Expanding School-Based Health Services Through Mobile Clinics

Models, Metrics, and Sustainable Impact

Panel Presentation | School-Based Health Alliance | 2026

Learning Objectives: Assess mobile clinic effectiveness • Design sustainable integration strategies

Continuing Education Credits

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Voices from the Field

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Session Overview

The Problem & Model

Access barriers, equity gaps, and how mobile extends School-Based Health Center (SBHC) reach

Implementation

Data analysis, engagement, deployment, and field operations

Metrics & Impact

Key Performance Indicators (KPI), clinical outcomes, and translating data for district leaders

Sustainability & Funding

Three-pronged funding model, Memorandum of Understanding (MOU), and long-term program viability

Panel leaders from Community Health Centers share real-world approaches, implementation strategies, and lessons learned.

The Problem we are trying to solve / Why Mobile Healthcare Matters in Schools

4x
Reach Extension

Mobile extends SBHC reach vs. traditional brick-and-mortar clinics

70%+
Medicaid/CHIP

Students served are uninsured or enrolled in public insurance programs

↓ Cost
Per Emergency Department (ED) Visit

Early mobile intervention prevents costly emergency department encounters

Key Access Barriers Mobile Clinics Address

- Transportation insecurity
- Long wait times
- Distrust of unfamiliar settings
- Missed instructional hours
- Social determinants of health

The Model: Mobile Clinic as Satellite SBHC

The Satellite Clinic Approach

Mobile clinics travel to schools — complementing fixed-site SBHCs rather than replacing them.

✓ Medical, behavioral health & dental in one unit
✓ Deployed during school hours to minimize disruption
✓ Reaches Title I, transportation-insecure students
✓ Integrative model with school nurses & counselors
✓ Culturally & linguistically responsive care

School Physicals, Sports Physicals & Sick Visits

Behavioral Health & Dental Care

Chronic Disease Management

Vaccinations & Screenings

The Model - PanCare

Strategy

11 mobile units serve school-age children across multiple counties in rural northwest Florida with annual medical screenings, two dental visits, follow-up optometry, and sports physicals.

Summer deployments support assisted living facilities, detox centers, and Head Start programs.

Execution

Station-based school screenings (vision, hearing, BMI, scoliosis); no on-site dental procedures.

Clinics staffed by PAs/NPs, 3–4 dentists, hygienists, and assistants; pediatric referrals as needed.

Operate 8-9 hrs/day, 5 days/week

Financial Sustainability Strategy

- SCHOOL-BASED CARE PARTNERSHIPS
- MEDICAID PAYER MIX ADVANTAGE
- 340B PHARMACY PROGRAM
- MEDICAL & DENTAL REVENUE
- BEHAVIORAL HEALTH SERVICES
- OPTOMETRY SERVICES
- HRSA EARLY CHILDHOOD DEVELOPMENT GRANT
- BEHAVIORAL HEALTH EXPANSION GRANT
- SCHOOL-BASED SERVICE GRANTS
- STRATEGIC PEDIATRIC INVESTMENT (PLANNED)
- OPERATIONAL EFFICIENCY STRATEGY

The Model – FamilyCare

- School-based mobile clinics operate across multiple counties require coordination between providers, schools, and community partners
- The care model is multifaceted incorporating medical, behavioral health, dental and social services with close integration and communication to promote students and community health and wellness
- Our Model: Data drives deployment decisions, identifies unmet needs, measures outcomes, and supports sustainability and funding

- Engagement from school nurses, counselors, administrators, and staff is critical
- Provider and staff integration into the school and community as a whole is paramount to success
- Providers view mobile healthcare as a way to strategically redistribute care into high-need schools using population health and SDOH data

The Model – East Georgia Healthcare Center

Build Sustainable Partnerships
Strong partnerships with schools and community groups create consistent pipelines to accessible care

Invest in Infrastructure & Innovation
Customize units for on-site needs and grow sustainably with grants and telehealth

Mission & Sustainability can Coexist
Outreach efforts should be mission-driven, but they must also link back to sustainable revenue streams. Programs that ignore financial viability risk burnout and collapse

Layer of Services for Year-Round Viability
No single outreach model (except school-based case) is sustainable alone. Programs must weave together multiple services into a year-round plan

Prioritize Access
Mobile healthcare succeeds when care is delivered where students already are. Reducing transportation barriers and time away from class increases utilization and continuity of care

Focus on Employee Satisfaction
Staff retention is key to revenue – without incentives, clinics lose talent to hospitals and other healthcare facilities

Adaptability Drives Sustainability
Successful programs adapt their services, staffing, and deployment strategies to meet the needs of the communities they serve. Long term sustainability depends on continually evaluating performance and evolving the model as those needs change

Implementation Process: From Data to Deployment

01

Data Analysis & Needs Assessment

- Review student health profiles & consent histories
- Identify unconsented/unserved students
- Assess wait times vs. class time lost
- Use Teacher Cancellation Low Income (TCLI) data to target Title I schools

02

Engage & Deploy

- Cultivate School Champions (nurses, principals)
- Design consent outreach (digital + paper)
- Align deployment to academic/sports calendars
- Designate family & community program advocates

03

Maintain & Optimize

- Electronic Health Record documentation & Health Insurance Portability and Accountability Act (HIPAA)/ Family Educational Rights and Privacy Act (FERPA) compliance
- Rotate services based on evolving needs
- Track no-show & utilization rates
- Run Plan-Do-Study-Act (PDSA) cycles aligned to semesters

Engagement Strategy: The School Champion Model

"If they buy in, we typically have a success. Once we have a breakdown somewhere in that chain, those are the schools we're struggling at."

School Nurse

Justifies need to leadership; knowledge of student health needs is invaluable

Principal

Empowers operational decisions; grants administrative buy-in for scheduling

Counselor / Liaison

Connects families; facilitates consent collection and student referrals

Community Champion

Students, families, and staff who amplify program visibility and trust

Common Challenges & Field-Tested Solutions

Low Consent Return Rates

→ Targeted outreach with champion coordination; multilingual materials; QR code digital consents

No-Show & Scheduling Conflicts

→ Align deployment to academic and sports calendars; send reminders; build in makeup days

Data Integration

→ EHR/Universal Data System (UDS) readiness; centralized data tracker; separate mobile from fixed-site data

Staffing Models

→ Nurse / Dental Practitioner-led teams with Medical / Dental Assistant and behavioral health support; telehealth backup for coverage gaps

School Coordination

→ Joint planning meetings; clear MOU roles; school staff as co-owners of the program

Student/Family Trust

→ Culturally responsive care; familiar setting; community ambassadors and testimonials

Case Studies

PanCare – EKGs and Sports Physicals

FamilyCare – Data driven and Staff Engagement

East Georgia – Staff well being / increasing consents

Metrics That Matter: KPIs & Impact Measurement

Clinical KPIs

- Immunization compliance ≥95%
- Behavioral health screening (PHQ2/PHQ9)
- ≥80% chronic disease control (asthma)
- ≥75% follow-up visit continuity
- 600+ counseling sessions / year

Operational KPIs

- No-show rate ≤10% (from 18%)
- Cost per visit ≤$150
- SDOH screening ≥80% of patients
- EHR compliance ≥95% within 72 hrs
- 1.5 visits/student/year utilization

School KPIs

- Consent return rate per school/grade
- Academic disruption time per visit
- Referral completion rate
- Health-related absenteeism reduction
- Year-over-year patient retention

Integrating Mobile Clinics with Existing SBHC Systems

Integration Principles

- Complement, don't compete with fixed-site SBHCs
- Shared EHR and care coordination pathways
- Joint planning with school nurses & district health staff
- Referral loops: mobile ↔ fixed site ↔ specialty
- PDSA quality improvement cycles by semester
- MOU frameworks that define roles & responsibilities

MOU: Key Elements

District Provides:

Space/parking, utilities (electricity), staff coordination, championing

Organization Provides:

Licensed staff, billing, HIPAA/FERPA compliance, consent management, services, championing

Joint Commitments:

Planning meetings, community engagement, advocacy for sustainability, championing

Compliance:

HIPAA + FERPA data security; applicable licensure and credentials, championing

Impact Starts with the Problem we are trying to solve
Whose problem is it?

The Most Important Metric: The One That Solves Your Problem

- Not every organization is trying to solve the same challenge
- Impact cannot be measured until the problem is clearly defined
- The right metric is the one that shows progress toward your mission
- A metric that matters for one program may be irrelevant for another

Key Question:
"What problem are we trying to solve, and how will we know if we're solving it?"

The most important metric - (Conversation)

- **What tells your story?**
- **How do you show impact?**
- **What metric are you proud about that other programs can use?**

Sustainable Funding: The Three-Pronged Model

PILLAR 1

Clinical Revenue

- Medicaid/CHIP billing (≥70% of students)
- FQHC encounter rate maximization
- Sliding fee scale for uninsured
- Dental services: highly reimbursable
- 15–20 billable visits per clinic day

PILLAR 2

Institutional Support

- County government funding commitments
- School district in-kind contributions
- State contract & grant revenue (e.g., VA RFP)
- Nonprofit hospital community benefit funds
- Department of Health partnerships

PILLAR 3

Philanthropic & Grant Revenue

- Foundation grants (child health, equity)
- Corporate & employer partners
- Federal program grants
- Mission-aligned storytelling & reporting
- Rural Health Transformation Program

Lessons Learned from the Field – Questions

Year 1 is slow — and that's normal

Expect slower utilization in Year 1 as consent rates build. Programs typically become cost-effective in Year 2.

Champion relationships are everything

The school champion is the single biggest predictor of program success. Invest in that relationship first.

Align to the academic calendar

Deploy during physicals season (Aug–Sep) for highest utilization. Align surge staffing to match school demand.

What is your strongest revenue stream?

For example, dental services are highly reimbursable under Medicaid and build community trust rapidly. It is an entry door

Translate data into education language

District leaders respond to absenteeism metrics, not clinical KPIs. Bridge that gap in every report you share.

Diversify funding from day one

Relying on a single revenue stream is fragile. Build the three-pronged model into your launch plan — not as an afterthought.

Thank you!

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