	KEQ 8
Grantee Interviews	✘	✘	✘	✘	✘	✘	✘	✘
Staff and volunteer survey	✘	✘	✘	✘				✘
PFST Data	✘							

KEQ 1: Serving priority populations

Grantee interviews

All Mobile Health Unit Program Pilot Program interviewees described their work as explicitly serving priority populations named in HB 4052, including Black or African American people; four of the nine Federally Recognized Tribes in Oregon and the descendants of their members; immigrants;

refugees; migrant and seasonal farmworkers; and low-income individuals and families. The extent to which services were delivered varied considerably across grantees because of where each was in the implementation cycle: Central City Concern, El Programa Hispano Católico, Lincoln County Public Health, Medical Teams International, Raíces de Bienestar and Tayas Yawks were actively delivering services during their funded period; Saint Alphonsus was just launching Oregon services at the time of interview; and the Urban League of Portland had not yet taken delivery of its mobile unit because of procurement constraints, but had been delivering services through staff vehicles and existing programming.

Mobile Health Unit Pilot Program grantee focus areas

Central City Concern reported serving people experiencing houselessness or extreme low income, with priority on those who are unsheltered. According to Central City Concern, people of color are vastly overrepresented in those data sets, so the mobile teams "see quite a lot of people from the Black and African-American communities, from Native and Indigenous communities and from the Latinx community."

> "Our agency, Central City Concern, primarily focuses on people experiencing homelessness and/or with extremely low to no income in transitional recovery housing or supportive housing. Our mobile health team is primarily focused on folks living in emergency shelters or in places not meant for human habitation."
>
> — Interviewee

El Programa Hispano Católico reported serving a bilingual, bicultural population centered in East Multnomah County, with significant indigenous identification. The focus on serving Latino and Spanish-speaking populations.

> "Primarily, we are serving Spanish-speaking, Latino communities, but also indigenous communities. A lot of our participants also identify with an indigenous community, either from Mexico … and seasonal and farm workers as well."
>
> — Interviewee

Lincoln County Public Health reported working in collaboration with Arcoiris Cultural and Conexión Fénix, to serve "non-English speaking, particularly Hispanic, Latinx, Mesoamerican and Guatemalan community, Indigenous community" in coastal Lincoln County, providing services in Spanish and Mam.

> "We're targeting specifically the community, so we're communicating specifically through channels that they use. Right now, what's really important for the community is WhatsApp … We do a lot of word of mouth."
>
> — Interviewee

Medical Teams International used the OHA grant to deepen partnerships with three Tribal Nations, the Confederated Tribes of Warm Springs, the Burns Paiute Tribe and the Cow Creek Band of Umpqua Tribe of Indians, selected because of their distance from any other dental care.

> "[Tribal Nation] is one of those partnerships and situations where they are so remote that mobile health is really … their lifeline, especially for dental. They have one dentist in town, he does not take Medicaid, and he requires $500 to make an appointment, and that $500 is $500 in cash."
>
> — Interviewee

Raíces de Bienestar described serving Latino communities in Washington County with a focus on mental health, working primarily with low-acculturated, low-formalized-education families, including many recent immigrants. The Founder and Executive Director described both the cultural alignment of Raíces de Bienestar with its community and the heightened clinical complexity that arises in a mobile setting:

> "We are not doing traditional crisis response. We are doing therapy in the field with Latino individuals, with people with a lot of barriers, and we are having to manage different ethics, different standards, trying to adapt and figure it out, because there is no model for this in mental health."
>
> — Interviewee

Saint Alphonsus identified the migrant farm-worker and Hispanic population in Malheur County as the priority focus for its planned Nyssa library and Ontario shelter clinic sites.

> "It's super important for everyone to come in to have as much dignity and respect as you would if you went somewhere else. Just because we're out there on wheels and we're a little bit different, it doesn't mean it should change."
>
> — Interviewee

Tayas Yawks operated across fifteen rural and remote communities in Klamath County, identified the Klamath Tribes (a federally restored, formerly terminated Tribe) and Spanish-speaking farm-working families.

> "Getting in all the communities and actually establishing their sense of it's not a bad thing to have this service. It doesn't demean your town. It doesn't make you less of something. It starts there with education and reducing those stigmas."
>
> — Interviewee

The Urban League of Portland reported developing a program focused on the Black community across Oregon and Southwest Washington. During the interview, the Urban League noted the interesting historical context: "It was the Black Panthers who originally started the mobile health initiative, so we wouldn't have mobile health units without them kind of creating that blueprint." Although the unit itself had not yet been delivered, the Urban League had been running services with personal and existing organizational vehicles.

> "If we need to, we will hold your hand. We will be there until you tell us you don't need us, and it's not typical for us to close out a client's case unless they feel like they're ready to move forward independently."
>
> — Interviewee

Public Facing Survey Tool data

The Mobile Health Unit Pilot Program used a PFST to collect demographic information, using REALD & SOGI[4] questions, from clients or patients of the grantees. The PFST is a secure, web-based form that allows people to enter their REALD & SOGI data for automatic reporting to the Oregon Health Authority (OHA) anonymously. Over the 39 days of data collection, a total of 50 individuals served by one of five MHU grantees (Lincoln County Public Health, Saint Alphonsus, Tayas Yawks, Central City Concern and Medical Teams International) filled out the demographic survey. However, most (82%) of individuals who completed the PFST during the data collection period were served by a single grantee, potentially resulting in overrepresentation and bias in data reporting. All demographic data listed below should be interpreted with this limitation in mind. Based on the collected data, the effectiveness of grantees in reaching priority populations appears promising, but without more complete data, no conclusion can be drawn.

Respondents were between the ages of newborn and 77 years, with a mean age of 42.6 years. Other notable demographic characteristics of the respondents:

- 74% of respondents identified as Women
- 62% identified as Straight
- 89% identified as non-White or Persons of Color
- 50% identified as Mexican
- 50% identified as Indigenous Mexican, Central American, South American
- 83% reported using a non-English language at home
- 73% report preferring a non-English Language when communicating with someone outside the home about important matters
- 74% reported preferring to read important information in Spanish only

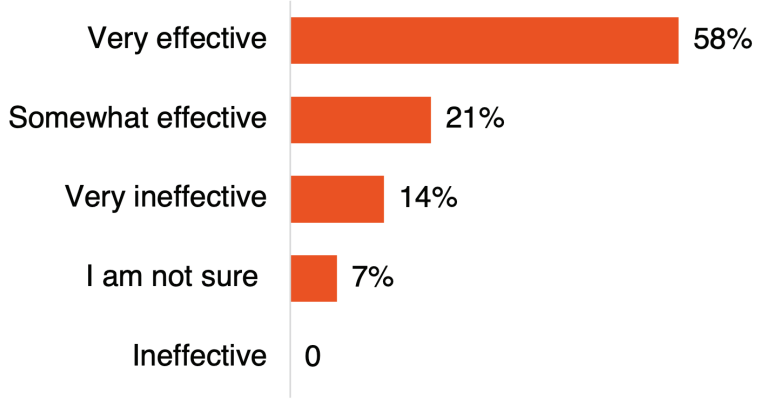
[4] Race, Ethnicity and Language, Disability (REALD) and Sexual Orientation, Gender Identity (SOGI). See more information here.

- 67% can be categorized as English Language Learners (speak English less than very well)
- 25% of respondents report needing an interpreter

Staff and volunteer survey

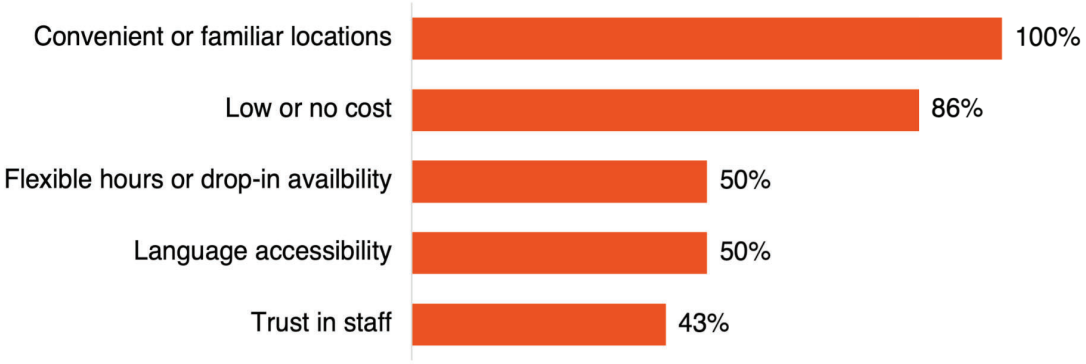
Survey respondents were asked to share how effective they thought the mobile program they work or volunteer at was at reaching its intended priority population. Just over half of respondents (58%) reported that the program was very effective in reaching its intended priority populations (Figure 2).

Figure 2. How effective is the mobile health program you work or volunteer for in reaching its intended priority populations? (n=14)



Respondents were asked to select up to three factors that make it easier for clients from priority populations to access care at the organization where they work or volunteer (Figure 3). 100% of respondents reported that having services in convenient or familiar locations makes it easier for clients to access them, and 86% reported that having low- or no-cost services improves access.

Figure 3. What factors make it easier for clients from priority populations to access services at your organization? (n=14)



KEQ 2: Connecting clients with care

Grantee interviews

Interviewees discussed their processes for making referrals to other providers for necessary care. Two grantees with internal primary care or shared electronic health records were able to track a meaningful share of completed referrals, while six grantees without case-management staffing or shared records reported strong referral practices but limited ability to confirm the receipt of follow-up care.

Across the board, the most consistent barriers to a closed loop were appointment wait times, the absence of dedicated case management on mobile teams and patient mobility — particularly for people who are unsheltered or who lack the time, transportation, technology access, or English-language access to follow through during weekday business hours.

> "An appointment for a new [dental] patient, especially a new Medicaid patient, can be 11 to 15 months out. So many times, we become the primary care provider for folks if they have significant work that needs to be done that we can do."
>
> — Interviewee

> "When a referral is made to an outside provider, we will follow up within 30 days to make sure that the appointment was made, and if not, what were the barriers? Also, following up on

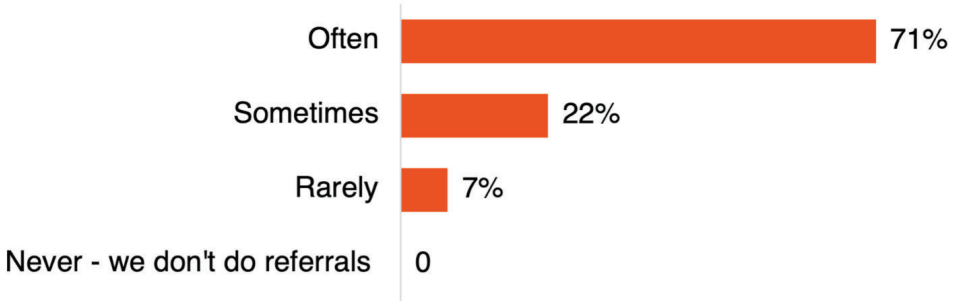
> the care … Did they receive adequate care? Did they feel heard?"
>
> — Interviewee
>
> "The people that we serve tend to be low-acculturated, with low formalized education — many of them don't read or write. Many people can maybe come to a mobile service on a Saturday, but they're not going to have access or time during the week to follow through with anything else."
>
> — Interviewee

The pilot exposed clear evidence that closed-loop referrals (verifying receipt of care) required either a shared electronic health record, a dedicated case-management or community-health-worker function or a deeply embedded partner who already has those touchpoints. Interviewees also surfaced two structural problems beyond grantee control: the long wait for new Medicaid dental and specialty appointments, and the difficulty of maintaining contact with unhoused or off-grid clients.

Staff and volunteer survey

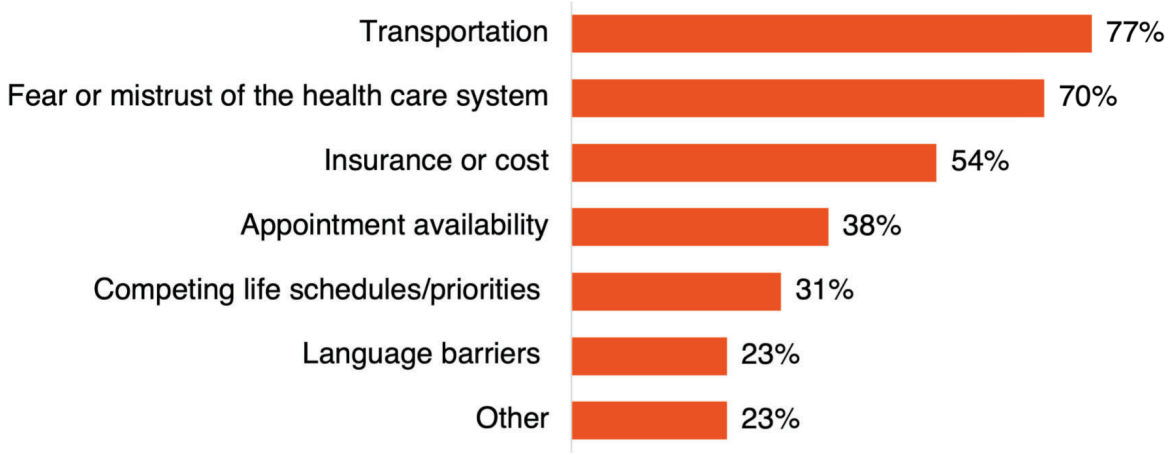
Staff and volunteers were asked, from their perspective, how often they believed clients were connected to care or resources outside the mobile health operation they worked or volunteered for. A majority (71%) said they thought clients were often connected to outside care, and none of the respondents shared that they do not do referrals (Figure 4).

Figure 4. How often were clients connected to care outside of your mobile health operation? (n=14)



Staff and volunteers were also asked what barriers they most often observed when clients tried to access follow-up care or resources outside of the organization they work or volunteer for. They were asked to select all that apply from a list of six potential barriers and were provided an option to write in additional barriers not listed. Respondents shared that transportation (77%), fear or mistrust of the health care system (70%), and insurance or cost (54%) were the major barriers to accessing follow-up care (Figure 5). All of the respondents (n=3) who selected "other" shared that patients or clients not having a phone with reliable service was a barrier to accessing follow-up care.

Figure 5. Barriers to accessing follow-up care outside mobile health operation observed by staff or volunteers (n=14)



KEQ 3: Culturally and linguistically responsive care

Every interviewee reported building a culturally and linguistically responsive care strategy that went substantially beyond translation. Interviewees reported three common practices that were central to providing culturally and linguistically responsive care:

1. Hiring staff from the priority population,
2. Using trusted-voice partner organizations as the front door to mobile services,

3. Adapting health-education materials to the community's literacy and trust profile, and
4. Selecting service times, locations and channels that match community life.

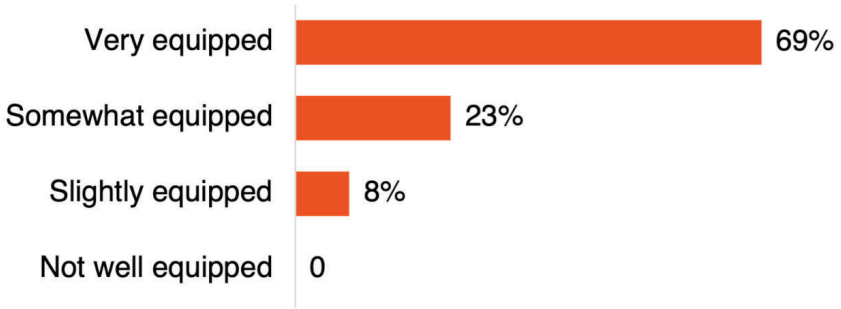
> "I'm bilingual, so I'm able to fluently speak with Spanish speakers ... The first time that I went out to those communities back in September, when I started here, everyone was shocked to see somebody who spoke their language or who was from their community."
>
> — Interviewee

> "We acknowledge that not everybody has literacy skills or can read and write, but we also do language adaptations to info sheets. We do info sheets that are primarily photos for people who may have a hard time with health literacy."
>
> — Interviewee

Staff and volunteer survey

Staff and volunteers were asked to what extent they felt equipped to provide culturally responsive care or services in their role. 69% of respondents report feeling very equipped to provide culturally responsive services, 23% report feeling somewhat equipped to provide these services (Figure 6).

Figure 6. How equipped staff or volunteers feel to provide culturally responsive care and services (n=14).



Staff and volunteers were also asked what approaches helped them respond to clients culturally and linguistic needs the most. They were asked to select all that apply from a list of six potential barriers and were provided an option to write in approaches that were not listed.

Respondents shared that having bilingual or multilingual staff (85%), learning directly from clients (77%) and support from coworkers or supervisors (62%) helped them the most.

Figure 7. Approaches that helped respond to cultural and linguistic needs of clients

In addition, 23% of respondents reported that they have had situations where the cultural or linguistic needs of clients were difficult to meet. When asked, open-ended, how they navigated challenges in meeting clients' cultural and linguistic needs, participants shared,

> "I use simple and clear communication, and an advantage of mine is being bilingual so I was able to communicate with Spanish speakers without needing a translator. I also build trust by being nonjudgmental and supportive of their culture and learning more about it rather than making them feel like I am just closed off to it."
>
> — Staff Survey Respondent

> "The primary way we navigate cultural needs is by staffing our mobile unit with Traditional Health Care Workers with lived experience and shared cultural backgrounds with the communities we serve, particularly Native American, Hispanic and those from rural backgrounds. This approach helps by bridging barriers and addressing the historical mistrust of these communities."
>
> — Staff Survey Respondent

KEQ 4: Safe and trustworthy services

Direct client voice was not systematically collected by all grantees during the pilot period; several grantees reported conducting formal patient-experience surveys. Interviewees discussed methods for building and gauging trust with the groups they served through the following methods:

- Policies and operational practices designed to communicate with safety and dignity,
- Staff observations of repeat engagement and word-of-mouth referrals into the program,
- Qualitative client feedback and stories such as the quote below:

> “I'm very grateful to belong to this group because it has helped me with my stress, and I have also learned many things. I love the the advice that they give me.”
>
> — Interviewee

All interviewees described barriers to building trust arising from fear of immigration agents and a hostile political environment for immigrants, refugees and people of color. One interviewee described having grown up with the experience of people being taken from her community, and that lived experience mirrored what current community members feel. The interviewee said this fear was “one of the biggest barriers" alongside stigma, and that it took sustained relationship-building and the presence of trusted, culturally connected peers to overcome it.

Across all eight grantees, the most-cited safety practices were privacy-protective intake, Immigration and Customs Enforcement (ICE) response protocols, hiring for compassion and lived experience and the use of trusted partner organizations as the front door.

Grantees reported working to bridge the trust gap created by external conditions. Work described included partnering with community organizations to provide “Know-Your-Rights” training, providing training to clients on how to manage the stress and anxiety of immigration control

tactics and the daily experience of racism, building safety systems into every mobile deployment, conducting ICE protocol briefings with staff before every clinic and exercising extreme caution around collecting and sharing demographic data.

Staff and volunteer survey

Just over half (54%) of the staff or volunteer respondents reported that they have experienced moments where client trust felt fragile or difficult to establish. When asked, open-ended, what made those moments difficult and how they navigated them, respondents shared,

> "These moments were navigated by meeting people where they were at and leading with relationship first engagement. Rather than pushing services, our Traditional Health Worker's focused on building genuine connections through conversation. They take time to listen, acknowledge fears rooted in past experiences, and create a safe, non-judgmental space where individuals could ask questions and move at their own pace. This approach helped alleviate anxiety and allowed trust to develop … By consistently showing up, following through, and guiding clients in a hands-on way, we were able to turn initial hesitation into trust and meaningful engagement with services."
>
> — Staff Survey Respondent

KEQ 5: Engaging community members in service development

As described by interviewees, community engagement took five forms:

1. Standing community-leadership groups housed in the grantee organization,
2. Needs analysis through community-health-needs-assessment data,
3. Listening through partner organizations and trusted voices,
4. Staff and volunteer relay of community feedback
5. Iterative service adjustment in response to attendance and direct conversation.

Community engagement was strongest where the grantee organization already had a long-standing presence in the priority community and operated standing structures (leadership groups, cultural centers, schools) that continuously surfaced community priorities. Grantees consistently reported that OHA's grant application timeline limited their ability to conduct the kind of pre-application community design they would have preferred.

Specific examples of engaging community members in developing services included:

- Engaging the community through Family Leadership Teams, which meet monthly at a Schools Uniting Neighborhoods (SUN) school in the community, and asking them what services they want and need from the grantee.
- Working with a standing partner group of community-based organizations with close ties to priority populations to develop demographic data collection tools that fit cultural needs.
- Relying on community feedback found in Community Health Assessments.
- Dividing a service area into regions and having outreach workers conduct weekly "community audits" to identify high needs areas.
- Surveying program staff, most of whom are case managers from the community, on what they were hearing about wellness needs, and acting on that information.
- Adaptive programming, such as reworking schedules and calendars, based on on-the-ground, real-time information from partners and clients, particularly related to where mobile services will be deployed at any given time.

KEQ 6: Sustaining the pilot program

All interviewees identified continued, predictable funding as the first sustainability requirement, but grantees also identified four other structural elements:

1. A payer landscape that compensates the actual mobile health workforce.
2. Supply-chain and equipment access on terms similar to FQHCs.
3. Sustained workforce in hard-to-staff roles such as drivers with a commercial driver's license (CDL), community health workers, naturopathic doctors, supervising clinical staff for Chart of Accounts-based billing.
4. State-level coordination across mobile providers.

Two grantees with strong existing institutional anchors in mobile health reported the most concrete sustainability paths; smaller grantees that focused on specific priority populations were the most reliant on continued external funding.

The two grantees with the most concrete sustainability paths have plans in place to receive funds ($75,000 annually) from a community hospital fund and to sustain the program primarily through a firmly established Medicaid billing infrastructure. However, concerns about the federal Medicaid work requirement affecting clients and the sustainability of mobile health operations affected interviewees' views about the future.

Other grantees reported plans to continue operations with Rural Health Transformation funding (specifically through Tribal health dollars) and seeking partnerships with health systems, hospitals and philanthropic organizations to secure grants for ongoing operations. A few grantees who are not yet established as Medicaid-billable providers discussed longer-term plans to pursue that pathway as a source of operational funding. However, several grantees explained that Medicaid billing alone is likely insufficient to fully sustain mobile health operations.

Workforce issues identified by grantees included driver staffing (due to the requirement for a driver with a Commercial Drivers License), community health workers and individuals who provide linguistically responsive services. Notably, grantees did not cite staffing concerns regarding hiring health care providers.

Grantees reported sustainability needs related to equipment and supplies. Mobile health units are not only expensive, but wait times to procure them can be long due to regional supply constraints and the fact that they are typically built to buyer specifications. Lastly, community-based organizations (CBOs), which are a critical component of healthcare community linkages, do not have the same purchasing advantages as FQHCs, meaning that, without access to discounted supplies and equipment, mobile health operated by CBOs may be more expensive.

Four grantees discussed the need for better statewide coordination. They discussed ways coordination could improve sustainability in mobile health, such as guarding against duplication of services, dispersing the administrative burden of compliance activities, such as collecting demographic data, and connecting specialty services to provide more referral options for clients.

KEQ 7: Scaling the pilot program

Grantees described scaling as a function of three factors:

1. More vehicles or service locations.
2. More staff with the right scope of practice.
3. A statewide regulatory or registry framework that allows mobile health to operate at scale without sacrificing quality.

Grantees described specific ideas to scale operations into neighboring geographic regions, increase the recurring presence of mobile health units at specific locations, or add new services.

One grantee differentiated between scaling mobile health and increasing the number of mobile health vans. They noted:

> "Mobile health can mean a lot of different things. It doesn't have to mean health care out of a vehicle because that's a really costly way of doing health services. Really running the trade-offs of providing street-based medicine or pop-up

> medicine with vehicle-based medicine is critical for any organization attempting to launch a mobile health program."
>
> — Interviewee

Grantees offered key insights into state-level policies that would better support the sustained and scaled implementation of mobile health in Oregon. Ideas included an approved vendor list with central purchasing weight, signage, and incentives built into agency wrap rates and, as noted in the previous section, centralized support for a coordinated mobile health approach to improve efficiency, protect partners and priority populations from over-saturation and foster collaboration, innovation and advocacy.

KEQ 8: Lessons learned

In sharing lessons learned, grantees focused on critical insights for organizations entering the mobile health landscape. Five lessons recur thematically across the eight interviews with grantees:

1. Build mobile health on top of an established, community-trusted program, not from scratch.
2. Define mobile health and plan for expenses related to mobile vans.
3. Plan for vehicle reliability, drivers and fleet logistics as core program functions.
4. Invest in trusted-voice partnerships rather than scaling outreach by advertising or other means.
5. Coordination is essential to prevent duplication and improve referral flow.

Start with an established community-trusted program - Grantees reported that success in mobile health operations may be tied to an established relationship of trust between a provider and the community. One grantee explained:

> "It's important to have pre-established programs. I would very much caution people away from building something brand new to put on a unit, because the unit itself is new, so you

> want to make sure that you have programs that are trusted, well utilized, and have very positive and obvious outcomes."
>
> — Interviewee

Define and plan, especially for expenses - While grantees did not advocate for a particular definition of mobile health for the pilot program or for the state in general, they did report that the ambiguity in definitions made community partnerships and co-creating mobile health solutions more difficult, especially on a tight timeframe for gathering partners to submit an application for funding to OHA. Grantees also stated that future programs, or individual organizations considering starting mobile health operations, must be prepared for the associated costs. They reported that mobile health is often promoted as a cheaper option for delivering health care services, but their experience tells a different story about long and short-term costs.

> "It's not a cheaper option. It's very, very expensive, and owning that expense is part of the delivery of this service. And so I would make sure that anyone coming into it new would just understand that it's going to be expensive."
>
> — Interviewee

Vehicles, drivers and reliability are core program functions. While they understood that mobile health may not always be configured around a vehicle, grantees described mobile health vehicles as central to the model. Grantees who were standing up mobile units for the first time described challenges with decision-making and manufacturing delays. Further, the ongoing need for specialty staff must be a clear consideration related to hiring and other expenses. One grantee experienced delays when a driver left employment, and they had difficulty hiring a replacement. Another grantee described the costs, noting:

> "Medicaid is going to pay us, let's say, $100 for that clinician. They're not going to pay what it costs for the driver — and if the clinician is the driver, what about the liability of that? They're not going to pay for the two hours it takes the unit to set up, the time in the field, the one hour the clinician drives to

> the field, and the one hour back … Even if we do fee-for-service, which would be good, we need overall funds for the general operations that are not direct clinical services."
>
> — Interviewee

Trusted-voice outreach - In addition to starting from a place of trust as an organization, grantees described the need to form and maintain partnerships with community providers and organizations. One grantee reported these relationships as essential to building a client base, noting that endorsements from other community organizations outperformed paid advertising to promote mobile clinics. One grantee explained that even when a service is needed, trust must be built for many clients to access it.

> "Patients will come to us because they are the clients of our partners. And they trust those people and those organizations. And so then they feel comfortable coming to us … Those community partnerships are just essential for success."
>
> — Interviewee

The extent to which all grantees evince a deep understanding of the role that trust plays in health care delivery to specific populations whose needs may be best met through mobile health is clear. Their descriptions of how to build trust with communities provide a window into the need for mobile health services.

Continuity of care is core, not optional - Grantees recognized that a single mobile health encounter rarely produces sustainable improvement on its own. The pilot suggests that when designing mobile services for any condition that requires ongoing engagement — behavioral health, chronic disease, prenatal care — program planners must expect the program to fund the connection back into recurring care, not just the encounter.

Staff and volunteer survey

Respondents were asked what supports make their work more effective. They were provided a list of eight potential supports and could select all that apply. Respondents reported that having sufficient and appropriate

clinical staff was the most important support (82%), followed by supportive organizational leadership (69%) and partnerships with other organizations (62%).

Figure 8. Supports that make mobile health work easier or more effective (n=14)

OHA's commitment to health equity

To ensure progress toward the Oregon Health Authority's goal to eliminate health inequities by 2030, the Mobile Health Pilot Program embedded equity and inclusion-focused practices throughout its design, implementation and expansion.

MHAC, which was responsible for providing guidance on establishing, funding, and operating the pilot program, included members with varied lived experiences, cultural backgrounds and professional perspectives as prescribed by House Bill 4052. The diversity of the makeup of members helped strengthen the alignment of decisions made about the pilot program with the needs of communities most impacted by health disparities. MHAC was instrumental in the development of multiple Requests for Grantee Proposals (RFGP) during the pilot program by helping to define terms, formulate allowable program activities, and proposal scoring criteria. Their valuable input ensured trauma-informed practices and cultural competency were interwoven in the grant process at every stage, from drafting to finalizing.

The Mobile Health Pilot Program staff worked diligently to craft Requests for Grantee Proposals (RFGP) in alignment with the authority's goals for equity and inclusion and the goals of HB4052. The RFGP included clear definitions to ensure all applicants shared a common understanding of the program's purpose and the populations it was designed to serve. The proposal criteria clearly described the competencies expected of grantees, including the ability to deliver culturally responsive care, engage meaningfully with underserved communities and operate mobile health services in a way that reduces barriers to access. Applicants were required to provide evidence of past work with priority populations and organizational practices that support equitable service delivery. The requirement of evidence of support from entities in the region, county, or other areas where the proposer would perform activities reinforced the expectation that mobile health services must be grounded in community voice and co-designed with those most impacted. To reduce ambiguity and support implementation, the RFGP provided a detailed list of allowable program activities that aligned with program goals while maintaining flexibility for community-specific approaches. The RFGP functioned as a tool for operationalizing equity by setting clear expectations, requiring demonstrated cultural competence and grounding the process in community and expert input. The program created a strong foundation for selecting grantees capable of advancing mobile health and reducing barriers for priority populations. Through the RFGP process, the program ultimately selected grantees who demonstrated strong operational capacity and a deep commitment to providing culturally responsive care to priority populations through their mobile health initiatives.

The program's close collaboration with OHA's Equity and Inclusion Division and Office of Tribal Affairs also supported the alignment of strategies with established equity and community engagement frameworks. The Equity and Inclusion Division played a key role in supporting the program with the use and implementation of the PFST for data collection in accordance with legislative requirements. The tool modifications as a result of

community engagement centered on community voice and allowed individuals to self-identify while maintaining a level of anonymity. The Office of Tribal Affairs director and liaisons were instrumental in the review of grantees' proposals and work plans, ensuring that Tribal sovereignty was honored and Tribal leadership was consulted regarding implementation of projects that sought to serve their members.

The program strategies reflect a deliberate and thoughtful approach to building a Mobile Health Pilot Program rooted in equity, cultural responsiveness and community partnership.

Feasibility study

HB 4052 directed OHA to study the feasibility of expanding mobile health units throughout Oregon. To conduct this study, Rede:

- Conducted a thorough environmental scan of all mobile health operations in Oregon.
- Analyzed Areas of Unmet Health Care Needs.
- Systematically reviewed community health assessment data.
- Interviewed 39 healthcare, public health and mobile health experts in Oregon.

Environmental scan of mobile health operations in Oregon

Rede conducted an environmental scan of all mobile health operations in Oregon. Over the time period between August, 2025 and March, 2026, Rede used a multi-method approach to create a database of mobile health operations in the state of Oregon that matched inclusion criteria and the following definition, "Any combination of people and equipment which increase capacity to provide Mobile health services directly to individuals in their communities, to overcome common barriers of time, geography and trust, etc. that they experience when attempting to access health care in traditional settings."[5]

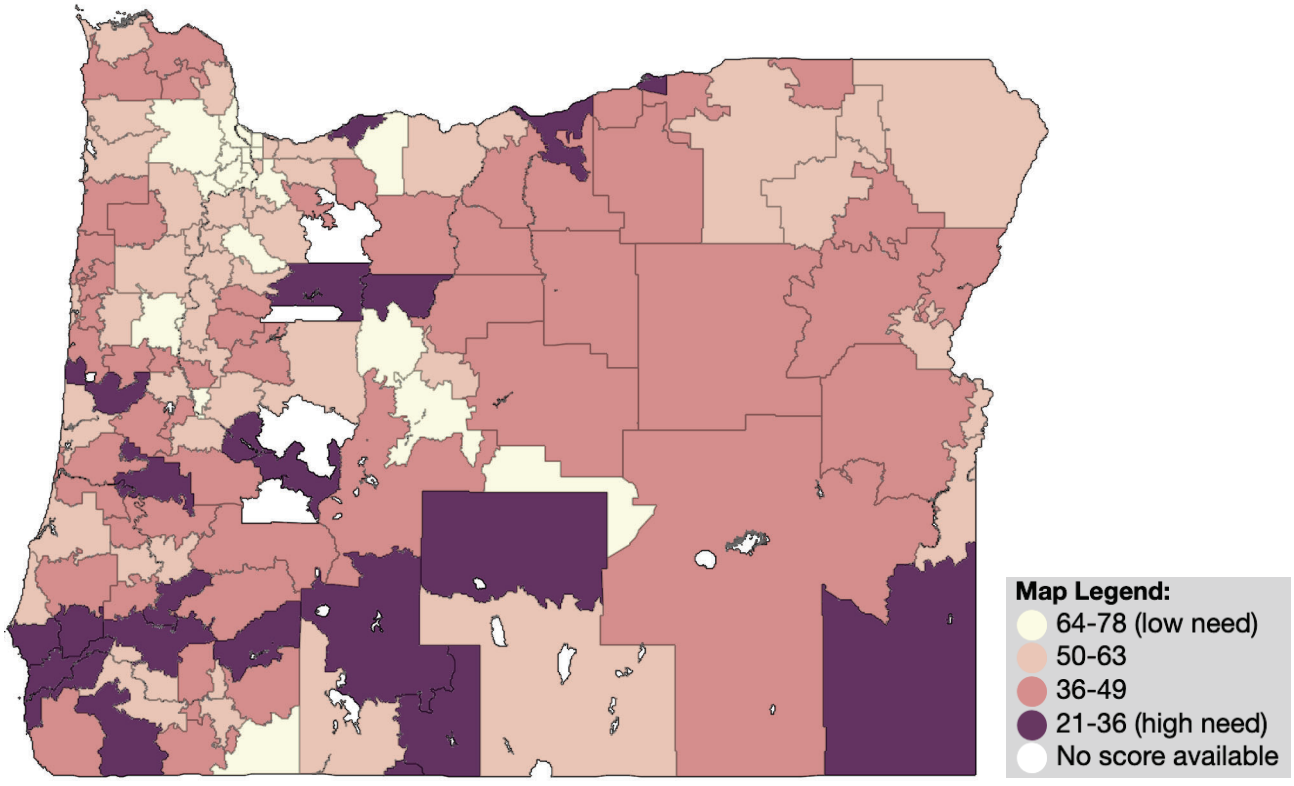
The methods used to identify mobile health operations in Oregon included desk research using three established online mobile health unit databases, an online survey for mobile health operators to describe their operations, outreach to FQHCs and hospitals, snowball sampling and networking throughout the project. The scan found that 42 mobile health operators (including the 10 Mobile Health Unit Pilot Program grantees, past and present) operate 52 mobile health units across the state. All the details of the environmental scan can be found in (Appendix B).

[5] Rede Group developed this definition for the purposed of the environmental scan based input from OHA and national studies.

Areas of unmet health care need

Each year, the Oregon Office of Rural Health (ORH) conducts an assessment of the areas of unmet health care needs (AUHCN) of Oregonians. The AUHCN designation uses nine variables that measure primary, dental, and mental health care availability, affordability, and utilization to calculate a composite Unmet Health Care Need score.[6] Figure 9 shows the AUCHN 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).

Figure 9. Areas of unmet health care need (scores) in Oregon[7]

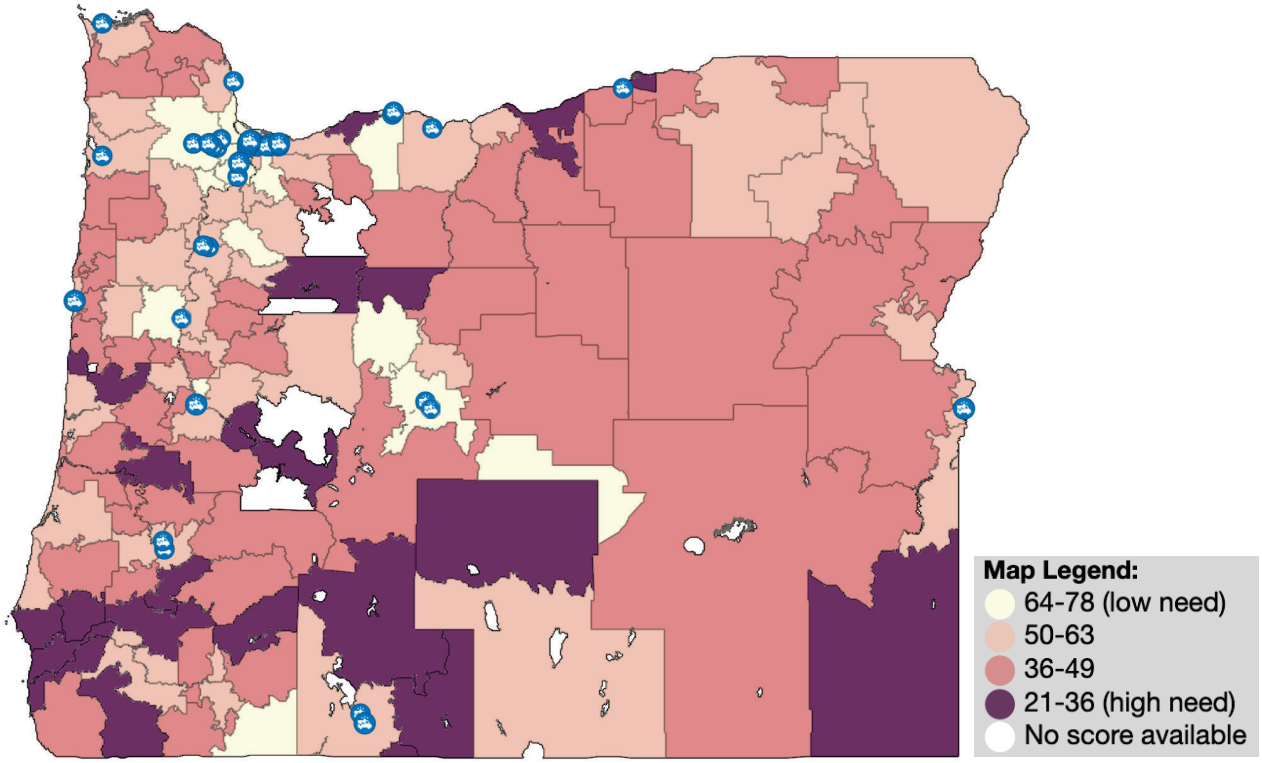


[6] Oregon Office of Rural Health. (2025). Areas of Unmet Health Care Need. Oregon Health & Science University. https://www.ohsu.edu/sites/default/files/2025-09/AUHCN%20Report_2025%20-%20FINAL.pdf

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

Figure 10 below shows the locations of mobile health operators identified in the mobile health operators scan 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 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,[8] and the absolute number of people with unmet health care needs might still be significant.

Figure 10. Mobile health operators' locations along with AUHCN[9]



[8] World Population Review. Oregon counties by population (2025) [Internet]. World Population Review; 2025 [cited 2026 May 14]. Available from: https://worldpopulationreview.com/us-counties/oregon

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

Community Health Assessment, Community Health Needs Assessments and Community Health Improvement Plans review

In an effort to analyze community-identified needs for mobile health, Rede analyzed 20 community health assessments (CHAs) and nine 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 or motor. Rede then assessed the method by which CHAs and CHNAs engaged and 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 or 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 houselessness, caregivers, older adults, people with disabilities, etc.

CHA and 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 bicultural or multicultural (that is, 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 and 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

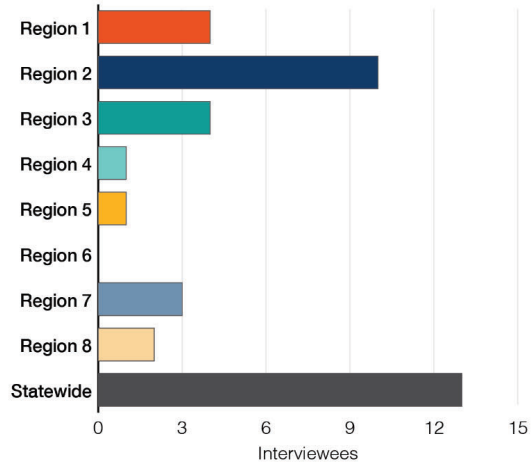
reflect the communities they serve and are trained in culturally and linguistically responsive care.

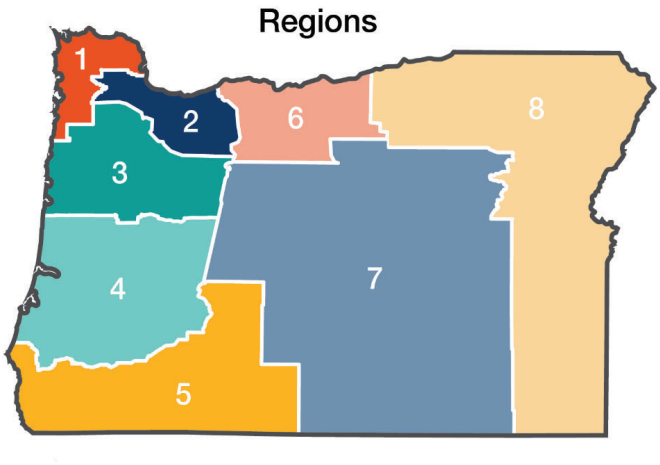
Key informant interviews

During October 2025 - March 2026, Rede conducted structured interviews with 29 organizations and 39 interviewees serving the priority populations and health care and public health leaders in Oregon

Methods

Figure 11. Interviewees by Region





Interviewee Organizations

AGE+
Arc of Benton County
Central Oregon Disability Support Network
Clackamas Free Clinic
Clatsop County Health & Human Services
Columbia County Public Health
Crook County Health Department
Crossroads Communities
Eastern Oregon Center for Independent Living
Elkton Community Education Center
Klamath Health Partnerships, Inc.
Lane County FQHC and Public Health
Malheur County Health Department
Multnomah County Health Department
Multnomah County Public Health Division
Northwest Family Services
OHSU Casey Eye Institute
Oregon Coalition of Local Health Officials
Oregon Community Foundation
Oregon Health Authority
Oregon Latino Health Coalition
Oregon Office of Rural Health
Oregon Primary Care Association
Oregon Spinal Cord Injury Connection
Pacific NW Mobile Healthcare Association
Samaritan Health Services
Tillamook County Community Health Centers
Washington County Public Health
Winding Waters Medical Clinic

Key informant interview findings

Models of mobile health delivery

Interviewees described a range of mobile health models, reflecting both existing operations and aspirational designs. Understanding these models is foundational to any statewide policy framework, as each carries distinct licensing, billing, workforce and coordination implications.

Traditional Mobile Health Unit

The most commonly referenced model involves a vehicle-based platform (van, bus or trailer) staffed by clinical providers delivering direct healthcare services at community sites such as parking lots, community centers, schools or faith institutions. This model is closest to a clinic-on-wheels and is most naturally suited to FQHC or rural health clinic structures. Multiple interviewees noted that this model's success depends on consistent presence at the same location, regular scheduling so communities can plan around it and strong relationships with locally-trusted anchor institutions.

> "We need providers who come back every month, who the community gets to know over time. One-off visits just don't build the trust you need."
>
> — Interviewee

Community paramedicine or Mobile Integrated Healthcare

Community paramedicine, also called Mobile Integrated Healthcare, is an Emergency Medical Services-based model in which paramedics and emergency medical technicians extend beyond traditional emergency response to deliver non-emergency, in-home health services. This model is particularly well-suited to serving homebound patients, high-users of emergency departments for non-emergent services and individuals with complex chronic conditions who cannot easily travel to a clinic, including many individuals with disabilities and older adults in rural Oregon.

Oregon currently has approximately 18 Mobile Integrated Health programs operating statewide, mostly fire department-based and loosely

organized through the Oregon Mobile Integrated Healthcare Coalition (a 501(c)(3) entity). However, Oregon lacks a Medicaid billing pathway for community paramedicine services. A 2023 bill (HB 2222) that would have created this pathway did not advance. States that have established such pathways — including Minnesota, Ohio and Missouri — have demonstrated reductions in avoidable emergency department visits and hospitalizations among enrolled populations.

> "Community paramedicine is doing incredible work in Oregon right now, but it's almost entirely grant-funded. Without a Medicaid billing pathway, it cannot scale."
>
> — Interviewee

Specialty mobile circuits

OHSU described a model in which specialists rotate to rural communities on regular circuits — quarterly or more frequently — rather than relying on patients to travel to Portland. The OHSU Casey Eye Institute mobile unit and OHSU Knight Cancer Institute's partnership with rural sites offer examples. This model can be coordinated with a traditional MHU so that specialty visits supplement primary care delivered on-site.

> "We think of it as bringing the specialist to the community on a schedule. Eye care, cancer screening, audiology — all of these can travel. We just need the coordination infrastructure."
>
> — Interviewee

Street medicine and outreach

Street medicine is a model in which providers and CHWs reach unhoused individuals where they live — in encampments, shelters and transitional housing — without requiring a vehicle or formal clinic structure. This model complements mobile health units by reaching populations that may not approach a van even when it comes to their neighborhood.

> "The van is great for some people. But the most marginalized folks — people living in encampments — often won't walk up to it. You have to go to them, on foot, where they are."
>
> — Interviewee

One-stop shop or co-located mobile assets

Interviewees described an emerging model in which multiple mobile health units — cancer screening, eye care, audiology, dental — are deployed simultaneously to the same community site, creating a one-stop shop event. This approach reduces transportation burden and can be combined with social services, food distribution or immigration legal assistance for maximum community impact. It requires significant coordination but can be organized periodically (for example, quarterly) as a complement to monthly or biweekly primary care visits.

> "We brought multiple units to the same parking lot — cancer, eye, audiology. People could get checked for everything in one afternoon. The community response was extraordinary."
>
> — Interviewee

Public health and immunization mobile units

County public health departments described longstanding mobile immunization and Women, Infants & Children (WIC) outreach operations. Several interviewees noted that these existing platforms could be expanded to include primary care or behavioral health services without starting from scratch. Counties already have vehicles, scheduling systems and community relationships that mobile health programs should build upon rather than duplicate.

> "We already go out to rural areas for immunizations. We could be doing so much more on the same trips if we had the right staffing and billing structures."
>
> — Interviewee

Models of mobile health summary

Overall, interviewees described a mobile health landscape that is varied, complex and firmly rooted in community need. The variation in mobile health services described by interviewees is mirrored by the different delivery models found among the Mobile Health Unit Pilot Program Grantees. The diverse approaches of the eight grantees, ranging from full-service mobile dental clinics on sovereign tribal lands, to peer-led

trailers in rural Klamath County, to street-based medicine in unsheltered encampments in Portland, to the country's first electric mental health mobile unit serving Latino communities, demonstrate that mobile health in Oregon is not a single model but a family of approaches shaped by population, geography, partnership, clinical scope and funding. Key informants reinforced this view, describing specialty mobile circuits, community paramedicine delivered in patients' homes and co-located multi-unit health fairs as equally legitimate expressions of mobile health. The implication for a statewide mobile health program is significant: prescribing a single vehicle type, service mix or delivery structure would exclude the very communities and conditions that mobile health is best positioned to serve.

Need for mobile health

The most consistent finding across all 39 interviewees was the critical shortage of dental care, behavioral health services and primary care. Interviewees shared the following insights:

- Dental care was the most urgently needed service reported, with wait lists of 7,000+ patients, high cost and extreme access barriers.
- Behavioral and mental health services have three to six-month wait times.
- Primary care (chronic disease management, preventive screenings, vaccines) was noted as a critical need and is foundational to a healthy population.
- Vision care was underprovided, particularly for rural, Tribal and older adult populations.
- Integrated multi-service units or co-located mobile services (physical, behavioral, dental) were preferred over single-specialty units.
- Community health navigation and social services wraparound support were also deemed essential.
- Reproductive health, prenatal care and maternal health services were reported as high priorities for immigrant or farmworker women.

Cultural and linguistically responsive services

Across all interviews, cultural and linguistic responsiveness emerged as non-negotiable for effective mobile health delivery. Community Health Workers who share the language, culture and lived experience of the populations served were seen as the critical workforce component, and distrust of the healthcare system among immigrants, refugees and communities of color was a central barrier. Interviewees noted the following:

- Language barriers remain a persistent and critical obstacle, especially for Spanish, Somali and other non-English speakers.
- Immigration status fears significantly deter people from seeking care, including for U.S.-born children.
- Historical trauma and systemic racism have created deep distrust of healthcare institutions among historically marginalized communities.
- Cultural humility and community presence (showing up consistently) are more important than any single intervention.
- Diverse clinical staff reflecting priority populations are preferred and create better health outcomes.
- LGBTQIA2S+ communities need affirming providers who understand their specific health needs and vulnerabilities.

> "I had a farm worker who passed away because he was afraid to go and get his care. He kept saying no, no, I don't want to be deported and he died."
>
> — Interviewee

> "We know that trust and cultural responsiveness are critical for reaching underserved communities … communities need to see themselves reflected in the providers and staff who serve them."
>
> — Interviewee

> "The best thing you can do for any population that has historically been underserved is to hire from within that

> community. Bring people in who understand the language, customs, fears ... ”
>
> — Interviewee

> “Our community members don't even trust people from their own community sometimes. They need to experience the service before they'll recommend it to others. Word of mouth is everything.”
>
> — Interviewee

Regions with the highest need

Interviews reported that Eastern Oregon, rural remote areas, Tribal communities and agricultural corridors had the highest level of unmet health care needs, while also noting underserved urban pockets in metro areas.

Interviewees reported:

- Rural and remote regions are the highest priority for MHU deployment.
- Multi-county service areas require flexible routing and scheduling strategies.
- Tribal communities (nine federally recognized Tribes in Oregon) need dedicated mobile health access.
- Agricultural communities have seasonal farmworker populations with limited care windows.
- Urban areas (Portland metro) have significant immigrant and refugee populations that are underserved.
- Transportation distance to the nearest provider is a primary driver of unmet need.
- Coast and mountain communities face geographic isolation, compounding access barriers.

> “We serve an eight-county region, so all of OHA Region 7, which is Deschutes, Crook, Jefferson, Wheeler ... Most of the areas that we work in are extremely rural and small communities, it's just a lack of access of providers.”

> — Interviewee
>
> "Access has really remained a significant challenge in our area because there's no public transportation, people don't always have cars and the nearest specialist can be 80 miles away."
>
> — Interviewee
>
> "If you think about eastern Oregon, the sheer distance to get a farm worker or an agricultural community member from one end of the state to the other … mobile health is not just nice-to-have, it is the only viable model."
>
> — Interviewee
>
> "We work with eight of the nine federally recognized Tribes throughout the State of Oregon. And within our community partnership list, we've got partners [CBO organizations] …we cover pretty much every population under the State of Oregon."
>
> — Interviewee

Workforce capacity

Workforce development emerged as the most critical non-financial resource for scaling mobile health in Oregon. Interviewees identified community health workers and bilingual and bicultural outreach staff as the irreplaceable foundation, with significant challenges in recruiting and retaining clinical providers, especially in rural areas.

Interviewees reported:

- Community Health Workers (CHWs) are critical to a mobile health workforce.
- Bilingual and bicultural staff recruitment is an acute statewide challenge, especially for Spanish speakers.
- Mid-level providers (NPs, PAs, dental hygienists) are more viable for mobile deployment than physicians.
- Driver, logistics and operations staff are often underestimated but critical; MHU operations are specialized and often require specialized workers.

- Rural provider retention requires incentives such as loan forgiveness, housing support and pay equity.
- Vehicle maintenance and operational infrastructure require dedicated administrative staff.
- Training pathways for CHWs serving mobile health units are underdeveloped and need investment.

> "Staffing is a separate issue from cost. Finding a physician to go out in a mobile unit — that's probably not going to happen. You're going to have to go with a mid-level provider, a Nurse Practitioner or a Physician Assistant, and that's actually a better model for community-based care."
>
> — Interviewee

> "I have two community health workers that are working with the Healthy Oregon Project program. They are our boots on the ground. They are the ones that our clients trust. You cannot do this work without them."
>
> — Interviewee

> "The workforce piece is huge. We can build the van. We can equip the van. But if you don't have the staff to fill it, you've got a very expensive parking ornament."
>
> — Interviewee

> "We're sending an interpreter and helping the family advocate for what their needs are. We have staff that speak multiple languages, and that's not easy to find. You can't just hire anyone."
>
> — Interviewee

> "One thing that's important is that we also have to be cognitive of the Stark Law[10] ... What that reinforces is that community-based service model where our community partners take responsibility."
>
> — Interviewee

[10] Stark Law: "prevents a physician from referring patients to the DHS if there is a financial relationship between the physician and the healthcare entity, their immediate family member, and the healthcare entity" National Institute of Health. (2022). Stark Law. https://www.ncbi.nlm.nih.gov/books/NBK559074/

Financial analysis

The financial picture for mobile health in Oregon is complex: high startup costs, reimbursement gaps for underinsured and uninsured populations, and the fundamental challenge that mobile delivery costs more per encounter than fixed clinics but reaches populations that generate no revenue in the current system. Multiple interviewees emphasized that sustainable mobile health programs require a braided funding model combining federal reimbursement, state appropriations and philanthropic support. Community-based organizations often have the closest ties to and established trust with priority populations, but face structural disadvantages related to health services reimbursement and the costs of supplies compared to FQHCs.

Interviewees reported:

- Mobile health delivery costs more per encounter than fixed clinic care due to vehicle, fuel and scheduling overhead.
- Serving uninsured or undocumented populations requires subsidized care models; it cannot be reimbursement-only.
- Startup capital for vehicles, equipment and licensing is a major barrier for new and small operators.
- FQHC-based models offer financial sustainability through braided federal grant and Medicaid billing.
- Return on investment: mobile health reduces costly emergency department visits, diagnostic delays and preventable hospitalizations.
- Philanthropic and hospital community benefit funds provide an important but unreliable revenue layer.

> “I've got two bullets for legislators: return on investment, and positive health outcomes for populations that are otherwise very hard to reach. [MHUs] aren't feel-good programs — they prevent expensive emergency care.”
>
> — Interviewee

> “It takes two years to ramp up operations [for an MHU] to be able to bill Medicaid. You're burning through your nest egg

> and you're waiting to be able to bill. It's just really a heavy lift to begin."
>
> — Interviewee

Opportunities to leverage federal funds

Key informants consistently identified Medicaid or Oregon Health Plan reimbursement, federal Health Resources and Services Administration grant programs and the federal Centers for Medicare & Medicaid Services' Rural Health Transformation funding as the primary federal funding opportunities. Some interviewees noted the criticality of strategically focusing investments to ensure the highest returns.

Interviewees reported:

- HRSA Rural Health grants and workforce development grants are proven funding sources for mobile health.
- Coordinated care organizations (CCOs) can invest global budget dollars into mobile health as a cost-effective care model.
- Medicaid billing for mobile encounters requires regulatory clarity and potential Centers for Medicare & Medicaid Services (CMS) waivers.
- 340B Drug Pricing Program through FQHCs provides significant cost savings for pharmaceutical services.
- Federal COVID-era programs (American Rescue Plan Act, HRSA emergency funding) piloted mobile models needing continuation.
- Philanthropy (major health foundations, hospital community benefit funds) and state or local government can be necessary to fill uninsured care gaps.

> "[Oregon is] a small state. We can't afford to try to field a team that's going to change everybody's life and put services everywhere. We have to focus on those key areas, the key cost drivers, the key opportunities."
>
> — Interviewee
>
> "Reimbursement: if you can get CMS reimbursement and then downstream reimbursement from the CCOs. Philanthropy is

> great but it's not reliable. We need official state and federal recognition of mobile health as a reimbursable delivery model."
>
> — Interviewee
>
> "People who are on Medicaid are low income and they have health needs. The CCO model should be paying for mobile health services because it saves money downstream."
>
> — Interviewee
>
> "Official recognition at the state level of the importance of mobile health … should OHA have a mobile health department? I think if CMS reimbursement is tied to that, that's worth doing."
>
> — Interviewee

Policy barriers and opportunities

Medicaid billing

The single most consistent policy barrier across all interviews (including Mobile Health Unit Pilot Programs) is the absence of adequate Medicaid billing mechanisms for mobile health delivery in Oregon. This manifests in several distinct but related ways:

- Oregon has no Medicaid billing pathway for community paramedicine services, despite approximately 18 Mobile Integrated Health programs operating statewide. A 2023 bill (HB 2222) that would have created this pathway did not advance. Several interviewees described that mobile health performs clinically meaningful work (for example, medication reconciliation, chronic disease monitoring, fall prevention, post-discharge follow-up) and is almost entirely grant-funded (outside of FQHCs), as there is no sustainable public-payer mechanism.
- The FQHC Prospective Payment System (PPS) rate, which is calculated from each center's historical fixed-site cost data, does not account for the higher per-encounter costs of mobile delivery, including provider travel time, vehicle depreciation and lower visit volume per provider hour; simply put mobile health units are losing

money on every Medicaid encounter because the reimbursement rate was designed for a clinic building, not a van navigating rural roads. One interviewee explained that without a mobile-specific PPS supplement or alternative rate methodology — likely requiring a CMS State Plan Amendment — FQHCs will never be able to sustain mobile operations at scale.

- Provider travel time is a largely invisible billing problem. For instance, when a nurse practitioner spends 90 minutes driving to a rural community, sees six patients, and drives 90 minutes back, three hours of provider time are entirely unpaid under current Medicaid codes. This creates a financial incentive against mobile delivery relative to fixed-site care.
- CMS Place of Service Code 27, established specifically for street and community outreach encounters, represents an existing federal billing mechanism that Oregon has not implemented within the Oregon Health Plan's encounter data system. This is a near-term, non-legislative fix that could generate meaningful Medicaid revenue for mobile programs without waiting for broader statutory reform.
- Also related to Oregon Health Plan policy, interviewees reported that inconsistent or unresolved issues surrounding CHW billing presented barriers to the long-term outlook for mobile health.

> "CMS created Place of Service Code 27 for exactly this kind of outreach work — services delivered in the community, not in a clinic. Oregon hasn't caught up. Implementing this should be a near-term priority for OHA."
>
> — Interviewee

Regulatory environment

MHUs in Oregon operate under the health care regulatory and compliance umbrella of their parent organizations (hospital license, FQHC designation, county health department authority, CBO operational license) without any requirement to separately register or report as mobile health units. Therefore, the state has no mechanism to know, in real time, how many

mobile health units are operating, where they are going, what services they are providing and the quality of mobile health services provided. The lack of a regulatory framework in Oregon presents specific challenges. For example, OHA interviewees described ambiguities related to school-based clinics, the applicability of the Clinical Laboratory Improvement Amendments in mobile settings, and prescribing authority outside a licensed facility, which have no clear resolution and are limiting program development. These are not novel regulatory problems; they stem from the fact that Oregon's existing health facility licensing framework was designed for buildings, and mobile platforms do not map cleanly onto it. Without a dedicated mobile health regulatory chapter or formal rulemaking addressing these scenarios, each OHA program must navigate them individually, and OHA staff suggested this led to conservative or possibly incorrect interpretations.

Key informants described the absence of coordination infrastructure as a consequence of the regulatory gap, noting that there is no mechanism for one mobile health program to know what another is doing, no shared scheduling to avoid duplication, no patient referral infrastructure and no data aggregation. In counties with larger population centers, coordination is essential to truly assess need (and financial viability) before launching mobile health operations and to provide communities with cohesive care. A regional collaborative led by Multnomah County is a self-organized effort to coordinate care and support mobile health operations through collective planning. Interviewees also spoke to the benefit of regulation for definitional purposes. They reported that clarifying the definition of mobile health and articulating its role in the larger health care system would benefit the sector by grounding its awareness and understanding of purpose and function.

Interviewees reported:

- Oregon has no central registry for mobile health units; identifying all operating units requires extensive fieldwork and produces

incomplete results, as the state's own environmental scan confirmed.

- MHUs serving immigrant and mixed-status communities face additional complexity in the current federal environment, as programs that maintain a lower profile to protect clients may be further obscured from any future registration or quality monitoring system.
- Approximately 18 Community paramedicine or Mobile Integrated Healthcare most of which are fire department-based, operate in a parallel regulatory gap, with no statewide scope of practice framework and no Medicaid billing pathway following the failure of HB 2222 in 2023
- Without a registration requirement, programs can close abruptly with no notification to OHA, no patient transition planning requirement and no data captured from the closing program.
- Other states, including California and Texas, have developed dedicated mobile health unit licensing or permit requirements, creating searchable registries and quality baselines. Models exist to explore replicability.

> “There are no metrics for mobile programs in the state. So, I don't know how we define success on a population health level, which makes it very hard to justify continued staffing investments.”
>
> — Interviewee

Considerations for Improving Mobile Health in Oregon

The Mobile Health Unit Pilot Program Evaluation and the Oregon Mobile Health Feasibility Study, together with findings from peer-reviewed scientific literature, speak to the need for and potential effectiveness of mobile health as part of a robust health care system. In particular, mobile health plays an essential role with populations with low trust due to trauma (including trauma of racism, poverty, immigration enforcement and healthcare system failures) and geographic barriers. However, to meet the needs of these communities, mobile health in Oregon must be stabilized and expanded. The following recommendations outline key considerations for improved mobile health delivery.

1. Pursue a statewide dual-model mobile health system that deploys both traditional mobile health units (MHU) and community paramedicine or Mobile Integrated Healthcare in a coordinated, sustainable infrastructure.
2. Create a regulatory framework that balances the need for coordination and some oversight with administrative burden, especially for small community-based organizations.
3. Develop partner-informed definitions of mobile health, accompanied by clear policy statements on its role within the broader health care system.
4. Support mobile health fiscal sustainability through strategic changes to the Oregon Health Plan around billing rates for mobile health services and billing for Mobile Integrated Healthcare workers.
5. Provide support for culturally responsive delivery models by disseminating insights on specific strategies used by mobile health operators who are effectively providing care to diverse audiences throughout the state.

Medicaid Division
Mobile Health Unit Program
500 Summer Street, NE, E-20
Salem, OR 97301-1097
medicaid.engagement@odhsoha.oregon.gov
Click or tap here to enter Program website

Appendix A: Mobile Health Unit Pilot Program evaluation details[11]

Key evaluation questions

The following key evaluation questions (KEQs), developed in collaboration with OHA and Cohort 1 Mobile Health Unit Pilot Program grantees, guided this evaluation:[12]

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 or 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 responsive 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?

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

[12] 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 employed three processes or methods to gather credible information to answer the key evaluation questions. These are as follows:

Individual structured interviews with Mobile Health Unit Pilot Program grantee leadership

Rede arranged and conducted interviews or site visits with key staff from each of the eight Mobile Health Unit Pilot Program grantees funded in 2025. Interviews were conducted both in person and over Zoom and ranged from one to two hours.

- Recognizing that the eight grantees were at varying stages of implementation, the interview guide was tailored to reflect the specific stage of implementation for each grantee.
- Rede developed a semi-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) conducted the interviews, and interviewees were offered anonymity to improve the quality of information gathered.
- There was a subset of questions that were asked of the OHA Mobile Health Unit Pilot Program grantees who had received two rounds of funding to better understand the process of implementing a longer-running pilot project.
- Interviews were recorded and transcribed using Rev, a transcription service.

This method helped 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 or 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 responsive 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 conducted a questionnaire survey of OHA Mobile Health Unit Pilot Program grantees (non-leadership) staff and volunteers and gathered insights from their unique perspectives. The survey included 20 questions and average response time was about 15 minutes.

- Rede developed a survey that was sent to all direct service staff, providers and volunteers of Mobile Health Unit Pilot Program grantees.
- Rede worked with Mobile Health Unit Pilot Program grantees and created a survey distribution list.
- Questions focused on lessons learned from launching and maintaining a culturally-responsive mobile health unit.
- The survey was open for the month of March 2026, and there was a gift card drawing for incentives.

- Rede analyzed survey data by conducting descriptive analyses accompanied by data visualizations.

This method helped 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 or 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 responsive 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?

Public Facing Survey Tool

The Race, Ethnicity, Language, Disability & Sexual Orientation and Gender Identity (REALD & SOGI) survey was designed to capture detailed, self-reported information on race, ethnicity, language, disability, sexual orientation and gender identity to support equity-focused analysis to measure health disparities. The survey used standardized community-vetted questions with inclusive response options that allowed respondents
to identify themselves with specificity beyond broader federal categories. Effective implementation of the REALD & SOGI survey relied on consistent staff training, supportive environments that encouraged trust, and technical infrastructure that could collect, store and report these data accurately.

- The language questions consist of three questions about spoken, written and communication preferences in different contexts, one question about interpreter needs and a question about facilitation with English. These questions closely followed those asked by the American Community Survey. There were also questions regarding the need for other types of accommodations (sign language interpreter, CART, etc.)
- The disability questions consisted of nine questions from the American Community Survey, the Washington Group on Disability and the Oregon Health Authority. These questions asked about functional limitations ranging from self-care to difficulties in communication.
- The race and ethnicity questions consisted of 64 race and ethnicity categories. Respondents can identify with as many categories as they want. There was a question that asked about primary race for respondents who identify with more than one race and ethnicity category.
- The sexual orientation and gender identity questions consisted of three questions. Both the sexual orientation and gender identity questions allow respondents to identify with as many orientations and identities as they want. There was one question on transgender identity.

The Mobile Health Pilot Project asked REALD & SOGI questions using the PFST. The PFST is a secure, web-based form that allows people to enter their REALD & SOGI data for automatic reporting to the Oregon Health Authority (OHA). The PFST was designed to help providers without EHRs that can be configured for REALD & SOGI questions. The PFST allowed respondents to take the survey in multiple languages, including Spanish. Data were analyzed using Stata v.18, and counts of fewer than five were suppressed for confidentiality. The PFST data reported below represents data collected over 39 days (March 2 to April 10, 2026) from five grantees.

Limitations

- Respondents could have felt overwhelmed by long or highly specific identity categories, which can cause confusion or lead them to skip questions and impact data quality.
- Respondents could have worried about how their sensitive information would be used, reducing their willingness to disclose.
- Data collection may not have felt private or safe, making respondents less comfortable sharing personal demographic details.

This method helped answer the following evaluation questions:

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

Analysis & interpretation

Qualitative data:

- Rede analyzed individual interview transcripts using best practices for qualitative content thematic analysis or inductive analysis. Analysis of transcripts was conducted using Atlas.ti, a qualitative analysis software. Transcripts were human-coded.
- Beyond thematic analysis, by using the data collected, the evaluation team focused on “impact narratives” or stories that demonstrated the effect of the Mobile Health Unit Pilot Program grantees’ services on members of the priority populations.

Quantitative data:

- Rede tabulated numeric data from the staff and volunteer survey, applying standards for data management and quality control.
- Rede analyzed numeric data from the staff and volunteer survey using an analysis software and applied industry and best practices for descriptive statistics.

Data interpretation

Rede designed and conducted a participatory interpretation process (meaning-making session) with the OHA Mobile Health Unit Pilot Program, program grantees and partners. 35 individuals (partners, grantees, interviewees) attended this meaning-making session where Rede reviewed preliminary results and elicited feedback on data interpretation from attendees. Rede guided discussions about effective and appropriate uses of descriptive data, which informed correlative, causal or program effect assessments.

Appendix B: 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 March 2026) mobile health operations in Oregon. The **mobile health operators scan** captured over 52 mobile health units (MHUs) that met the assessment's definition, operated by 42 organizations (including 10 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 10 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 (that is, 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 pg 77. 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 or telephone.
- Collaborative meetings, including interviews and discussions with mobile health leaders in Oregon.

Secondary data collection

- Harvard Mobile Health Map[13]
- Oregon Primary Care Association's Mobile Clinic Map
- Internet desk research results
- Previous environmental scan conducted by Rede in 2023[14]

[13] Harvard Mobile Health Map [Internet]. Boston (MA): Harvard University; [date unknown] [cited 2026 May 14]. Available from: https://www.mobilehealthmap.org/

[14] Rede Group, Oregon Health Authority. Mobile health pilot program evaluation plan and environmental scan [Internet]. Salem (OR): Oregon Health Authority; [date unknown] [cited 2026 May 14]. Available from: https://www.oregon.gov/oha/HSD/Documents/Mobile-Health-Pilot-Evaluation-Plan.pdf

- Journal articles, peer-reviewed research and university research on MHUs in Oregon
- Systematic review of Community Health Assessments and Community Health Needs Assessments (CHAs and CHNAs) and Community Health Improvement Plans (CHIPs), described above on pg 49.

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.[15] Specifically, units were excluded if they:

- Did not use specialized vehicles as the primary means of delivering or transporting care;[16]
- Operated solely from fixed locations, rather than being mobile and community-integrated;
- Functioned primarily as transportation services or medicine delivery models (for example, 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 (for example, 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).

[15] Georgetown University. Beyond the clinic walls: exploring the potential of mobile health [Internet]. Washington (DC): Georgetown University; [date unknown] [cited 2026 May 14]. Available from: https://chir.georgetown.edu/wp-content/uploads/Beyond-the-Clinic-Walls.pdf
[16] The exclusion criteria in the mobile health operators scan may differ from general definitions of mobile health, particularly regarding specialized vehicles.

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.

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 used 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 05/14/26) of mobile health operations identified in the scan and meeting the inclusion criteria. The scan found that 42 mobile health operators (including the 10 Mobile Health Unit Pilot Program grantees, past and current) are operating 52 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 or wound care
- Insurance enrollment
- Language services
- Mental health or wellness checks
- Mother & infant care
- Opioid treatment and prevention
- Optometry
- Referrals
- Showers
- Sports physicals
- Sexually transmitted Infection (STI) testing and prevention
- Vaccinations
- Wraparound services

Mobile Clinic Name or 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 or wound care • Mother & infant care • STI 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 or wellness checks
Clatsop County Mobile Health and Clinic	Communities(y) of color	1 MHU	Clatsop County	• Referrals • STI 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 or wellness checks
Columbia County Health Services Mobile Health Van	Communities(y) of color, low-income	1 MHU	Columbia County	• Mental health or 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 or wellness checks
Envision Eye Care	Communities(y) of color, LGBTQIA2S+, low-income, persons with disabilities, Tribal communities(y)	1 MHU	Gilliam, Hood River, Sherman,	• Chronic disease management • Language services • Optometry • Referrals

Mobile Clinic Name or Organization	Population served	Number of MHUs	Geographic service location	Services of MHU
			Wasco Counties	
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 or wound care
Good Samaritan	Communities(y) of color, LGBTQIA2S+, low-income, persons with disabilities,	1 MHU	Benton County	• Mother & infant care
Lincoln County Mobile Van*	Communities(y) of color, low-income	1 MHU	Lincoln County	• Vaccinations • STI testing and prevention • General medical attention or wound care • Referrals • Insurance enrollment (Oregon Health Plan)
Marion County Health & Human Services Van	Communities(y) of color, LGBTQIA2S+, low-income, persons with disabilities	1 MHU	Marion County	• STI 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,	• Mother & infant care • Referrals

Mobile Clinic Name or Organization	Population served	Number of MHUs	Geographic service location	Services of MHU
			Clackamas counties)	
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 or wound care • STI testing and prevention
Mosaic Community Health	Communities(y) of color, low-income	2 MHUs	Central Oregon	• Chronic disease management • Food & water provision • General medical attention or wound care • Language services • Mental health or wellness checks • Opioid treatment and prevention • STI 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 or wound care • Mother & infant care • Opioid treatment and prevention • STI 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 or wellness checks • Opioid treatment and prevention

Mobile Clinic Name or Organization	Population served	Number of MHUs	Geographic service location	Services of MHU
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
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 or wound care • Mental health or 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 or wellness checks • Vaccinations • Wraparound services

Mobile Clinic Name or Organization	Population served	Number of MHUs	Geographic service location	Services of MHU
Project Happy Face	Communities(y) of color, low-income	1 MHU	Deschutes County	• Skin care • Chronic disease management
Raíces De Bienestar*	Communities(y) of color, low-income	1 MHU	Columbia, Multnomah, Washington and Yamhill Counties	• Mental health or wellness checks
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 or 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 or wound care • Mental Health or wellness checks • Referrals • Vaccinations
Smile Care Everywhere	Communities(y) of color, LGBTQIA2S+,	1 MHU	Clark, Gilliam, Hood River,	• Dentistry

Mobile Clinic Name or Organization	Population served	Number of MHUs	Geographic service location	Services of MHU
	low-income, persons with disabilities, Tribal communities(y)		Multnomah, Polk, Wasco, Washington and Yamhill Counties	
St. Alphonsus Mobile Fleet*	Communities(y) of color, low-income	2 MHUs	Malheur County	• Chronic disease management • General medical attention or 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 Program)*	Tribal communities(y)	1 MHU	Grand Ronde Tribal Area	• Opioid treatment and prevention
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 or wound care • STI testing and prevention
Virginia Garcia Mobile Health Unit	Communities(y) of color, low-income	2 MHUs	Washington, Yamhill Counties	• Dentistry • General medical attention or wound care • STI testing and prevention

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

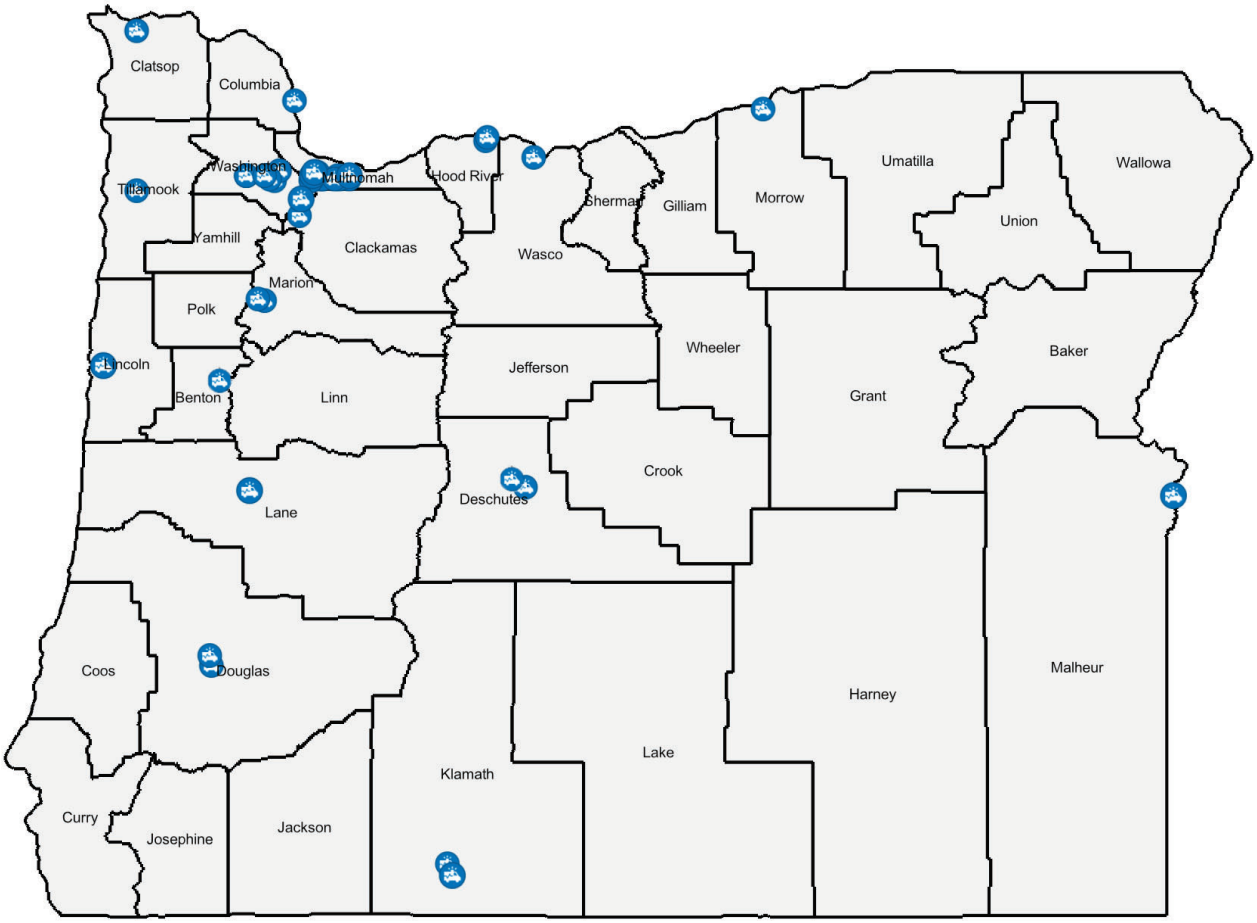
Mobile Clinic Name or Organization	Population served	Number of MHUs	Geographic service location	Services of MHU
Wy-Kan-Ush-Pum	Communities(y) of color, low-income, Tribal communities(y)	1 MHU	Columbia River and Surrounding Communities	• Dentistry • General medical attention or wound care • Insurance enrollment

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

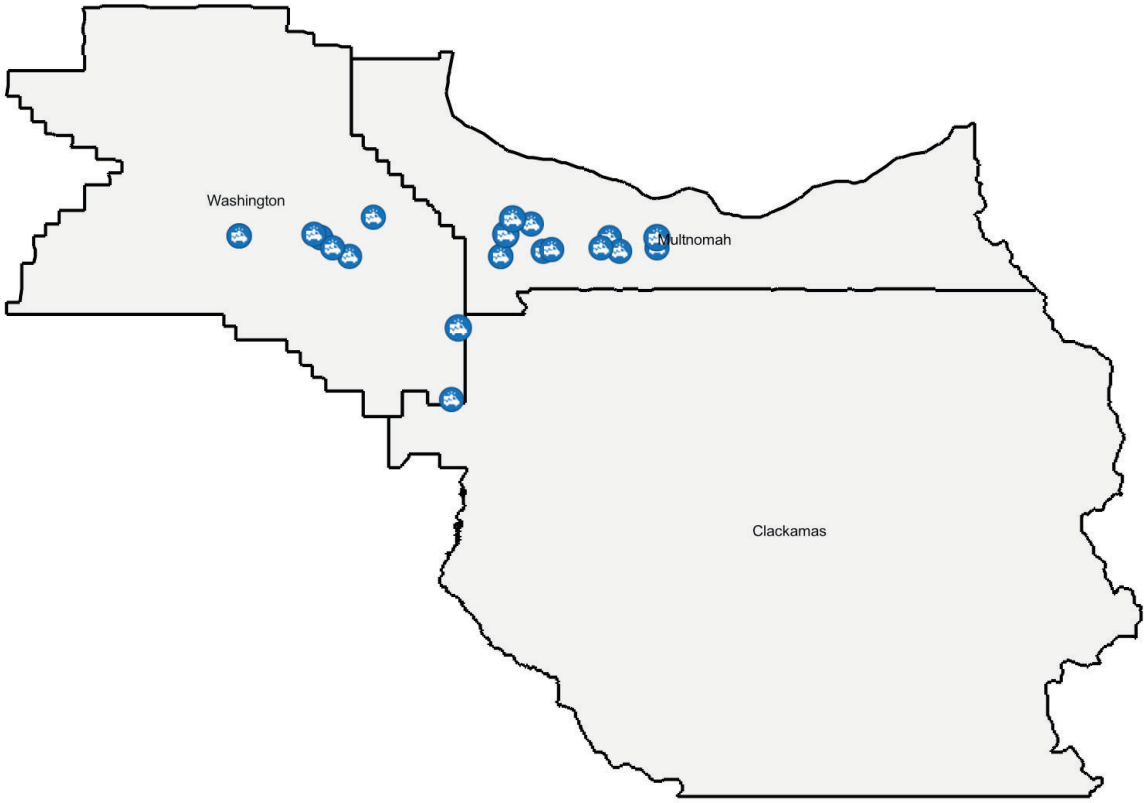
Geographic locations of mobile health operators

The figure 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.

Point locations of mobile health operators in Oregon



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	18
General medical attention or wound care	15
Referrals	12
Mental/Behavioral health or wellness checks	12
STI testing and prevention	11
Vaccinations	11
Dentistry	9
Optometry	6
Opioid treatment and prevention	6
Mother and infant care	6

Service	Count of MHUs delivering service
Food & water provision	4
Communicable disease control and prevention	4
Language services	3
Insurance enrollment	3
Blood testing	2
Showers	1
Skin care	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	39
Low-income	37
LGBTQIA2S+	19
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 people who are underserved

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, 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. Mobile Integrated Health, also called Community Paramedicine, 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 Oregon Mobile Integrated Healthcare Coalition, Mobile Integrated Healthcare programs have been shown to reduce 911 call volume, emergency department use 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.[17]

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.[18] ORH is working with Wheeler County to launch a pilot a Mobile Integrated Healthcare project and study the potential to scale this program to other rural regions in Oregon.

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 the environmental scan

Shifts in the 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

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

[18] 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/

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 (for example, “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.