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# Eliminating Patient Barriers to Healthcare by Identifying New Opportunities

- Applying Leadership Principles from the Healthcare Leadership Program
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# Introduction

- HealthWorks mission & population served.
- Importance of reducing barriers.
- Focus- Innovative, strategic opportunities to expand access.


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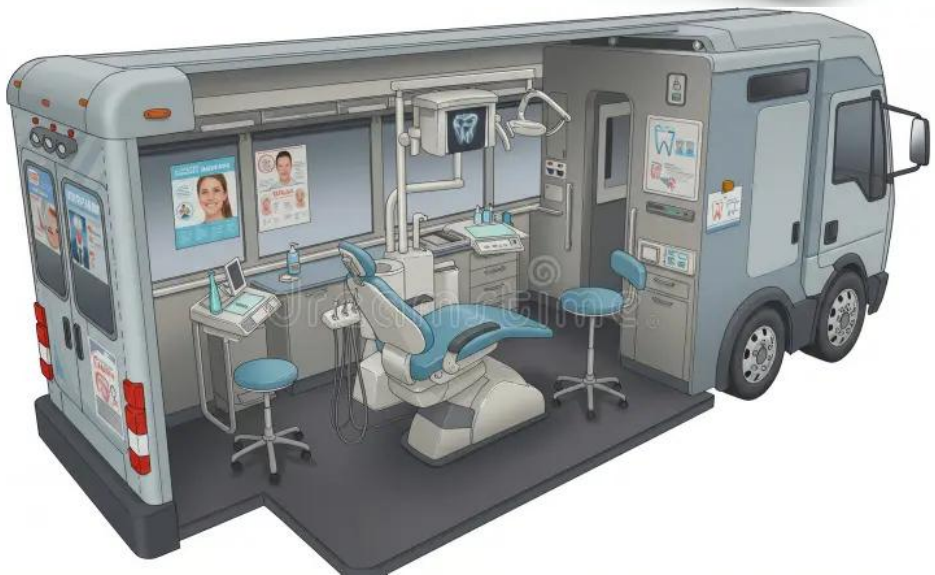
# Challenges to FQHCs

- Transportation, language, tech barriers
- Staffing & funding limitations
- High demand areas
- UDS & compliance pressures

# Opportunity 1- Mobile Health Units

## Financial Modeling

- Funding/Grant Opportunities
- Vehicle+ staffing costs
- ROI Through improved access & retention
- Multi-year budgeting



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# Opportunity 1- Mobile Health Units

**Mobile Health Units with school base health integration:**

**Why schools?**

- Reach children, parents and caregivers simultaneously
- Mobile outreach with School partnership
- Offer consistent location with built in trust
- Provide opportunities to deliver prevention early
- Reduce missed work or class time
- Help Identify unmet behavioral and physical health needs

**Services Provided Through Partnership:**

- Routine Screenings
- Vaccinations
- Health Education Sessions
- Behavioral Health  engagement and referrals
- Oral Care
- Labs
- Insurance Enrolment -ACA

# Opportunity 1- Mobile Health Units

| Barriers to healthcare access | |
|---|---|
| **Barrier Category** | **Data / Description** |
| **Economic Disadvantage** | 20.5% of students classified as economically disadvantaged, impacting their ability to access healthcare<br>Loudoun County Publi Schools, 2023 |
| **Lack of Insurance** | Over 30,000 children were uninsured, limiting access to healthcare services<br>Fairfax County, 2021 (reported 2023) |
| **Language & Cultural Barrriers** | Large minority student populations face language barriers and cultural misundersntings when seeking healthcare |

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# Opportunity 1- Mobile Health Units

## Fairfax County: Key Data Supporting School-Based Mobile Units -Fairfax County Public Schools

- 36% of students qualify for Free or Reduced Meals (FRM)
- Indicates significant economic vulnerability
- Large multilingual population
- High number of English Learners (ELL), especially Spanish-speaking families
- Youth Behavioral Health Concerns
- 22% of FCPS students reported feeling sad/hopeless for 2+ weeks
- Rising anxiety and depression among teens (Fairfax Youth Survey)
- Chronic Disease Prevalence
- Asthma, diabetes and allergy management are top reasons for school clinic visits
- Immunization Gaps
- Many schools show conditional enrollment due to missing vaccines
- Transportation Barriers
- Families in lower-income pockets struggle to access routine care

## Loudoun County: Key Data Supporting School- Based Mobile Units Loudoun County Public Schools

- 8–20% of students qualify for Free or Reduced Meals
- Lower than Fairfax but still significant in certain clusters
- 13.9% of students are English Learners (EL)
- Growing Spanish-speaking and multilingual population
- Youth survey shows rising anxiety, depression, and stress
- Schools report high demand for mental health support
- Preventive Care Gaps
- Schools report vaccine delays and chronic absenteeism in certain regions
- Fast-Growing Student Population
- Transportation Challenges in Rural Pockets
- Families in Purcellville, Sterling outskirts, and Aldie have limited clinic access
- Brings services to rapidly growing, underserved neighborhoods
- Helps reach uninsured or underinsured families
- Supports EL students and multilingual families
- Provides behavioral health and preventive services where gaps exist
- Complements LCPS wellness efforts and county public health strategies

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# Opportunity 1- Mobile Health Units

**Why School Base Mobile Units fit the need in Fairfax and Loudoun county public schools ?**

- Reaches high-need communities directly
- Helps address behavioral health gaps in teens
- Supports immunizations, chronic care follow-up, and preventive services
- Reduces transportation and language barriers
- Helps reach uninsured or underinsured families
- Supports EL students and multilingual families
- Complements LCPS wellness efforts and county public health strategies
- Aligns with equity goals in FCPS and Fairfax County Health Department

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# Opportunity 2-Remote Patient Monitoring

**What is RPM?**

- Remote Patient Monitoring (RPM) is a healthcare model that uses technology to collect a patient's health data from home ,such as blood pressure, glucose levels, oxygen saturation, and weight  and sends it securely to healthcare providers through your EMR Interface
- This allows the Centers to monitor chronic conditions without requiring in-clinic visits, eliminating major access barriers


**Why RPM Is a High-Impact Access Strategy for FQHCs**

RPM directly addresses:

- Transportation challenges
- Work schedule conflicts
- Language & cultural access issues
- Health literacy barriers
- Gaps in chronic disease management
- Patients who cannot come to the clinic regularly can still receive continuous, high-quality care

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# Opportunity 2-Remote Patient Monitoring

## Improves Chronic Disease Outcomes

### Hypertension & Diabetes


### Congestive Heart Failure


### COPD/asthma & Weight management



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# Opportunity 2-Remote Patient Monitoring

## RPM platforms includes:

- Medication adherence tracking
- Sleep monitoring
- Stress/heart rate variability data

## Reduces Emergency Room and Hospital Visits:

- BP readings trending high over several days
- Blood sugar spikes
- Rapid weight gain indicating fluid retention
- Oxygen saturation dropping

## Strengthens Patient Engagement:

- Patients become active participants in their care by:
  - Seeing their numbers at home
  - Learning patterns
  - Taking responsibility for daily management

## Early detection = timely intervention

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# Opportunity 3- Community Care Hubs

## What is Community Care Hub (CCH)?

A CCH is a small, strategically placed access point in the Community.

CCH often located with in the following:

- Libraries
- Community Centers
- Food pantries
- Churches
- Housing complexes
- Senior Centers
- Shelters

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# Opportunity 3- Community Care Hubs

## CCH requires a very low cost

## You don't need :

- Clinic space
- Exam rooms
- Staff dedicated full time
- Full equipment

## CCHs can support Access:

- Health Screenings
- BP checks
- Glucose checks
- Health Education
- Insurance Enrollment
- Enrollment for a Slide Fee Program
- Care Coordination
- Behavioral health warm hand offs

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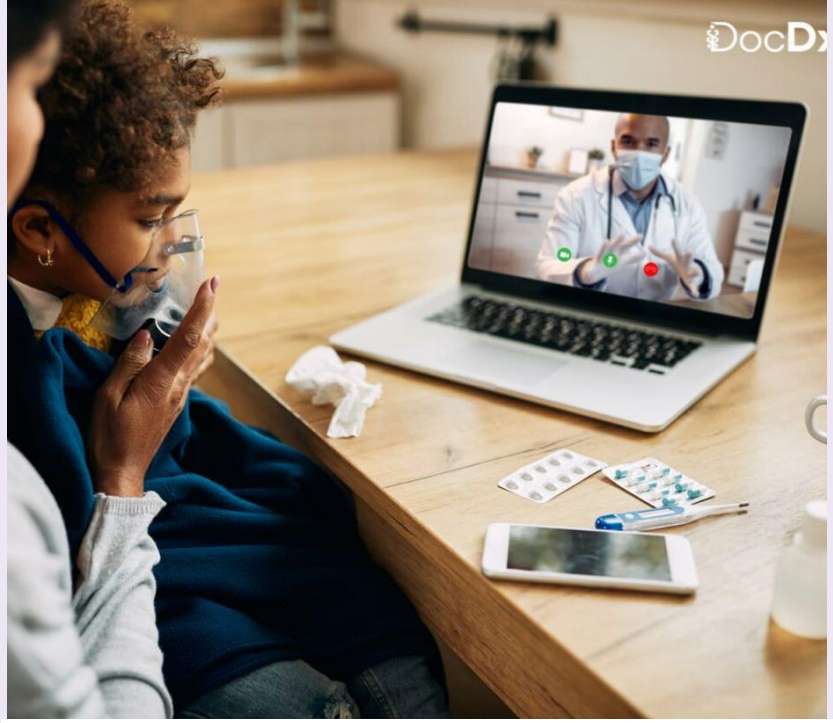

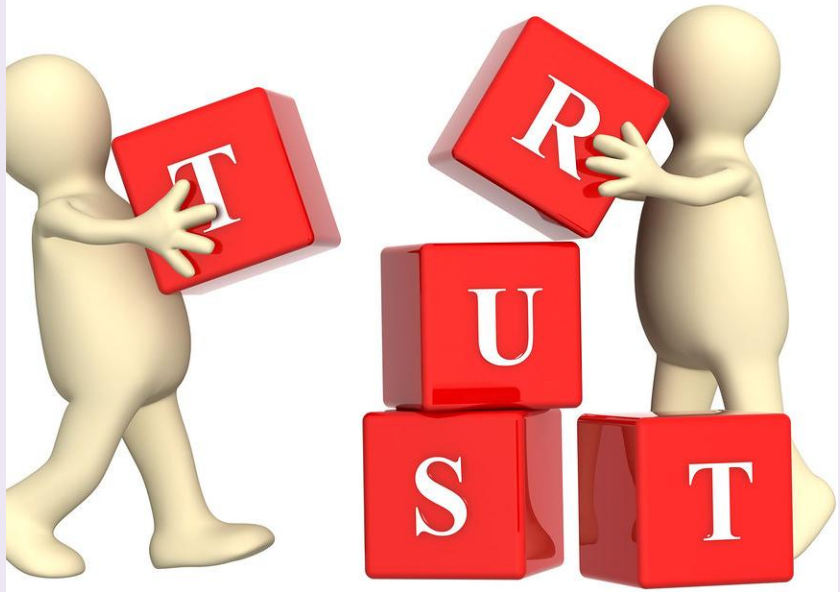


# Opportunity 3- Community Care Hubs

✓ **Community Care Hubs can:**

- Serve as mobile unit stops
- Provide telehealth rooms for people who lack technology
- Assist with RPM training
- Coordinate follow-up appointments

✓ **Builds Trust**

- People are much more likely to engage in care when it is located in a safe, familiar environment.

# Eliminating Patient Barriers to Healthcare by Identifying New Opportunities


- Expanding access is not only possible, it is achievable.
- These models do more than improve convenience, they fundamentally reshape how care is delivered by meeting individuals and families exactly where they are: in schools, in neighborhoods, and in their homes.
- By leveraging technology, partnerships, and community engagement, Centers can move from a traditional clinic-centered model to a comprehensive, community-integrated model that truly reflects the needs, strengths, and diversity of the populations it serves.