GEORGETOWN UNIVERSITY
McCourt School of Public Policy

CENTER ON HEALTH INSURANCE REFORMS

Beyond the Clinic Walls: Exploring the Potential of Mobile Health

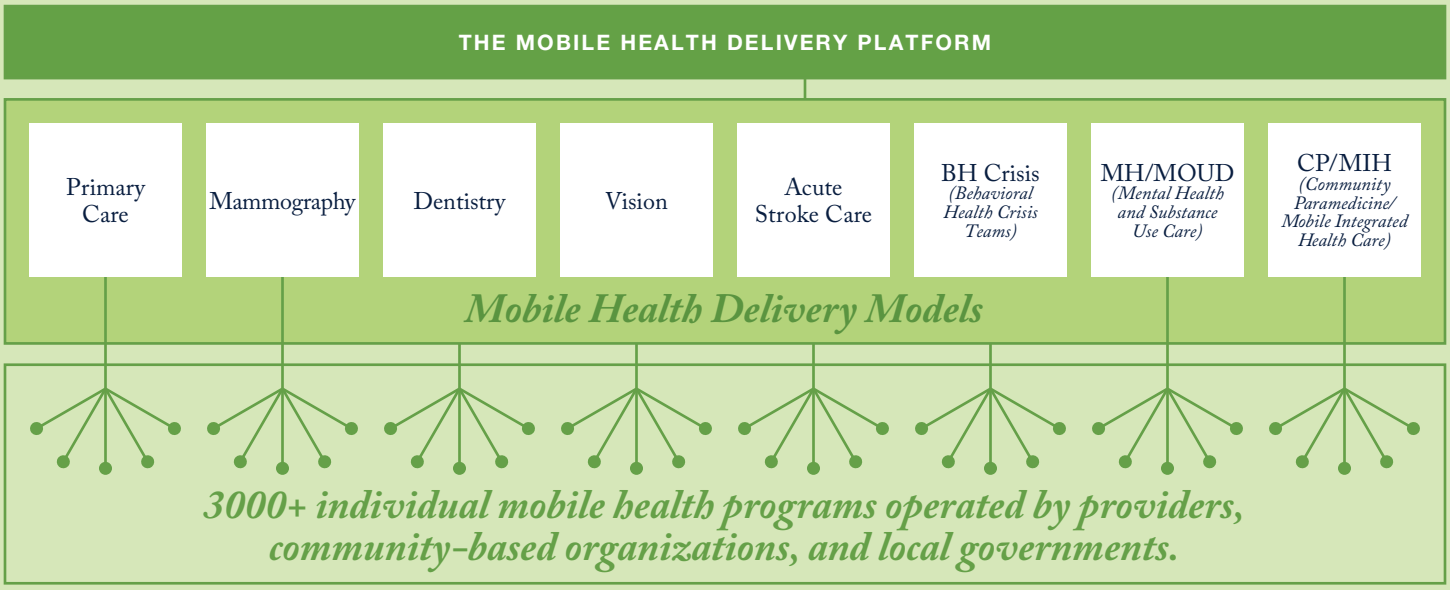
Executive Summary

Despite nearly $5 trillion spent on health care annually, millions of Americans remain unable to access basic health care services. Current evidence, across more than 160 studies,* indicates that mobile health–clinical and preventive care delivered by different health care professionals with the help of a specialized vehicle–is a promising solution bringing health care workers and clinics directly to communities across America.

WHAT DOES MOBILE HEALTH LOOK LIKE IN PRACTICE?

Today, many providers, public health agencies, and community-based organizations run **individual mobile health programs that vary widely** in terms of the populations they serve, the staffing models they use, and the types of services they provide.

Together, these individual programs demonstrate that the concept of **mobile health—delivering care directly into the community through the use of specialized vehicles—serves as a very malleable delivery platform** that can be repurposed to meet many communities' needs.



MOBILE HEALTH IN ACTION: PRIMARY CARE

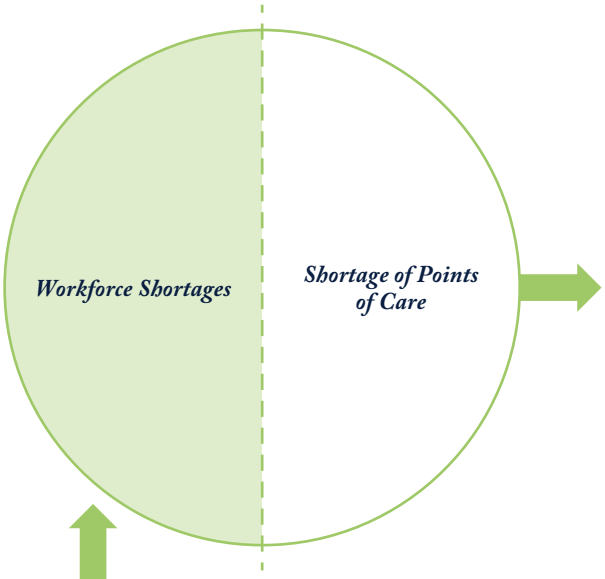
A student-run mobile primary care clinic in rural Kentucky provides basic care, chronic disease management, and referrals to care to people experiencing homelessness, while also providing necessary experiential training for medical, nursing, pharmacy, and physician assistant students (Firchow 2025).

**All information in this document is derived from a narrative review on the impacts of mobile health conducted by Georgetown University's Center on Health Insurance Reforms, titled "Beyond the Clinic Walls." Research conducted by April 30, 2025; and report published in September 2025. The complete report along with a reference list is available at https://chir.georgetown.edu/mobile-health.*

MOBILE HEALTH HELPS MITIGATE ACCESS GAPS

Expanding mobile health is a cost-effective way to increase the availability and proximity of care sites—expanding the reach of fixed site facilities and telehealth, particularly in rural areas, or operating independently in areas that fixed site facilities and telehealth can't reach—while complementing efforts to address workforce shortages.

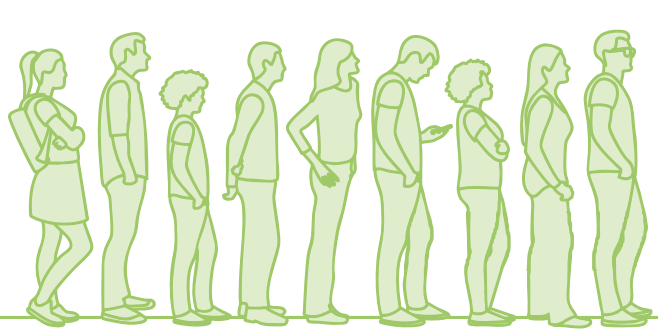
KEY CONTRIBUTORS TO ACCESS GAPS

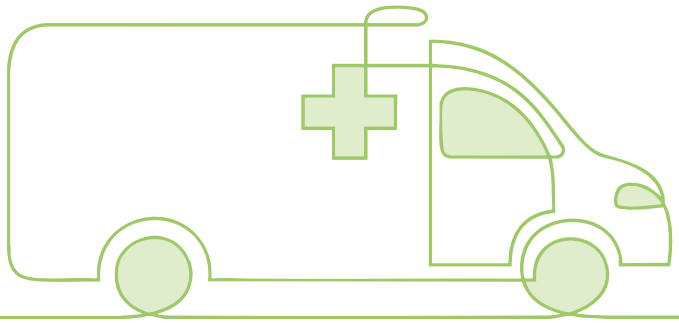


EXPANDING POINTS OF CARE DELIVERY

	Fixed Site	*TeleHealth*	*Mobile Health*
Delivers hands-on care	✓		✓
Requires minimal digital access/literacy	✓		✓
Can host telehealth visits and bring broadband to disconnected areas	✓		✓
Does not require patient transportation		✓	✓
Reduces infrastructure and overhead costs		✓	✓
Quickly scalable across regions or populations		✓	✓

Evidence shows that mobile health can help develop a culturally competent workforce





MOBILE HEALTH IN ACTION: MENTAL HEALTH AND SUBSTANCE USE CARE (MH/MOUD)

A mobile clinic in Chicago, IL provides care for those struggling with Opioid Use Disorders (OUDs). It brings an interdisciplinary team of providers to areas of Chicago with high overdose rates (Messmer 2023).

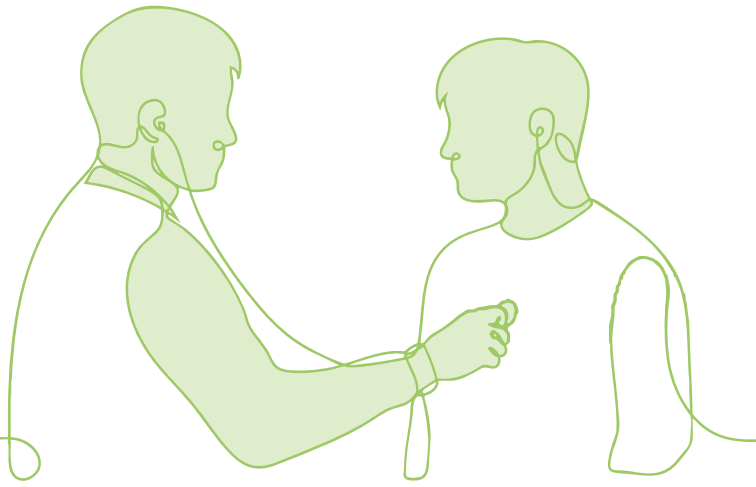
MOBILE HEALTH IMPROVES ACCESS FOR THOSE WHO NEED CARE THE MOST

Mobile health models consistently reach populations historically left out of the traditional health system—those facing geographic, financial, cultural, or systemic barriers to care. Existing evidence shows that many mobile programs either:

- specifically target their services to hard-to-reach populations; or
- as a result of their ability to reduce structural barriers to care, have been able to serve hard-to-reach populations.

For example, a Detroit mobile primary care program uses social vulnerability data to identify and more effectively reach communities with the highest need (Levy 2021). Another Minnesota mobile program spared patients in rural areas a 30- to 60-mile trip they would otherwise have made to receive basic care (Iqbal 2022).

POPULATION	MODELS WITH DOCUMENTED IMPACT ON POPULATION
Rural Residents	Primary Care • Vision • Dentistry • MH/MOUD Mammography • Stroke Response • Community Paramedicine
Low-Income & Uninsured Communities	Primary Care • Vision • Dentistry MH/MOUD • Mammography
Racial & Ethnic Minorities	Primary Care • Vision • Dentistry MH/MOUD • Mammography
Older Adults	Vision • Dentistry • Mammography Stroke Response • Community Paramedicine
Low-Income Children & Adolescents	Primary Care • Vision • Dentistry Behavioral Crisis Intervention
People Experiencing Homelessness	Primary Care • Vision • MH/MOUD Behavioral Crisis Intervention
Justice-Involved Individuals	MH/MOUD • Behavioral Crisis Intervention
People Who Inject Drugs	Primary Care • MH/MOUD



MOBILE HEALTH IN ACTION: VISION

A school-based mobile vision program in Baltimore, MD provides free eye exams and glasses at public schools to students in pre-K through grade 8 (Guo 2021).

MOBILE HEALTH DELIVERS TANGIBLE, CLINICAL, FINANCIAL, AND COMMUNITY BENEFITS

Mobile health programs don't just expand access—they deliver measurable clinical, financial, and community-level impact.

BETTER HEALTH OUTCOMES, PATIENT SATISFACTION AND CARE CONTINUITY

- Identification + control of cardiometabolic risk
- Early identification + treatment of HIV/Hep C among high-risk adults
- Sustained retention on medication for opioid use disorder
- Early-stage (0–1) cancer detection in underserved women

10 mmHg drop in BP (Song 2013)

- Shift from invasive to preventive care; drop in tooth decay
- Immediate and durable vision gains after on-site glasses
- Faster stroke intervention → higher functional independence at 90 days
- Higher patient satisfaction and trust; demonstrated preference
- Better continuity & linkage to care

11 pp gain in functional outcomes (Grotta 2021)

COST SAVINGS AND GREATER EFFICIENCY

- Reduced ED visits
- Reduced hospitalization
- Lower overall spending on stroke care in certain contexts (Stroke Units)
- Lower per-encounter costs (Dental and MOUD)

3:1 ROI on CP/MIH (Roeper 2018)

$108 per MOUD visit (Shah 2024)

NEW TRAINING OPPORTUNITIES, BETTER STUDENT ACHIEVEMENT, AND INCREASED SAFETY

- Workforce development and a culturally competent training pipeline
- Educational gains for school children (Vision)
- Drop in minor crime and arrests (MOUD and BH Crisis)
- Curbing the spread of infectious diseases

34% fewer drug arrests (Fixler 2024)

BUILDING THE EVIDENCE BASE: WHAT POLICYMAKERS CAN DO

Current evidence provides policymakers with a solid foundation for immediate action and investment in mobile health. Policymakers can also help fill remaining evidence gaps to foster expansion of mobile health programs by taking the following actions:

1. **Standardize data collection across mobile health programs:** Include patient demographics and key health/utilization outcomes as metrics for grant recipients and pilot program participants.
2. **Track the use of mobile health, telehealth, and fixed site care by different populations across time to better understand trends and patterns of use:** Ensure that all payers and providers are consistently denoting the site of service in their claims data
3. **Fund further research to understand how to most effectively deploy mobile health:** Prioritize funding studies that (1) compare the long-term impacts of mobile delivery to that of fixed site or telehealth delivery; and (2) compare programs combining these three delivery models to traditional fixed site-only care.
4. **Build a community of mobile program operators, researchers interested in this space, and public health officials to encourage shared learning:** Develop a learning collaborative to support and build the mobile health field.

Learn more: chir.georgetown.edu/mobile-health