RAPID EVIDENCE SUMMARY

DELIVER
Research for better healthcare closer to home

Mobile Health Clinics for Health Promotion and Preventative Care

Summary

The challenge

A rural Victorian health service is looking to implement a community outreach model to improve access to healthcare services, education, and social connection for older adults in their catchment. This model will likely take the form of a mobile, multidisciplinary initiative where health services staff travel to community areas. To support this effort, the DELIVER research team conducted a rapid evidence summary to examine relevant models of mobile and "pop-up" health clinics internationally.

What we did

A search of academic articles was conducted in two electronic databases. Twenty-one papers were selected based on their relevance to the research questions and synthesised.

What we found

- Mobile health clinics (MHCs) have been implemented in diverse settings internationally.
- Benefits of MHCs include improved access to healthcare, population health improvements (e.g., detecting and lowering high blood pressure), and potential health system cost savings (e.g., by reducing unnecessary emergency department visits).
- Challenges related to MHCs include continuity of care and sustained funding.
- Strong partnerships with multiple stakeholders such as community organisations and local primary healthcare providers are likely to be critical for successful MHC implementation.
- The quality of the evidence is low due to most studies being descriptive in nature (relying on observations rather than rigorous methods that test outcomes).

What this means for the health service

- Key learnings from existing MHC models highlight the importance of early and ongoing community engagement to better tailor services to local needs.

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- Implementation can be facilitated through strong partnerships. Partnership-building activities include stakeholder mapping and collaboration with local stakeholders such as community organisations.
- Student clinician staffing models may offer value but require careful oversight to ensure service quality and continuity.
- Efforts to maintain continuity of care, e.g., through referrals and follow-up, should be integrated.
- A well-planned evaluation strategy developed alongside the service model can build evidence around the impacts and outcomes of MHCs and support funding advocacy.

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Mobile Health Clinics for Health Promotion and Preventative Care

Authors

Written by Dr. Emma West and Michele Conlin, Research Translation Coordinators for DELIVER

Background

Following a consensus mapping workshop facilitated by the DELIVER research team, staff from Western District Health Service came together to identify local challenges and opportunities in providing community-based care for older adults in their catchment. One key idea to emerge was a co-designed, community-based outreach model to improve health service access, education, and social connection. In response, the health service is now considering a mobile, multidisciplinary approach that partners with local communities to deliver targeted health interventions to older adults at risk. To support this work, the DELIVER team conducted a rapid evidence summary of similar mobile and "pop-up" health clinic models used internationally. This rapid evidence summary seeks to address the following key questions that were co-developed with the health service and research team:

- *What models of mobile health clinics or pop-up health clinics have been implemented and documented in peer-reviewed literature?*
- *What are the reported impacts and outcomes of these models?*
- *What lessons have been learned about operating mobile or pop-up health clinics?*

Literature search

A search of articles published in English was conducted in November 2024 using two electronic databases (Medline [Ovid] and CINAHL). Search terms and inclusion / exclusion criteria are detailed in Appendix 1. From the initial search, 21 papers were selected based on their relevance to the above questions.

Quality of the evidence

The quality of the evidence encountered is low due to the mostly descriptive nature of the available studies. Studies selected for this summary include:

- **5 literature reviews** of varying robustness and scope, three focused on mobile health clinics based in the U.S.A.[1-3] and two examining visiting primary health care services in rural and remote areas.[4,5]
- **2 case reports** which examined both clinical impacts and cost effectiveness of an urban mobile health clinic in the U.S.A.[6,7]
- **14 case reports** which described a variety of mobile health clinics providing health promotion and disease prevention interventions, as well as primary care (e.g., for chronic disease management). These case reports generally included an overview of short-term impacts and challenges encountered.

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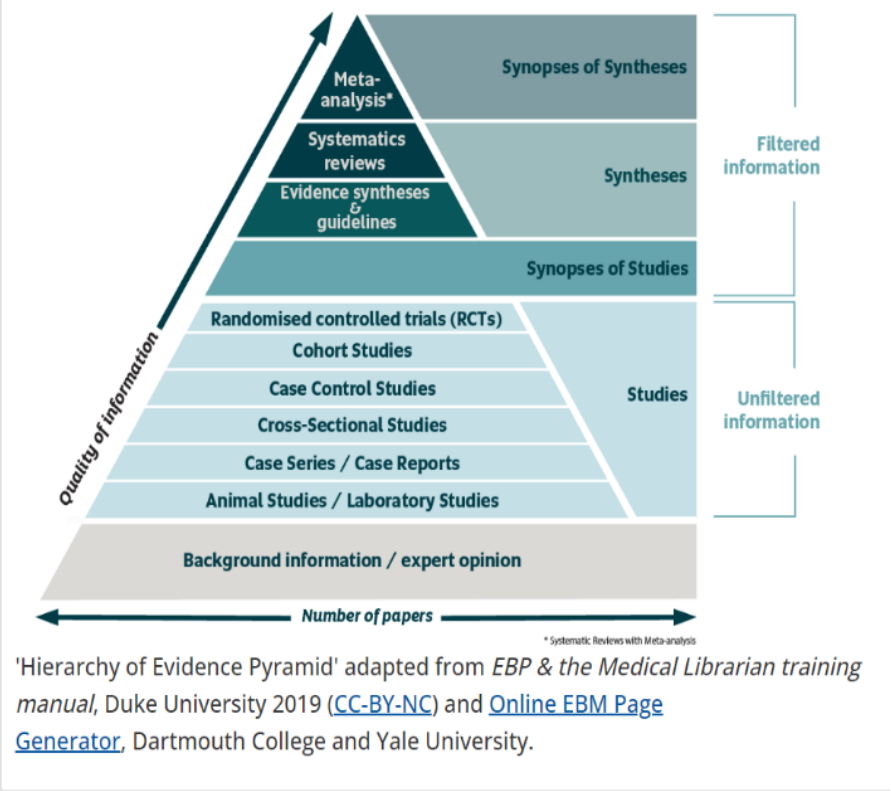

'Hierarchy of Evidence Pyramid' adapted from *EBP & the Medical Librarian training manual*, Duke University 2019 (CC-BY-NC) and Online EBM Page Generator, Dartmouth College and Yale University.

Figure 1 The Hierarchy of Evidence Pyramid outlines how the quality of evidence is rated

Findings

Findings have been divided into two parts. Part 1 provides an overview of the included reviews (Table 1), whereas the second section presents findings from individual studies. The reviews have been considered separately as their inclusion criteria were much broader than the inclusion criteria applied in this evidence summary (i.e., they included mobile health clinics with specific target audiences or services, such as paediatric populations or HIV screening).

Of the individual studies presented in Part 2, most mobile health clinics were based in the U.S.A. (10 studies). Two were located in Australia, one in the U.K., and one in Canada. Two implemented a "pop-up" model of care, whereas all others described mobile, vehicle-based health clinics. Four programs were based in urban centres, three operated across multiple areas (urban/regional/rural), and seven were exclusive to rural or regional areas.

A "**pop-up model of care"** is a flexible, short-term healthcare care service that is set up temporarily to meet a specific patient need.

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Part 1: Findings from literature reviews

Table 1. Summary of literature reviews on mobile health clinics (MHCs)

Review	Inclusion criteria	*N* studies included	Key findings from the reviews (n=5)
Yu, 2017	1996-onwards, U.S. based mobile clinics	51	Benefits of Mobile Health Clinics: • Improve access to healthcare (especially for underserved populations) • Positive patient perceptions and experiences • Engage various populations in health screenings and education • Contribute to health system cost savings (e.g., reducing unnecessary emergency department visits, improving quality adjusted life years (QALYs) • Contribute to improvements in health outcomes (e.g., better chronic disease management) Limitations of Mobile Health Clinics: • Challenges in maintaining continuity of care (i.e., risk of fragmentation of care) • Frequent reporting of logistical challenges (e.g., staffing, privacy concerns, equipment maintenance) • Financial considerations around purchasing and maintaining a vehicle • Quality of evidence from studies is low Lessons learned: • Effective MHCs require community engagement and needs assessments, collaboration with local health providers, and integration with existing services such as hospitals and laboratories. • MHCs must be flexible and adaptable to specific needs and circumstances of the populations they service • MHC operations require careful scheduling to ensure regular and effective services, contributing to building trust • MHCs which integrate student clinicians have been well received by patients and offer unique learning opportunities
Carey, 2018a Carey, 2018b	1990–2013, based in a high-income country, providing primary healthcare, focus on visiting services in remote areas	23	
Coaston, 2022	2010-2021, U.S. based mobile clinics	12	
Sabo, 2025	2017-2024, U.S. based mobile clinics	38	

MHCs: Mobile Health Clinics

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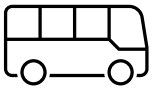
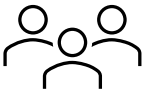
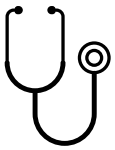
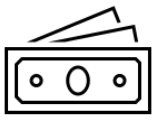
Part 2: Findings from individual studies

This section summarises findings from 16 studies reporting on 14 MHCs. Further details of individual studies are provided in Appendix 2. Please note that findings from six of the 16 studies are also captured in the review articles summarised in Part 1 (Table 1).

Description of models (n=14)

Type of MHC 	• Ten MHCs were "on wheels" including custom built units/trailers, vans, refurbished RVs and school buses [6-17] • Two MHCs were pop-ups[18,19] • Two unspecified [20,21]
Staffing 	• Interdisciplinary teams included wide range of healthcare professionals; nursing was common across many programs[8-15,17,18,20,21] • Non-clinical staff (e.g., driver, office staff, community volunteers)[13,16,17] • Student staffing models potentially cost-effective but brought their own challenges in terms of supervision/training, legalities, limited scope of practice, managing rosters around study obligations and lack of continuity[11-13,15-18,20,21] • Consistent staffing acknowledged as a challenge[9,17]
Digital capabilities 	• Two MHCs with tele-medicine capabilities [14,17] • Enabled access to psychiatry, dermatology, endocrine neurology and orthopaedic specialists and remote diagnosis via video conferencing[17] • Afforded flexible staffing models and inclusion of speciality services • Electronic health record integration described by one MHC[15] and recognised as a challenge by another[17]
Services 	• Services generally tailored to the needs of the target population with some programs targeting specific diseases (diabetes [10,16] and metabolic syndrome [8]) • Health education often offered in addition to clinical services [8,9,18] • Referrals/linkages to other services were also a common feature [8,13,18,20] • Fragmentation of healthcare a potential adverse effect[15]
Location 	• Convenient areas with foot traffic such as community centres, shopping centres, supermarkets, and fairs/community events[8,9,13,15,16,18,20] • Locations specific to the target population (e.g., senior centres, shelters, soup kitchens/food banks)
Collaboration 	• Collaboration with a wide variety of stakeholders including government, local council, universities, community organisations, and healthcare providers • Partnerships were described as enhancing resources, fostering support and buy-in from community, expanding the reach of the MHCs, and providing opportunity to coordinate services • Effective communication between stakeholders was crucial to long-term success[9]
Funding 	• Funding was reported to come from a range of sources, both public and private • Funding recognised as an ongoing challenge for many of the MHCs[6,9,17]

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Outcomes

Clinical

MHCs were successful in identifying people at high risk for diabetes and hypertension as well as those with high cholesterol and BMI.[8,10,16,18,20] In some instances, this initiated health discussions between staff and participants, with recommendations made regarding healthy behaviour changes.[18]

One pre-post study reported significant positive change in clinical outcomes following engagement with the MHC. Patients who presented with high blood pressure during their initial visit experienced 32.2% and 44.6% reductions in the relative risk of myocardial infarction and stroke, respectively [7].

Patient reported

While formal analyses on patient satisfaction were not conducted, several studies reported anecdotal evidence of satisfaction with the MHC model of care.[14,15,18,19,21] Other patient outcomes included success in reaching vulnerable populations and build trusting relationships[9,15,19] and increases in knowledge of health and social support organisations.[19] There was also some evidence of self-reported behaviour change with 37% of participants from a pop-up model of care reporting they made positive changes to their health behaviours or sought further medical care based on the clinic findings.[18]

Economic

An initial calculation based on data from the Harvard Medical School-affiliated mobile clinic (the Family Van) estimates a return on investment (ROI)* of 36:1. For every dollar invested in funding for the MHC $36 may be returned in combined ED costs avoided, and the value of life years saved.[6] A more conservative estimate based on the savings from reduction in blood pressure and patient-reported avoided ED visits produced a ROI of 1:3.[7]

In healthcare **return on investment (ROI)** is a financial ratio that assesses the profitability of an investment by measuring the financial benefit derived from it relative to its cost.

Workforce

Student-led models were found to be a cost-saving resource that also offered valuable learning opportunities.[11-13,18,21] Student involvement in MHCs may also influence preferences for employment after graduation. More than 60% of the students who participated in the Senior HealthMobile van expressed a desire to work with older adults after graduation, with many also expressing a desire to work specifically in a rural community.[11]

Lessons learned / key takeaways

- MHCs have been successfully implemented in a range of settings. Services and staffing should be designed around the specific needs of the population.
- MHCs potentially offer several benefits including increased access to health services, population health improvements and cost savings to the health system (e.g., by reducing unnecessary emergency department visits).
- Funding is an ongoing issue that threatens the sustainability of MHCs. Student staffing models may be a cost-saving solution but bring their own challenges. Evaluation is essential to ensuring MHCs are effective in advocating for ongoing funding.
- MHCs by nature won't be able to offer a fully comprehensive service and may introduce fragmentation. Efforts to provide continuity of care should be considered, such as providing referrals or linkages to other services or follow-up calls.
- Partnerships and effective communication are essential for buy-in and successful implementation of MHCs. Partnerships can also enhance resources which is particularly important in rural areas where there may be fewer resources.

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What does this mean for Western District Health Service?

Effective partnerships appear to be essential in the successful development and delivery of MHCs. The studies described in this summary have drawn strongly on formal and informal partnerships with a wide variety of stakeholders involved in both the planning and delivery of the MHCs. WDHS should consider developing a stakeholder map and engaging with community to identify and prioritise needs.

Sustainability is an ongoing issue highlighted within the summarised studies. Consideration should be given to developing a robust evaluation plan in order to advocate for ongoing funding. An evaluation plan should be considered prior to implementation of the MHC, ideally, during design and development of the MHC to ensure essential data is captured and associated resources are budgeted for.

See *Other Resources* below for further information.

Limitations

The information presented here is a rapid evidence summary of a selection of papers which aims to provide quick insights on relevant models of mobile and "pop-up" health clinics internationally. This approach does not allow for a fully comprehensive synthesis of the extant literature. It cannot be ruled out that a systematic or scoping review using different methodology would highlight different findings.

While this rapid evidence summary has highlighted important learnings, the quality of the evidence encountered is low. A fundamental challenge to evaluating MHCs is the absence of robust patient outcome data which MHCs often lack the resources to collect. The reported impacts and outcomes of the MHCs should be interpreted with caution as further research is needed to draw firm conclusions.

This document has been prepared specifically to support Western District Health Service is exploring the co-design of a community outreach model to improve health service access, education, and social connection for older adults in their catchment.

Other resources

Community engagement for planning and implementing mobile health clinics:

Dedmon DD, Beasley LD, Manasco C, Nellis K, Mcelravey TR, Rickard MN, Rhoads SJ. Engaging with the community before deploying a rural mobile health unit. *J Nurse Pract* 2024; **20**(9): 105167. https://doi.org/10.1016/j.nurpra.2024.105167

Zimmer R, Sosaita D, Perez A, Daniel S. The integration of community voice in the implementation of a mobile health program. *Prog Community Health Partnersh* 2023;**17**(1): 87-97. https://doi.org/10.1353/cpr.2023.0013

Model for planning and evaluating mobile health clinics:

Healy LJ, Beccaria G, McIlveen P. Revised model for evaluating visiting health care services in rural and remote settings. *Aust J Rural Health* 2021;**29**(5):779-788. https://doi.org/10.1111/ajr.12774

U.S. network of mobile health clinics (provides multiple resources):

https://www.mobilehealthmap.org/

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9. Dorans J, Lepore C, Mulroney EM, Chlebus V, Myles S. Community Wellness Bus: a partner-led initiative to improve service integration and address unmet needs of underserved populations in Algoma District, Ontario. *Healthc Q* 2023; **26**(1): 31-7.
10. Harris DE, Hamel L, Aboueissa AM, Johnson D. A cardiovascular disease risk factor screening program designed to reach rural residents of Maine, USA. *Rural Remote Health* 2011; **11**(3): 1-15.
11. Hayward KS. Facilitating interdisciplinary practice through mobile service provision to the rural older adult. *Geriatric Nursing* 2005; **26**(1): 29-33.
12. Neill KS, Powell L. Mobile interprofessional wellness care of rural older adults. *J Gerontol Nurs* 2009; **35**(7): 46-52.
13. Heller BR, Goldwater MR. The Governor's Wellmobile: Maryland's mobile primary care clinic. *J Nurs Educ* 2004; **43**(2): 92-4.
14. Iqbal A, Anil G, Bhandari P, et al. A digitally capable mobile health clinic to improve rural health care in America: a pilot quality improvement study. *Mayo Clin Proc Innov Qual Outcomes* 2022; **6**(5): 475-83.
15. Palma ML, Arthofer A, Halstead KM, Wahba JM, Martinez DA. Service learning in health care for underserved communities: University of Iowa mobile clinic, 2019. *Am J Public Health* 2020; **110**(9): 1304-7.
16. Shubrook JH, Patel M, Young CF. Community-based diabetes awareness strategy with detection and intervention: the Mobile Diabetes Education Center. *Clin Diabetes* 2023; **42**(1): 125-34.
17. Gardner T, Gavaza P, Meade P, Adkins DM. Delivering free healthcare to rural Central Appalachia population: the case of the Health Wagon. *Rural Remote Health* 2012; **12**: 2035.
18. Coombs NM, Sewell L, Jackson MR, Borgelt K, Lee J, Porter JE. Student-led pop-up health check clinics: innovative health prevention strategy for a low socioeconomic community. *Aust J Prim Health* 2023; **29**(6): 606-12.
19. Russell G, Westbury S, Clifford S, et al. Improving access for the vulnerable: a mixed-methods feasibility study of a pop-up model of care in south-eastern Melbourne, Australia. *Aust J Prim Health* 2022; **28**(2): 143-50.
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Appendix 1: Search strategy

Criteria	Included	Excluded
Population	Older adults High income countries	Not inclusive of older adults in target population Highly specific target populations, e.g., migrants, homeless, first nations LMICs
Intervention/exposure	Primary care, health promotion, disease prevention Nursing or allied health led	Services provided are medical only, dental only optometry/ophthalmology only Cancer screenings only STI/HIV screenings only
Mechanism	Mobile or pop-up clinic (e.g., van, non-traditional locations for short-term clinics)	Fixed location clinics
Publication types	Peer reviewed studies English language full-text articles only	Theses, conference abstracts, commentaries, editorials, published books, protocols, grey literature Full text articles not published in English
Publication date	All	-

Search terms:

Concept 1	Concept 2
Mobile health units/ mobile health unit mobile health units.mp. mobile health service.mp. mobile health services.mp. mobile healthcare.mp. mobile health care.mp. mobile adj3 clinic* mobile adj3 outreach pop-up adj3 clinic* pop-up adj3 care visiting adj2 healthcare.mp. visiting adj2 health care.mp. health adj3 van health adj3 bus	Rural population/ Vulnerable population/ rural remote regional isolated vulnerable underserved

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Appendix 2: Data extraction from individual studies (n=16)

Study (country)	What	Target population	Location	Staffing	Services offered	Key findings
[6] Oriol 2009*(Urban USA)	The Family Van	Under-served neighbourhoods	Serves six neighbourhoods	Health educators Registered dietitian HIV counselors	Health screening Monitoring Coaching Referrals Does not diagnose or treat	By using a sample mobile healthcare program and published research a ROI value was calculated that suggests that, for every dollar invested in funding for the mobile healthcare program, $36 may be returned in combined ED costs avoided, and the value of life years saved.
[7] Song 2013* (Urban USA)	See above					Among patients presenting with high blood pressure during their initial visit, there was a 32.2% and 44.6% reduction in the relative risk of myocardial infarction and stroke, respectively. The savings from this reduction in blood pressure and patient-reported avoided emergency department visits produced a return on investment of 1.3.
[8] Crowther 2018* (Rural USA)	West Alabama Mental Health Center mobile unit Refurbished RV	Rural-dwelling older adults (aged 55+)	Travelled to a high traffic area (e.g. community centers, shopping centers, grocery stores, and pharmacies) in each service site once per week from 9am-1pm	Rural medicine Psychology Nursing Social work	Screening: - blood pressure - glucose - mental health Other services where needed/when able Treatment referral Psychoeducation	Findings suggest low SES rural communities are at risk of developing metabolic syndrome. Innovative approaches such as mobile healthcare delivery are crucial to providing quality healthcare and preventive health

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Study (country)	What	Target population	Location	Staffing	Services offered	Key findings
						screens to underserved rural older adult communities.
[9] Dorans 2023 Mixed Canada)	Community Wellness Bus	Individuals underhoused or living with a mental illness and/or addictions in the community	Visited six locations including soup kitchen, salvation army, low barrier shelters, and parking lots. Operating 10-12.5 hours per week.	Nurse practitioner Registered nurses Registered practical nurses Mobile crisis workers Certified peer workers Mental health and addiction service workers Anti-human trafficking workers Social service worker	Medical care (initial assessments, basic treatment) Health education Traditional indigenous medicine Harm reduction supports (e.g., clean needles, naloxone kits) Peer support Referrals Basic necessities (e.g., snacks hygiene items)	This article discusses in detail the successes, challenges and opportunities for the expansion of the Community Wellness Bus with a focus on effective partnerships.
[10] Harris 2011* (Rural USA)	Diabetic and hypertension screening van	Rural residents	The van visits community and workplace events including agricultural fairs	EMT Registered nurse	Health screening: - blood pressure - blood glucose	The van was successful in reaching rural residents; over 4 years, 2451 people from 254 towns were screened at 42 events located in 28 towns. Screenings held at agricultural fairs and in rural locations were particularly successful at attracting rural screenees. Rural screenees were at significantly higher risk for hypertension compared with screenees from urban areas.
[11] Hayward 2005 (Rural USA)	Senior HealthMobile Motorhome	Rural older adults	Serves five primary rural areas, arriving a minimum of twice a month in each community	Interdisciplinary teams involving students and faculty in nursing, physical therapy, occupational therapy,	Health and risk assessment Medication management Fall prevention Home safety evaluation Foot care	The Senior HealthMobile has been successful in providing interdisciplinary opportunities for students and in reaching the older adult, supporting healthy

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Study (country)	What	Target population	Location	Staffing	Services offered	Key findings
			Services are delivered in the motorhome at the senior centres in each area and at the homes of rural older adults	pharmacy, and dietetics, among other disciplines Undergraduate/graduate students enrolled in a health professions discipline Nursing clinical coordinator	Health education Memory loss assessment Hearing, vision, nutrition screening Referral and follow-up	lifestyles, and in building sustainable community partnerships. This article describes the conceptual framework and implementation model used including partnership responsibilities and contributions.
[12] Neill 2009 (Rural USA)	See above					Outcomes are shared as they relate to the experience of the students over the initial 6-year implementation of the project. Student clinical experiences with older adults in the community can provide a foundation for students' choice of professional practice with the majority of students reporting that they were much more interested in working with older adults after the Senior HealthMobile experience. Students also indicated interest in working in rural communities after graduation.
[13] Heller 2004 (Mixed USA)	Maryland's mobile primary care clinic	Underserved communities	Four mobile units that traverse the state from the city to the rural communities. The Well mobiles travel	Family nurse practitioner Nurse manager Graduate nurse practitioner students Driver	Physical assessments (diagnose and treat common illnesses and manage chronic health conditions) Screening (basic laboratory tests for early cancer detection) Health education	This article describes the development and implementation of the Governor's Wellmobile program.

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Study (country)	What	Target population	Location	Staffing	Services offered	Key findings
	33-foot mobile units		regular, established routes, making scheduled stops at community centers, senior centers, schools, and other locations		Immunizations and influenza vaccinations	Issues of long-term financial sustainability are presented, as well as lessons learned about the importance of public, private, and philanthropic partnerships and political support in ensuring the success of such programs.
[14] Iqbal 2022 (Rural USA)	Digitally capable mobile health clinic Mobile unit	Vulnerable rural populations	Four sites	Nurse practitioners Physician assistants Nurses Desk operations specialist Virtual clinicians	Primary care and family nurse visits Laboratory testing (blood and urine) Well-child visits COVID-19 and influenza immunizations Telemedicine access to primary care and specialists Sports physical examinations	This article describes the design and implementation of digitally capable MHC quality improvement initiative. By April 30, 2022, the MHC had provided 1498 patient appointments while maintaining standards of care. Newly established broadband internet access for these communities and their residents was a valuable secondary outcome.
[15] Palma 2020* (Mixed USA)	University of Iowa Mobile Clinic (UIMC) Retrofitted school bus	Underserved and rural communities	Monthly clinics at nine sites. Original clinic was a retrofitted school bus in migrant farmworker camps	Physicians Physician assistants Nurse practitioners Pharmacists Health science students Other clinical faculty	Screening: - blood pressure - diabetes - cholesterol Acute & chronic disease management Immunizations Health education	Approximately 44% (n= 12/27) of patients surveyed used UIMC as their only source of care and 6% (n= 4/69) returned monthly. Patient satisfaction was high with 97% of patients surveyed rating care as excellent or good (n= 66/68).

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Study (country)	What	Target population	Location	Staffing	Services offered	Key findings
					Referrals to higher levels of care Specialty services at lesser frequency: Physical therapy, dentistry, special health education	Fragmentation of health care was an unintended consequence with only 1.2% participated in referral follow-up visit.
[16] Shubrook 2024* (Urban USA)	The Mobile Diabetes Education Center (MOBEC) 65-foot trailer	General public	Initially went to seven metropolitan areas in the county. Later visited local organization's sites	Event coordinator Program manager (registered dietitian and a certified diabetes care and education specialist) Health professional students	Screening: - diabetes - mental health - blood pressure Health education	This article reports on the services and initial successes of MOBEC. With its strong community collaboration, MOBEC has helped to raise awareness of diabetes and ensure access to much-needed health screenings and education.
[17] Gardner 2012 (Rural USA)	The Health Wagon Mobile units and stationary clinics	Underserved rural population	Mobile unit visits eight sites on weekly, biweekly and monthly bases	Family nurse practitioners Nurses Office staff Social worker Data systems coordinator Program developer Clerk Also supported by volunteers	Comprehensive primary healthcare services including: Diabetic supplies & prescription medication Acute & chronic disease management Lab & diagnostic services Medication assistance Immunization programs Health education (including wellness classes) Cancer screening (including chest X-ray) Women's health Dental & eye clinics Specialty clinics	This article describes the operations of the Health Wagon, a full mobile medical clinic, in delivering free health care to those in rural Southwest Virginia in Central Appalachia. In 2009, a total of 157 clinics were provided and 2900 patients were seen (3165 patient encounters) in addition to 268 telemedicine specialty consultations at no cost to the patients.

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Study (country)	What	Target population	Location	Staffing	Services offered	Key findings
[18] Coombs 2023 (Regional Australia)	Student-led pop-up health check clinics	Low-socioeconomic regional community in Vic	Four temporary pop-up health clinics in vacant retail venues Operating hours were Tue-Fri from 11am-5pm and Sat 9.30-1.30 for 3 weeks	Nursing students Supervisors	Health checks Health education (self-select pamphlet information) Follow-up calls	Participants enjoyed the free and convenient nature of the health check program and the location of the venues. Feedback from participants indicate the health education provided was useful and advocated for changes in current behaviours. Many embraced the new information and community connections and made changes to improve their future health.
[19] Russell 2022 (Urban Australia)	Pop-up model of care	Vulnerable communities	Single event where a collection of service providers gathered at a convenient location	Community health services Providers represented 20 dental, housing, justice, employment and mental health services	Services provided guests with service details, contact information and made follow-up appointments where appropriate	Participants reported increased knowledge of services and access pathways, community members spoke of increased trust and partnerships between service providers were fostered.
[20] Maughan 2024 (Urban UK)	Mobile health clinic	Populations experiencing health inequalities and barriers to accessing traditional healthcare services	Locations selected based on footfall (e.g., supermarkets and community centre car parks)	Undergraduate pharmacy students Nurse educator	Cardiovascular screening: - blood pressure - cholesterol - blood glucose - BMI Health education Referrals	In this proof-of-concept study students provided services to 716 ethnically diverse users. The mobile health clinic effectively reached a diverse, underserved population, providing essential health services and facilitating student training.

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[21] Nguyen 2019 (Mixed USA)	University of Florida Mobile Outreach Clinic Bus	Vulnerable populations	Not specified	Undergraduate student volunteers (pre-health career) Clinic assistant Registered nurse manager Volunteer medical providers	Screening: - blood pressure - blood glucose - STI/HIV status Primary care visits Health education	This report describes the history of the Mobile Outreach Clinic and outlines the Care Coordination program framework, which is centered around the undergraduate volunteers who are vital to the sustainability of the program.

*Findings also captured in literature reviews

The DELIVER Research Project:

- Identifies what the people and healthcare providers of western Victoria need most in terms of home-based healthcare services
- Designs and tests the best way to deliver these services, so that home-based healthcare services will continue to grow and improve across the region and beyond
- Supports the growth of research in western Victoria, so that future research findings can quickly be translated to improvements in healthcare

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