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Recommended Citation

Gillispie, Melinda; Mobley, Catherine; Gibson, Lynette M.; and Moore de Peralta, Arelis, "Perceptions of and Preferences for a Mobile Health Clinic for Underserved Populations" (2016). *Publications*. 99.
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GREENVILLE HEALTH SYSTEM

Special Article

Perceptions of and Preferences for a Mobile Health Clinic for Underserved Populations

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Abstract

Background: Research has established that members of particular demographic groups are inordinately burdened by differential healthcare access. Mobile health clinics (MHCs) are emerging across health systems to improve access to care of marginalized populations. This study explored the perceptions and concerns of community residents living in underserved neighborhoods toward MHC services.

Methods: This study used a qualitative descriptive design with 5 focus group meetings. Purposive sampling was used to recruit ethnically diverse, English- and Spanish-speaking men and women ages 20–67 residing in 5 underserved neighborhoods in Greenville County, SC.

Results: Participants (N = 35) felt positive about obtaining personalized health care through an MHC unit. MHCs were viewed as convenient, situated in a central location in the community. Participants described positive qualities of MHCs, including cleanliness, attractiveness, convenience, comfort, consistency, compassion, and safety. Participants suggested the MHC should provide basic emergency "triage" care and transport to the hospital if necessary, and act as a conduit for offering health education and access to affordable prescriptions. Participants' preferences for days of service varied; however, consistency of service and placement in a safe community area were more important.

Conclusions: Findings demonstrated that it is important for health systems to ascertain the level of acceptance and readiness among residents in underserved communities for an MHC; this assessment should take place prior to launching the MHC. Delivering health care through an MHC involves more than providing tangible healthcare services to community residents. Consistent, respectful, and high-quality care should be the foundation of MHC development and ongoing implementation.

Research has established that members of particular demographic groups are inordinately burdened by differential healthcare access resulting from their race, ethnicity, social class, and geographic isolation.[1,2] Given predictions that our society will become even more diverse in the next several decades, these health disparities will likely continue to be a challenge. To address differential healthcare access, many healthcare systems have introduced mobile health clinics (MHCs) to their mix of service delivery options. MHCs are defined as "transportable healthcare units that enable the provision of community-based care off-site from institutions and healthcare agencies to underserved populations that may otherwise be hard to reach."[3] That is, MHCs aspire to reach the more vulnerable populations that would otherwise have inadequate access to high-quality health care. Many MHCs often operate as an extension of larger healthcare systems to which patients are referred if they need additional services not addressed by a particular MHC.

MHCs have become increasingly common in the past decade; estimates indicate that 2000 such facilities provide services to 6.5 million people each year.[4] MHCs provide a variety of preventive and primary care services, depending on available resources and on the particular community being served. Services include treatment of acute conditions (eg, common cold, minor injury care, etc.) and chronic conditions (eg, diabetes, hypertension, etc.); lab and diagnostic services; cancer screenings; specialty clinics; dental care; ophthalmology services; medication and prescription assistance; and health education. Over the past several years, MHCs have transitioned from addressing episodic, urgent healthcare needs to providing ongoing care to individuals with chronic conditions, a trend that is likely to increase in the future.[5]

In fall 2015, the Department of Community Relations at Greenville Health System (GHS) funded and initiated a community assessment to determine residents' attitudes and perceived needs pertaining to MHCs. This endeavor contributes to GHS' efforts to expand access to health care via an MHC in Greenville County, SC. The research effort reported here consisted of 5 focus groups conducted in 5 underserved neighborhoods in Greenville County. The study results provide a starting point for the design, development, and delivery of MHC services to communities across the county.

Methods

The focus group methodology was used to ascertain residents' general opinions about and preferences for an MHC. A hallmark of this methodology, which distinguishes it from the frequent, but inaccurate, label of "group interview," is its encouragement of interaction among group members to elicit richer qualitative data about the topic under discussion.[6] The dynamic nature of focus groups often brings information to the surface that would not otherwise emerge through other methods of research. The open-ended structure of focus groups allows researchers to learn *what* people feel about a particular issue, as well as *how* and *why*.[7] In that respect, focus groups have several advantages over other forms of research, such as surveys, which generally collect individual responses to closed-ended questions that often do not allow for elaboration.

Sample Selection and Participant Recruitment

The GHS Institutional Review Board approved this study in October 2015. Purposive sampling was then used to select ethnically diverse, English- and Spanish-speaking women and men ages 20–67 who resided in 1 of 5 underserved neighborhoods in Greenville County, SC, at the time of the study. The 5 underserved neighborhoods were chosen based on areas of high risk and need for healthcare services and were selected as pilot sites for initial MHC delivery.

Participants were recruited through community centers, churches, community outreach representatives, community-based service provider liaisons, and GHS neighborhood health partners. Three days prior to the focus groups, study researchers contacted participants to remind them about the study. At the conclusion of each focus group, participants were provided with a $25 gas card. All individuals who volunteered to participate and who were scheduled for one of the focus groups ultimately participated in the study. The demographic characteristics of the focus group participants are summarized in Table 1.

Focus Group Delivery

The focus groups were held December 2015 at locations convenient to the participants, including community centers and churches. Each focus group had a main moderator, who led the focus group, and the principal investigator who took field notes throughout. Before starting any study-related procedures, participants were issued the informed consent. Each page of the informed consent was verbally read to them to ensure participants had a full understanding of the study. All participants provided written informed consent and completed a brief demographic questionnaire, providing information about background characteristics, current health status, and primary source of health care. Eleven questions were asked in the 5 focus groups. All 5 focus groups were audio recorded.

Data Analysis

The data analysis proceeded in several stages. First, a professional transcriber transcribed each focus group interview; each transcript was then verified for accuracy. The Spanish-speaking transcripts were transcribed to English by a GHS certified Language Services employee. One study investigator (C.M.) then engaged in more in-depth analysis, first reading each transcript in detail and writing initial analytic notes on emerging insights that guided the subsequent coding and analysis. The final transcripts were then uploaded into the qualitative software package ATLAS.ti (Version 1.0.49), an analytical tool that aided in the initial categorization and cod-

ing of the data. Subsequent data analysis incorporated both deductive and inductive coding. The deductive analysis reported in this paper involved a more directed approach, guided by the interview protocol. Variables were coded according to the questions asked during the focus group. This coding was done to ensure that the primary research questions were addressed across all 5 focus groups. Then, using an iterative approach, these pre-existing codes were compared with the new codes and themes that emerged in the second stage of inductive analysis. (NOTE: Actual quotes from the focus group respondents appear in *italics* below.)

Results

Initial Perceptions of the MHC Model of Healthcare Delivery

The first main focus group question ("What is the first thing that comes to mind when you hear 'mobile health clinic'? What images come to mind?") served as an "ice-breaker" and allowed the researchers to learn about the participants' general understanding of the MHC concept. Their responses provided a starting point for contextualizing participants' more specific views about MHC service delivery.

A few participants were somewhat familiar with the concept of mobile healthcare delivery or had experience with similar healthcare offerings in the community. Some shared their perceptions about what an MHC looks like, comparing it to a local bloodmobile unit, a *car that has a camper*, *a big bus that can care for people*, *a tour bus*, and *something mobile, that keeps moving, here and there*, from one neighborhood to the next. Participants were aware that an MHC is not equivalent to a hospital and is *not an operating room*. However, they envisioned that the MHC facility would have the *basic equipment* necessary for offering general health care to the community. The MHC is viewed as a *doctor's office on wheels* that *comes with medicines, vaccinations for the kids, for people, for everybody.*

Participants were aware that MHCs offer *affordable* health care for those who cannot generally pay to see a doctor through the traditional healthcare system; they perceived that an MHC would be less expensive than a hospital. Participants felt that this model of healthcare delivery is thus valuable to those *in need* of low-cost health care, especially for those who *don't have insurance* and cannot *afford to take [their children] to the doctor every time they got a scratch*. Such a facility offers *easy access* for *the people who really need it, if they come and take*

Table 1
Demographic characteristics of focus group participants.

Characteristic	
N	35
Gender, no. (%)	
Female	28 (80.0)
Race/Ethnicity, no. (%)	
African American/Black	24 (70.6)
Caucasian/White	2 (5.9)
Latino/Hispanic	8 (23.5)
Age, years (mean = 44.8), no. (%)	
20–29	7 (20.1)
30–39	8 (22.8)
40–49	6 (17.1)
50–59	5 (14.2)
60–69	9 (25.7)
Education, no. (%)	
Junior HS or less (1st-8th grade)	3 (9.1)
Some high school	6 (18.2)
Graduated high school or earned GED	9 (27.3)
Some college/technical school, no degree	10 (30.3)
2-year college degree	4 (12.1)
4-year college degree	1 (3.0)
Employment, no. (%)	
Working full-time	5 (14.3)
Working part-time	8 (22.9)
Self-employed	1 (2.9)
A homemaker	6 (17.1)
Out of work for more than a year	2 (5.7)
Out of work for less than a year	1 (2.9)
Retired	2 (5.7)
Unable to work	10 (28.6)
Income, no. (%)	
Less than $10 000	16 (47.1)
$10 000–$19 999	9 (26.5)
$20 000–$29 999	2 (5.9)
$30 000–$39 999	3 (8.8)
$80 000–$89 999	2 (5.9)
Choose not to answer	2 (5.9)

Note: Not every focus group respondent answered every item on the questionnaire.

advantage of it. The health care offered through an MHC was equated to a well-known local clinic for low-income residents, in terms of affordability and access. Participants indicated that an MHC would also offer services to vulnerable populations, such as the *elderly* and *homeless*.

MHCs were viewed as *convenient*, situated in a central location in the community, thus offering *quick and easy access* to health care. As a model of *mobile sufficient care*, MHCs are important *because some people ... may need some [non-emergency] help. And by the bus being in the community, they may be able to get there quicker and to receive the help they need at that time*. This point is especially important for individuals lacking transportation and for those whose busy and complex schedules make it difficult to visit healthcare professionals in other locations. Thus, participants envisioned that an MHC would have a predictable schedule: *I imagine that the doctors come on a certain day, certain time, to a place that is conditioned to give care.* Patients would thus be able to get *an appointment to go there at a certain time and get out fast*.

Related to convenience, *accessibility* (*local health)* was an additional key characteristic. This more specific factor refers to the ease of seeing a particular doctor. As one participant indicated, the presence of the MHC would be much like having a *workplace nurse* that offers "on-the-spot" diagnosis at places of employment. In the words of one participant, *the nurse could say "you need to be seen right now. You need to go to the emergency room." [As a result, at an MHC], at least you could be told the seriousness of your situation, if it is serious.* Thus, the MHC is also where residents can get emergency treatment, especially if they cannot see their regular doctor and the MHC happens to be in the community at the time that they need such care.

Prior Experiences With the MHC Model of Healthcare Delivery

To learn more about participants' views on MHCs, participants were asked to describe their prior experiences with this model of healthcare delivery. Several participants indicated they had visited a local bloodmobile unit and remarked on several positive qualities of this facility, including cleanliness (*You wouldn't be afraid that you would catch something or be contaminated by; It's obviously very clean)*; attractiveness (*It's very visible and showy*; *You can't miss it)*; convenience (*You don't have to have an appointment)*; comfort (*It's not like it's small in there)*; safety; and the well-qualified staff *who know what they're doing*. Because the local bloodmobile unit has a *substantial and known presence* in the community, residents seem to trust the care it offers.

Some individuals reported they that had visited a mobile dental health clinic in the community. Another participant visited a mobile health facility offered by a local hospital at a local church. In this instance, the participant described receiving mammograms and other women-centered services through this healthcare modality. This participant was impressed with the convenience, the quality of services provided, and the friendly and attentive staff: *I arrived and they provided me with a great service, because they are very nice people, the ones there. Then, I had some tests done and it was fast. I don't have a reason to lie to you. They didn't take a long time. I even went, "Wow, this is faster than the hospital."* Another participant, who volunteered at the MHC sponsored by a local hospital, described the facility as *beautiful, state-of-the-art* and the staff as *wonderful, very friendly,* and *very much oriented to outreach*. She said that she *couldn't imagine someone hesitating to want to have any kind of health care on that bus.*

Nearly all of the participants in one focus group indicated they did not have prior experience with an MHC. Similarly, participants in another focus group indicated that they had no prior experiences with MHCs. However, when prompted, they said they were familiar with the local bloodmobile unit.

When asked about their initial perceptions of MHCs, several participants provided examples of health care offered through other kinds of entities, such as stand-alone facilities and a logistic transport service. Although not directly comparable to MHCs, the responses offer insights into the characteristics that should be considered when offering MHC services. One participant reported having a negative experience with a dental clinic offered through a community-based health clinic offering medical services to community members at no cost. She said she waited in line for a long time for this *first-come, first-served* service; due to the long wait, though, she ultimately had to be rescheduled for the next day.

Perceptions of MHC Delivery in Participants' Own Neighborhoods

After providing information about their initial perceptions and prior experiences with the MHC model of health care, participants were asked several more specific questions: "What do you think about health services provided on a

bus by the hospital system that would drive into your neighborhood?" and "How do you feel about using a mobile health bus in your neighborhood for healthcare needs?" These questions aimed to gather information about how participants would feel about an MHC unit coming to their own neighborhood versus obtaining health care through more traditional avenues. In this respect, then, these questions encouraged participants to imagine what it would be like, in more specific terms, if an MHC came into their community. As indicated below, participants provided more personalized examples and a greater variety of opinions in their responses to these questions.

Overall, participants felt very positive about the prospect of an MHC coming to their own neighborhood, saying it would be *fantastic*, *great*, *wonderful*, *nice*, and *beneficial to everyone, full circle.* As one participant said, *I would love it! That's all I've got to say. I would love it*. Another participant indicated she would feel *comfortable and grateful,* especially given that she faces language barriers when obtaining health care through a hospital. Participants felt they could gain access to a *variety of services* through MHCs and thus expressed that an MHC would be valuable to children, teens, elderly, and the disabled alike. In the words of one participant: *I have to take my son to the doctor when he has a problem … and make sure he's fine. But then in the long run, I don't worry about myself. I just make sure my child is OK.*

Another participant recognized that the MHC would be an asset for those people who won't or *can't get out and that would otherwise not get treatment*, perhaps because they are not able to, cannot afford it, or resist going to the doctor. For example, one participant indicated that she often cancels her regular doctor's appointments: *I say, "I've got a doctor's appointment. I don't want to go."… [then] I might call and cancel and then go the next time.* However, she indicated that if the MHC came to her neighborhood, she would take advantage of its services. Another participant corrected the assumption that an MHC only benefits very poor community residents, saying that it would *benefit a lot of people with different incomes, different background[s].* She continued by saying *a lot of people always think it's just about somebody who does not work or [is] just poor or homebound … but it really helps people like me. I'm working class and … self-employed. So, health care for me would be very, very expensive. So stuff like this really helps.*

The easily accessible health care available through an MHC is very important to participants who feel that the MHC would likely *curb visits to the emergency room.* Also, participants perceived that they would not have to wait as long to see a doctor at an MHC as they would at a hospital or at a regular doctor's office. In the words of one participant: *It would be just as good or valuable to you as being seen in a doctor's office, where you may wait 2 hours and then see a nurse practitioner.* Another participant noted that many people feel like they have to wait for a long time when they see a regular doctor*, and they don't have time to go, or don't want to go, so a lot of people get neglected by not going.* Thus, *convenient scheduling* is another important characteristic of a neighborhood-based MHC: *Maybe they will give you an appointment … You can go home and come back at the time they gave you, and this makes it more accessible.*

Although participants felt positive about the MHC coming to their neighborhoods, some noted that patients who access health care through an MHC may be stigmatized by their fellow community members, most probably because the MHC itself would have such a visible presence in the community (eg, community residents may see others waiting in line for MHC services): *I think some people would be ashamed to use it because [of the perception that it's] for homeless people, or people who can't afford to get in.* Such individuals may be *embarrassed* to use an MHC due to their strong sense of *pride*.

Others indicated that such stereotypes would not prevent them from seeking health care through an MHC: *It's [about] my health, and if it can help me, I don't care what's going on or what's being said … I will take care of myself.* Another indicated he *wouldn't care what people think. I'd be glad to use it*. Another participant felt that some community members would have *mixed thoughts* about the MHC given that it would be a new entity in the community: *There's going to be a segment of the population that will receive it very well, and I think there will be some people that will be hesitant to think it's a good thing. But that's just different mindsets and different generations … [and] the way they deal with anything new. It takes time for them to accept.*

Preferences Regarding Types of Services Offered Through the MHC

Participants offered a variety of suggestions for the services that could be offered through the MHC, ranging from basic "wound care" to comprehensive *total care … anything that does not require surgery.* They indicated that an MHC could treat

both acute conditions (such as the flu) to more chronic conditions (such as asthma). At the same time, participants were realistic in their expectations, recognizing that there are *certain things you can't take care of on a bus or a mobile clinic.*

Across all 5 focus groups, the most commonly requested service was for basic preventive care and a *general check-up*. As such, participants envisioned that the MHC would offer physical exams, during which the patient could receive a series of lab services and tests, such as blood pressure checks, cholesterol tests, pregnancy tests, and diabetes tests. They would like to receive wound care, plus treatment for fever, colds, and strep throat along with flu shots and X-rays. A few participants specified a need for basic ophthalmic and dental care (eg, checkups, dentures, etc.). They also felt it was important that the MHC have the ability to fill and refill prescriptions and that such prescriptions should be affordable: *We know that we need some type of medicine, and then if we don't have insurance, we have to pay out of pocket for that medicine and things like that. Most medicines I get from the emergency room, my prescription is $50 and above, and … I [don't] always have the money to pay for it.* Easy access to prescriptions was especially important in one of the communities where many residents do not have transportation and where there is no drugstore in the community.

In terms of more specialized care, several participants requested a variety of oncology services, including basic cancer screening, mammograms, and colonoscopies. Several women expressed a desire for OB/GYN care and pediatric services on the MHC. Participants hope that the MHC can offer specialized services for men. As one participant indicated, *the work for men here is so arduous, so hard.* Another participant stated that the men *don't eat well and they work too much, a lot of physical effort.*

Participants envisioned that the MHC would be able to offer basic emergency "triage" care and then transport patients to the hospital, if necessary. Similarly, they felt it was important that the MHC staff be able to refer patients to other doctors for further care, if necessary, and *to send us to the appropriate doctor that we need. Because sometimes we don't know if it is a nutritionist, a psychologist, neurologist, psychiatrist … We don't know.* In cases where a patient would need to be referred to another facility, participants requested that the MHC staff advise them about affordable alternatives for the additional health care. As a participant noted: *I don't have health insurance. [Every year], I go to a private doctor's office … he orders labs [tests and] sends me to a lab. That lab has an agreement with the doctor's office, and they give a big discount to that doctor so I can have my labs done there.* She would like similar arrangements to be available through the MHC.

Some participants see the MHC as a conduit for offering health education to residents; a participant suggested that patients could benefit from nutrition education, dietary services, and advice about exercise. In the words of another participant: *Doctors give you a lot of stuff, but they don't tell you why. They don't say, "You know, if you eat more of this, you can stop taking this pill." … They tell you to diet, but you know, [there are] all kind of diets out there that are bad for your health.*

Beyond obtaining general healthcare services, participants would also like to be able to access information about other services available in the community, to have the opportunity to talk to a social worker, to be able to see a doctor who could diagnose both physical and emotional causes (eg, stress) of illness, and to receive advice about payment plans. Several participants hoped the MHC would also offer a few "extras," including bathrooms, blankets (to keep people warm while they wait), toys, and a waiting room (both for the participants who may be visiting the MHC and their children). The facility should also be handicapped accessible, prioritize persons with disabilities, and have bilingual staff on hand.

Preferences Regarding the Schedule of MHC Services

Participants had a variety of opinions about the preferred days and hours of MHC services, ranging from twice a week to once a month. Although most preferred that the MHC visit at least once a week, they also recognized this option could be difficult. But even once a month would be preferable and *would be better than nothing at all, because this is really needed*; twice-a-month visits would be ideal. As one participant remarked, however, *consistency* of service was even more important than actual frequency. Such consistency would be a way for the MHC staff to show they cared about the community.

Regarding the preferred days of the week for MHC services, several participants preferred weekend hours; participants indicated that both Saturday and Sunday would be convenient for community members. However, it would be nearly impossible for many residents to attend on Saturday due to

childcare duties; thus, they preferred visiting the MHC during the week, when their children are in school. In addition, several female participants indicated that Saturday and Sunday hours would be ideal for the men in the community as it is very difficult for them to attend the MHC during the week (without taking unpaid leave from work).

Preferences Regarding the Location of the MHC

Regarding the ideal location for the MHC, participants offered suggestions based on their geographic locations. For example, participants in one focus group suggested the MHC rotate around a particular community so more residents could avail themselves of the clinic's services. The suggestion was also made to locate the MHC at a church so that healthcare services could be offered on the van and in the church, if necessary. Wherever the MHC is eventually located, several participants indicated that the MHC must be located in a safe area of the community: *And I think people probably would trust, would feel safe going to an area where the churches are versus the outskirts of the community that are maybe perhaps not perceived as safe.*

Limitations

As the study relied on a small, purposefully selected sample, the focus group results should not be generalized to the population within each of the 5 communities included in the study or to Greenville in general. Rather, the findings of the focus groups represent both the opinions of the particular individuals who participated, as well as additional opinions and viewpoints that may have taken form as a result of participating in the focus group.[8]

It is also possible that individuals who participated in the focus groups may have already been predisposed, one way or another, toward the concept of MHCs, and thus began the focus group with a strong bias about MHCs. However, that does not seem to be the case with this study as only a few participants had prior knowledge about or experience with MHCs. Although the focus group format capitalizes on a social context that encourages participants to reflect on one another's ideas, it may also limit the information any one participant can share, inhibit the expression of minority opinions, or limit the participation of individuals who are not particularly confident or articulate. Some individuals may not have expressed their full opinions because of concerns about the confidentiality of what they say in a group setting such as the focus group. It is also possible that some of the rich data and cultural nuances may have been lost when the Spanish focus group's comments were translated into English.

Discussion

Our study used the focus group methodology to more effectively capture the variety of opinions about MHCs in Greenville County. The 5 focus groups provide important insights into residents' opinions about MHC healthcare delivery. Importantly, all 5 focus groups included community residents who are generally disenfranchised from the traditional healthcare system (ie, by virtue of social class, race/ethnicity, geographic isolation, etc.) and thus often do not have the opportunity to express their opinions regarding healthcare delivery. We believe that the focus group methodology holds promise for assessing future community health needs and community interest in health programs and should be considered in the design of any future community health assessments.

In all 5 Greenville groups, the most commonly requested service was for basic preventive care and a *general check-up*; health education was suggested as a way to provide this preventive care. Other researchers agree that services needed include health promotion and disease prevention[3,9,10] instead of focusing on curative services.[3] Based on the results of the focus groups, it is recommended that the MHC provide health promotion and preventive services and consider providing health education. Additionally, although there were differing opinions about the frequency of MHC visits to communities, participants across all 5 focus groups indicated that consistency and predictability were also important. This finding reinforces Campos and Olmstead-Rose's research that emphasized the need for an ongoing provider-patient relationship in the context of MHC services.[5]

Across all 5 focus groups, participants generally felt very positive about the possibility of obtaining personalized health care through an MHC unit that would visit their own neighborhoods. Participants prefer MHCs to be *convenient*, situated in a central location in the community, thus offering *quick and easy access* to health care, and valuable to those who need low-cost health care. Other research studies report that MHCs, more than being geographically convenient, are perceived as offering services that are acceptable, user-friendly, and accommodating to vulnerable populations.[3,5,9,10]

Abbreviations and Acronyms

MHC = mobile health clinic; GHS = Greenville Health System

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Conclusion

This MHC presents an exciting opportunity for GHS to provide health care to underserved and vulnerable populations in Greenville County. Overall, participants had somewhat limited experiences with obtaining general health care through an MHC, although several reported familiarity with the MHC model (similar to that provided through the local bloodmobile unit) and others reported receiving specialized care through MHC-type facilities. Those who reported receiving such services through these facilities felt positive about the experience. Participants stressed the importance of the MHC to offer services with kindness and respect in a clean, safe, and confidential environment.

It is critical for healthcare providers and health systems to understand the needs of underserved communities prior to the launch of healthcare delivery projects and to ascertain the level of community readiness and acceptability. Across all 5 focus groups, participants had favorable opinions about the possibility of obtaining personalized health care through an MHC unit that would visit their own neighborhoods.

Participants desire sustainability and consistency of mobile health delivery services. Participants are especially interested in receiving preventive health care through the MHC, including health education. Thus, health systems may want to consider providing primary health care at the beginning of the MHC delivery initiatives and then consider additional services and programs as they learn more about the community. This process will allow health systems to better meet community members' primary healthcare needs and to develop an MHC that reflects the unique character of each community.

Using focus groups for community needs assessment is a powerful method for determining attitudes and perceived needs because information comes to the surface that would not otherwise emerge through other methods of research. In this study, the researchers, using focus group methodology, were able to successfully conduct a community assessment which determined that groups of residents in underserved communities expressed a desire and readiness for the MHC. Their enthusiasm was exhibited by their questions regarding the MHC start date.

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