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## Establishing Community Connections for a Mobile Health Clinic

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## **Executive Summary**

### **Introduction of the Problem**

Since the COVID-19 pandemic, mobile health units have been identified as a tool to decrease health disparities and increase the ability to reach vulnerable and isolated patient populations. There are many people who may feel uncomfortable with coming into health care clinics due to the fear of being judged and other reasons as well. The establishment of health units have provided patients care within their communities, thus decreasing gaps and disparities within the health care. We Care Clinic is an urban Midwestern university-affiliated clinic that provides care to vulnerable, underserved, and isolated patient populations. The clinic experiences hardships with patient return for follow-up and noncompliance with treatments. We Care Clinic provides services to patients within their communities with all insurance types. In 2022, the clinic's appointment "no show" rate was 25.2% and from January 2023-May 2023, the appointment "no show" rate had increased to 30.2%. The goal of the mobile unit is to help increase patient compliance and identify the needs of patients within the communities served.

### **Literature Review**

The literature suggests that mobile care clinics have been proven to increase patient compliance and fill social and economic gaps within rural and urban care communities (Bertoncello et al., 2020). There is also research that suggests that there is lack of information regarding mobile health units and the important roles they play within communities to decrease disparities. Mobile health units have been shown to provide both primary and preventative care within communities they serve. About 41% of care provided by mobile units is primary and 47% is preventative (Malone et al., 2020). Some of the top mobile health clinic services provided by mobile health units include childhood immunizations, obesity screenings, blood pressure

screenings, flu vaccinations, and cholesterol screenings (Mobile Clinic Impact Tracker, 2023). A study was conducted in Europe on the effectiveness of Mobile Health Clinics in reaching patients at increased risk for chronic diseases and was shown to increase the amount of patient compliance in management of newly diagnosed disease. The Mobile Health Clinic found a prevalence rate of 27.8% undetected hypertension, 37.5% hypercholesterolemia, and 5% diabetes among people who utilized the unit for screening services (Bertoncello et al., 2020). Managing chronic diseases aims to support compliance with medication and lifestyle changes. Studies have shown that Mobile Health Clinics have been effective in helping patients meet these challenges (Yu et al., 2017).

## **Methods**

This project aimed to establish community partnerships to increase awareness of the new mobile health unit and increase existing patient compliance. The mobile care clinic had no established community partnerships to provide parking locations and promotion of mobile unit services prior to this project. In addition, the types of health services desired by the community were unknown. This DNP project was determined to be a quality improvement project by the Institutional Review Board (IRB) of Southern Illinois University Edwardsville on April 26, 2023.

## **Evaluation**

The We Care Clinic is establishing a mobile health unit in hopes of decreasing health disparities. To provide the most effective care through the mobile unit, a determination of patients' needs were identified by We Care Clinic staff and administration. Clinic administrators created a survey to determine what services were needed in the community. Methods used to evaluate this DNP project included, the quality of information gained from community surveys

sent out by We Care Clinic, the quality and number of community partnerships formed during project implementation, and a review of patient demographic and diagnostic databases from the brick and mortar We Care Clinic.

The author of this DNP project worked to establish partnership with housing authorities in communities near the We Care Clinic. Despite attempts to establish community partnerships with three housing authorities, only one housing authority assisted in surveying their residents. However, this county-wide housing authority is large with twenty-five units throughout the county where We Care Clinic is located. This housing authority sent out the needs assessment survey to its residents. A total of 18 surveys were returned to We Care Clinic from housing authority residents. In addition to sending out surveys, this housing authority is willing to assist the clinic in parking locations for the mobile unit and advertising clinic days to the community. It is also willing to assist the clinic with private areas to conduct personal examinations if needed, such as well women examinations. Therefore, one quality, significant partnership was formed through this DNP project.

Health needs surveys were sent out to residents by the housing authority to residents of their units. These surveys contained open-ended questions and multiple-choice questions on health conditions most concerning to the residents in the community. These surveys provided valuable insight into the type of patient population and the type of care that patients would like to see provided within their community. Survey results revealed that there are many patients who need chronic condition management and evaluation. Chronic conditions included arthritis 61%, high blood pressure 61%, back pain 55%, allergies 55%, and anxiety 44%. There were many other concerns which included depression, diabetes, anemia, asthma, kidney disease, poor circulation, fatigue, and high cholesterol. Limitations to this project included the area in which

the survey was sent. The housing authority sent the needs surveys to housing units with a higher elderly population. Due to chronic conditions and some patients being elderly, surveys were sent via mail and a QR code placed in the mutual resident community area. More surveys were received via mail rather than the QR code.

A sample of deidentified data was extracted from the electronic medical records (EMR) of patients seen at We Care Clinic from January 2023-May 2023, to provide information on the top diagnoses of patients seen at the brick-and-mortar clinic. The top ICD-10 results of patients currently seen within their clinic were queried in the EMR. The top diagnoses included encounter for screening for infections with predominantly sexual mode of transmission Z11.3, type 2 diabetes E11.8, mild intermittent asthma J45.20, essential primary hypertension I10, and alcohol, tobacco, and drug use Z72.0.

Due to privacy, the surveys mailed to We Care Clinic were left anonymous completely void of all identifying data. This has become a barrier to calculating needs based on the patient's age. The need to provide patients with privacy was important and maintained in hopes of receiving enough surveys. Another limitation of this project was the prediction of the physical mobile health unit. The unit's date to launch was pushed back several times due to federal funding that limited the unit being available to provide services within the communities. Other limitations included partnerships within other communities. One partnership in particular included East St. Louis Housing Authority. We were unable to establish this community partnership due to changes within their organization that limited contact and communications. Future suggestions include to continue outreach for the establishment of different partnerships within the East St. Louis area because We Care Clinic serves many patient populations within this community.

## **Impact**

The project's immediate impact was We Care Clinic received a community partner to work with for future endeavors of the mobile health unit. The predicted long-term impact is that community partnership grows for St. Clair County, as well as other partnerships within the communities that We Care Clinic will serve in the future. It is anticipated that with further partnerships, We Care Clinic will provide mobile unit care within all communities they serve locally. Providing care through the mobile health unit will hopefully reduce the "no show" rates that the clinic currently experiences.

Alterations regarding ongoing implementations, that I would suggest for future projects, would be to include formal data collection for the elderly population. For future data collect among elderly populations mailed surveys would be suggested as the sole method of survey collection due to no response with QR codes. There are many more communities that could be reached. Vulnerable populations include elderly, children, those with chronic conditions, the LGBTQ population, and people living in poverty. Future outreach suggestions include boys' and girls' clubs, schools, public aid offices, homeless shelters and many more community partnerships that could be established. Due to time restrictions, these partnership locations could not be reached. This project should continue with more outreach to these locations.

## **Conclusion**

Overall, the project outcomes were helpful to know what services residents within the community would like to see the mobile unit provide. The survey sample size was not as large as desired but still provided useful data and insight into community healthcare needs. It also provided a community partnership between We Care Clinic and St. Clair County Housing Authority. Future projects are needed to assess community needs within St. Clair County. As

mentioned previously, more partnerships within the city of East St. Louis are needed. Other areas that We Care Clinic serves that could benefit from services include Cahokia, Fairmount City, Collinsville, and Granite City. Due to the large number of counties, we were unable to send the surveys to each unit at once. Mobile health one day will become a great asset to these vulnerable population groups and decrease disparities within the health care system.

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