

Recommended Steps to Implement a Mobile or Pop-Up Clinic



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Foreword

This manual was developed as a guide for nurses and other healthcare professionals who desire to implement a mobile or pop-up clinic in their communities. While it does not contain every little detail that goes into a community assessment or the planning, implementation and evaluation of a non-traditional clinic, this manual serves as a quick reference to ensure a non-traditional clinic has a solid foundation for operations.

This manual was created as part of my project for my Doctor of Nursing Practice (DNP) program at Duke University. A pop-up clinic in Denver, CO requested advice on evidence-based strategies to improve clinic processes. Very little literature was found on best practices for implementing operating a non-traditional clinic. With the few articles obtained from a literature review and web-based resources that were used in the writing of this manual, more information was still needed to conclude what are best practices for these types of clinics. Therefore, five individual, qualitative interviews were conducted with community experts in Colorado and South Carolina. These content experts were asked questions regarding how they implemented their respected clinics, either a mobile or pop-up, as well as budgets, supplies, and lessons learned. Information obtained in these interviews were included in the final version of this manual.

This manual was validated by three of the community experts. They reviewed and verified the manual was accurate and would be a valuable resource for those looking to implement a non-traditional clinic. After the manual was verified and validated, the manual was used as a resource for evidence-based practice to assess operations at the Denver-based pop-up clinic in a qualitative improvement (QI) project. Participants in the QI project verified that this manual was valuable and applicable to their work. Now, my hope is to share this information with current and future community leaders in the hope of improving non-traditional clinics and creating greater access to care.

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Recommended Steps to Implement a Mobile or Pop-Up Clinic

Assessment

Regardless of the scope of the clinic, whether a pop-up vaccination clinic, a mobile HIV testing clinic or a mobile women's clinic, the first step is to identify leading community members and organizations that may share similar goals, patient population and desire to start a clinic. Non-profit organizations, such as local coalitions, hospitals, clinics, and universities or colleges, governmental agencies, including local health departments, disaster response teams and state volunteer programs, as well as county or city officials, faith-based communities, pharmacies and laboratories should be considered as potential partners. Including these partners in vision and goal development of the clinic is essential to ensuring community buy-in.

A community needs assessment will need to be conducted to help identify health gaps. Tools to help with community assessments can be found here:

<https://www.cdc.gov/publichealthgateway/cha/index.html>. Community members, such as United Way or local medical universities, may have a current needs assessment available through their website, which could be applicable. Healthy People 2030 set national objectives for improving health outcomes over a decade, which should be considered when identifying areas of needed improvement (ODPHP, n.d.). The newly found partnership or coalition will need to prioritize any needs identified, decide which problems the clinic will help address, and begin to formalize a goal as it begins to plan the mobile or pop-up clinic.

Planning

In the early stages of planning a clinic, determining if the clinic will be operated by a parent 501(c) organization or if the clinic will be owned by the coalition is a necessary step. If a potential parent organization is identified, the organization will need to establish its ability to assist with funding or applying for grants, implementation and overseeing on-going operations. If a coalition is established between community partners and community members, the coalition can own and operate the clinic. The coalition will need to form a board of directors consisting of a Medical Director and members from its community partners. Then, the coalition can file for a business license and establish itself as a 501(c)(3) nonprofit organization. To establish the coalition as an organization and apply for the business license, an application will need to be filed with the state's Bureau of Regulations. Next, the organization will need to file an application for 501(c)(3) status with the IRS. Once established as a non-profit, the organization can apply for funding. The process of applying for 501(c)(3) status can be found here: <https://www.irs.gov/charities-non-profits/application-for-recognition-of-exemption>.

After community partners and stakeholders are identified and committed to establishing the clinic, a framework should be followed to preserve the integrity of the work. A community-based framework will establish a systematic approach to caring for patients in a non-traditional setting. Common steps in community-based frameworks include planning, engaging the community, developing a goal, conducting a health assessment, prioritizing health needs, developing a community health improvement plan, implementing and monitoring the community health improvement plan, evaluating process and outcomes (CDC, 2015). Several of these steps are already taken during the assessment phase, and several steps may happen simultaneously. A list of community frameworks can be discovered here: <https://www.cdc.gov/publichealthgateway/cha/assessment.html>. The parent organization or the newly founded non-profit should choose whichever framework works best for their community.

Determining the Scope of the Clinic

When creating a community health improvement plan, the scope of the clinic, clinic goals, and outcome measures should be determined. The clinic's purpose and scope, including the services offered, should be based on the needs of the community and should be directly related to the problem the clinic is trying to address. For example, the Palmetto Community Care, a clinic in Charleston, SC, identified a need to increase HIV testing within the community. A grant was obtained, a vehicle was purchased and modified to accommodate blood draws and counseling, and community partners were identified to help establish presence in the community.

The services a mobile or pop-up clinic can provide include, but are not limited to: dental, preventive care, primary care (Attipoe-Dorcoo et al., 2020a; Malone et al., 2020; Western Governors University, 2020), family planning (Doyle et al., 2019), vaccinations (Leibowitz et al., 2021), disaster relief, mental health services (Malone et al., 2020), case management and benefits assistance (Western Governors University, 2020). Additionally, one study indicated clinics may offer follow up services to treat abnormal findings on initial assessments, which may increase compliance with treatment (Greenwald et al., 2017). Questions to ask while determining scope of the clinic include: Is the focus on providing care for present illnesses or prevention and education? Will the team offer counseling, wound care, or other specialized care? Is the clinic going to offer vaccines? Is the clinic going to offer lab draws? Will there be patient navigators? Knowing the services to be offered will assist in designing the layout, establishing a budget, ordering supplies, and designing staff competencies in the planning process.

The clinic's service delivery model should align with the purpose and scope of the clinic. There are several service delivery models that could be applied to a mobile or pop-up clinic, including but not limited to: Trauma Informed Care, Disaster Response, Rural Community Health Worker Program, Street Medicine and Interprofessional Collaborative Practice Model.

Trauma Informed Care can be combined with other service models for a holistic approach. Trauma Informed Care focuses on recognizing the client, staff and community's trauma while avoiding re-

traumatization; by utilizing this model, organizations promote healing (National Health Care Council for the Homeless, 2022). A toolkit to assess if policies and procedures are aligned with this model can be found here: <https://nhchc.org/research/publications/trauma-informed-organizations-change-package/trauma-informed-organizations2/>.

A disaster response model would be implemented as outlined by FEMA, and clinical leaders may consult local medical reserve corps, community emergency response teams (CERT) and disaster action teams to coordinate efforts. A mobile clinic or pop-up clinic can be integrated into a disaster response effort (Attipoe-Dorcoo et al., 2020b; CDC, 2020). These non-traditional, or temporary, clinics can serve as mass vaccination sites in response to disease outbreaks. A checklist to operate a mass vaccination clinic can be found here: <https://www.cdc.gov/vaccines/hcp/admin/mass-clinic-activities/index.html>. If dispatching a mobile clinic, or setting up a temporary clinical site, in the event of a disaster behavioral health professionals, nurses, medical providers and social workers trained in psychological first aid can provide this service as a benefit to staff and patients alike (Paek et al., 2018).

Given decreased access to care in rural communities, mobile clinics can be an appropriate intervention (Attipoe-Dorcoo et al., 2020a; Malone et al., 2020; Aneni et al., 2013). The Rural Community Health Worker Program is an umbrella term for several service model types. Each program model includes public health and social service workers, who are familiar with the rural community, collaborating with medical professionals (Rural Health Information Hub, 2022b). Depending on the goals of the clinical and program, community health workers can focus on health screening and education, patient navigation, engaging community action, or provide outreach (Rural Health Information Hub, 2022c). A toolkit to implement this model, with examples for each focus, can be found here: <https://www.ruralhealthinfo.org/toolkits/community-health-workers/2/program-models>.

Street Medicine is an appropriate model for clinics working with homeless persons and “rough sleepers”, referring to homeless persons who sleep on the streets as opposed to shelters (Boston Health Care for the Homeless Program, 2014). With this model, there is opportunity to provide care on the street and in a mobile clinic. Providers and healthcare workers visit “rough sleepers” several times throughout the week; urgent and special needs are admitted to street clinic beds in local healthcare facilities (Boston Health Care for the Homeless Program, 2014). This model complies with the National Health Care for the Homeless Council’s general recommendations for providing care to homeless persons, including interprofessional and integrated care, multiple points of services, a clinical team with case management, and access to secondary and tertiary care (National Health Care for the Homeless Council, 2019).

Lastly, the Interprofessional Collaborative Practice Model is a team-based model that includes nurses, social workers, medical providers, nutritionists, as well as undergraduate nursing students and graduate students in various healthcare disciplines (Rosenberg, 2018). One program found that providers improved communication and collaboration with other disciplines after receiving training

on this model and gaining understanding of other team members' roles (Rosenberg, 2018). Interprofessional collaboration improves patient care by decreasing gaps in care (Alameddine et al., 2020; Rosenberg, 2018). Details surrounding the four competencies of Interprofessional Collaborative Practice Model can be found here: <https://www.aspph.org/teach-research/models/interprofessional-collaborative-practice/>.

Funding

When designing the clinic, consider sustainability. Will the clinic charge for services if insurance does not cover them? Is there grant funding that can be applied for? Clinic leadership will need to determine the answer to these questions before moving forward in the planning process. Grant applications will request plans for operation and evaluation, including budgets and fund management. Additionally, the clinic will need to comply with all requirements of the grant (AMA Foundation, 2015). Potential funding sources can be found here: <https://www.cdc.gov/publichealthgateway/federalprogramsandfunding/index.html>.

Medicaid will reimburse mobile clinic visits, under the fee-for-service methodology, as long as specific requirements are met (Medicaid, 2018). The mobile unit must be owned by the clinic. The state recognizes, licenses, or authorizes the mobile unit clinics to operate in the state; and the services are provided within the mobile unit. Lastly, services provided must be overseen by a physician (Medicaid, 2018). The billing code for services provided in a mobile clinic is POS 15 (HMSA, 2021). Preventive services CPT codes can be utilized when appropriate (Leibowitz et al., 2021).

Mobile Clinic Vehicles

One of the highest start-up and maintenance costs for mobile clinics is the vehicle. The type of vehicle used for a mobile clinic should be considered. Can the clinic operate out of a standard van, or would a bus be more appropriate to hold specialized equipment? A clinic in South Africa converted a 6 ton truck into a mobile clinic that provided HIV screening and education (Du Toit et al., 2019). If a semi-truck is to be used, drivers will need to obtain a class D license prior to implementing the clinic. If the clinic is in a modified van or camper, drivers will not need special licensing. Anticipant modifications costing 10,000-40,000 dollars. Possible items to consider in the design: a refrigerator/freezer, blood draw station, exam table, X-Ray area, and a place for staff or patients to sit. The vehicle should be insured for two staff members and at least one patient, as a staff member should not be left alone with a patient. The cost of insurance is approximately 10,000 a year. Fuel and regular maintenance should be considered when formulating the yearly budget. These expenses may fluctuate depending on the clinic's service area.

Supplies

Medical records can be electronic or paper charts. Creating and documenting in a centralized medical chart for each client is necessary for coordinating care with other clinics or facilities, billing, quality assurance, or mandatory reporting, among other reasons (AMA Foundation, 2015). Clinic leadership should determine if medical records will be kept on paper or electronic and secure supplies to establish chart keeping as necessary. However, the use of an EHR helps establish rapport and trust with other providers (Warshaw, 2017). Laptops with built-in hotspots may be appropriate if Wi-Fi is a concern (Leibowitz et al., 2021). Depending on the service area, an EHR that saves offline and uploads once connected to the internet may be valuable in rural areas that do not have a stable internet connection. EHRs will require technical safeguards, as well as physical safeguards, to ensure privacy is maintained (AMA Foundation, 2015). If a parent organization, such as a local hospital, owns the clinic, an EHR system may already be established and can serve as a budget-friendly option.

Some supplies can be provided by community partners as in-kind donations, including fliers, test tubes, band aids, gauze, tape, paper, and pens. Simple, or low technology, equipment will be needed, such as blood pressure cuffs, stethoscopes, pulse ox, and glucometer, for most mobile and pop-up clinics. Some individuals who are hesitant about healthcare may be open to blood pressure or glucose checks and this encounter can serve as an opportunity to build patient trust (IOM, 1988). Most mobile clinics will not have costly equipment or bulky equipment, such as X-Ray or EKG machines, as the objective for mobile clinics is usually to provide basic care while increasing access to healthcare services (McGowan et al., 2020). However, if designing a specialized clinic, such as a mammogram mobile clinic, ensuring the appropriate supplies necessary to perform these tests will be essential to the daily operations of the clinic. Each clinic should have an AED available, as well as glucose tables, Benadryl and epi pens. Procedures on how to use these supplies during an emergency situation should be established prior to the first day of operations and all staff should be familiar with them.

Medications may be prescribed in these clinics and there are several ways to acquire affordable prescription drugs for clients. Walmart has a \$4-dollar list, where the medication costs \$4 regardless of the individual's lack of insurance; and, providers may choose to prescribe these medications first when appropriate. Some pharmacies offer prescription saving programs or accept discount cards such as GoodRX. Additionally, clinics can partner with commercial pharmacies to have medications provided free of cost to clients, while the pharmacy bills the clinic directly at a discounted cost (AMA Foundation, 2015).

Lab Services

Point of care services include glucose checks, urine analysis, rapid flu, HIV and syphilis testing, GC/CT testing, pregnancy testing. The clinic may offer these tests after obtaining an exception license with CLIA. If the clinic would like to offer more advanced testing, the clinic will need to apply for a higher

level of clearance. To apply for CLIA licensing, visit <https://www.cms.gov/regulations-and-guidance/legislation/clia?redirect=/clia/>. An account should be established with a local laboratory, such as Quest or LabCorp. This can be done by visiting these companies' websites (Nature Biotechnology, 2020).

Sites of Operation

Finding sites to park and operate the mobile clinic can be a hardship. Community buy-in is essential for successful implementation (Yu et al., 2017). Staff availability may impact how the clinic is implemented (Leibowitz et al., 2021). The leadership team will need to determine what days and times the clinic can operate based on staff availability with consideration to evenings and weekend times. While identifying potential partners, consider sites where the mobile clinic can park and establish services for the day. Sites of operation may include local health departments, homeless shelters, grocery stores, local churches, and schools (Western Governors University, 2020). Additionally, when discussing if the vehicle can be on the premises, inquire about any advertising the site can offer. Is there a community board for fliers? Can the store make an overhead announcement? Can the site put a sign in front to advertise in advance or on the day of operations?

Sites of operations for pop-up clinics may be more difficult, as the site needs to include space large enough for the clinic to operate in. Potential sites should have a large enough area where staff can set up a reception/triage space, an exam or treatment space, and educational or counseling area. Due to this need, special consideration should be given to partnering with academic institutions, as well. Once a site of operations has been secured, a site plan visit should be conducted to ensure staff know where to set equipment up, how the clinic will flow, and any adjustments can be made prior to the day of.

Insurance

The clinic as a business should acquire a number of insurance policies, including general liability, worker's compensation, and property and casualty (AMA Foundation, 2015). If operating a mobile clinic, the vehicle will need to be insured as well. Healthcare providers may or may not be covered under Good Samaritan laws or Charitability Immunity laws. Therefore, practicing within scope is essential; clinic leadership and providers should consult legal counsel to determine the laws and statutes that are applicable to their area of operation (AMA Foundations, 2015). Professional insurance for healthcare workers is recommended.

Policy and Procedures

A parent organization's policy and procedures can be adopted and applied to a mobile or pop-up clinic. If the clinic is independent from other 501(c)(3) organizations, the clinic will need to establish its own policy and procedures with consideration to medical record keeping, missed appointment policies, creating referrals and conducting follow-up, and OSHA regulations (AMA Foundation, 2015). The medical team, including nurses and nurse practitioners, can serve as consultants when developing policies and procedures for the clinic. Clinic policy and procedures should be in compliance with federal, state and local regulations (AMA Foundation, 2015). These documents can be borrowed and modified between community partners. Professional guidelines, such as from the CDC, WHO, AGOG or APA for example, on how to assess, treat and follow up on patients being served should dictate the development of these documents as well. The clinic's policy and procedures should be congruent with its service delivery model.

Staff Licensing, Recruitment and Training

Staff and volunteer's license requirements are determined by state and federal laws (AMA Foundation, 2015). In some states, a nurse practitioner (APRN) has full practice capabilities. In other states, the APRN requires medical oversight provided by a physician. State laws should be consulted when determining appropriate staff to recruit. Community partners that allow their employees to volunteer at the clinic should have checked the individual's credentials and privileges. These will need to be verified to ensure individuals can practice in their field (AMA Foundation, 2015). If the clinic is considering hiring employees or volunteers specific to the clinic, and not a community partner, the leadership team will need to ensure this process is completed. The process of credentialing can be found here: <https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/public/ama-foundation/legal-operational-guide-free-medical-clinics.pdf>

For mobile clinics, staff positions may include nurses, APRNs and/or clinicians, as well as clinic volunteers or students (Cone & Haley, 2016). The clinic volunteers may include nurses who serve in an administrative capacity, track supplies or coordinate care for the patients. For pop-up clinics, staff positions may include: clinic volunteers, clinic/office manager, receptionist/office staff, and 1-2 providers. Clinic volunteers may include nurses who assist with scheduling staff, supervising non-provider staff, order supplies, and coordinate follow-up (AMA Foundation, 2015). Additionally, patient navigators (Vang et al., 2018), community health workers (Malone et al., 2020), behavioral health specialists and social workers (Paek et al., 2018) may be beneficial additions to the clinic's staff based on the clinic's purpose and goals. Clinics should consider hiring bilingual staff, or secure interpreter services (Leibowitz et al., 2021), for non-English speaking clients.

Training will be directly related to the service model selected and services offered. Staff may need to be trained and deemed proficient at safe vaccine handling and storage, biohazardous materials and

lab collection and processing (Nature Biotechnology, 2020), as needed. Psychological first aid (Paek et al., 2018), cultural competency training, HIPPA and OSHA training should be provided to all staff members. The clinic, if owned by a parent company, may choose to create and streamline training for community partners so all team members are working from the same mindset. Staff should be aware of the clinic's policies and procedures prior to the first day of operations. An employee handbook example can be found here: <https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/public/ama-foundation/legal-operational-guide-free-medical-clinics.pdf>.

Implementation

A site operations leader, such as a Lead RN or Site Manager, should be identified. Throughout active operation, this leader will continue to assess and track patient needs, as well as staff feedback. They may need to make real-time adjustments to the flow of the clinic, clarify questions or concerns, and limit patients seen due to low supplies. The site leader should communicate these changes to staff as they happen.

Clinic Set Up

Staff should anticipate arriving 15-30 minutes prior to the clinic start time. This will allow adequate time to set up supplies and hold a team huddle. The triage area should be placed separate from the area where patients are actively being seen (Haley & Cone, 2016). An area for staff and volunteers to take a break should be identified at the beginning of the day and be separate from patient care areas. The site leader should hold a huddle at the beginning of the day to communicate the flow of the clinic and number of anticipated patients. When possible, determine staff break times during the huddle. Lunch breaks should be staggering to limit interruptions of patient care as much as possible. If patients are in line before the cut off time, they should be seen and not turned away (Haley & Cone, 2016). However, an official cut off time should be determined before the clinic begins. After the last patient is seen, a team debrief should be conducted to wrap up the day (Haley & Cone, 2016). This wrap up huddle is a time to review any positive moments or any changes that may need to take place before the next day of operations. After the wrap up huddle, staff and volunteers will need to break down the site as needed.

Evaluation as a Continuous Effort

As the clinic continues to operate, clinic leaders should determine if advertising is sufficient and if patient turnout rates indicate continuing services is appropriate. New sites of operation may be identified and added to the roster. Partnering with other providers and facilities may be necessary to increase the clinic's reach.

Chart audits, or chart reviews, ensure quality of care provided (AMA Foundation, 2015), help mitigate risk and improve staff training. Chart audits may be conducted to assess prevalent patient needs (Haley & Cone, 2016). Depending on the findings, services offered may need to change and supplies, from the number of test tubes to the type of supplies ordered, may need to be adjusted over time. Staff compliance and competency should be reviewed regularly, through chart audits, check off procedures or other assessments. Outcomes set by the clinic prior to implementation should be continuously monitored for progress and quality assurance.

Evaluation

Formal evaluation of the clinic can be achieved through process measures and outcome measures (Rural Hub, 2022a; Fu et al., 2017). Process measures evaluate the services provided by the clinic and can include: patient demographics; number of clients seen; number of referrals made; and how clients became aware of the clinic. Outcome measures evaluate the quality of the services provided and may include: healthcare utilization reports, patient health outcomes, and costs analysis (Rural Hub, 2022a; Fu et al., 2017; Beks et al., 2020). Community-level benchmarks to compare clinic outcome measures can be found here: <https://www.cdc.gov/publichealthgateway/cha/data.html>.

A third formal evaluation includes assessing balancing measures. Balancing measures indicate if improvements in one area do not negatively impact another measure (HealthCatalysis, 2016). These measures may include staff engagement surveys and patient satisfaction surveys (McGowan et al., 2020). Tools and resources for performance measures and quality improvement can be found here: <https://www.cdc.gov/publichealthgateway/performance/resources.html>

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Appendix A. Steps to Implement a Mobile and Pop-Up Clinic

Steps to Implement a Mobile and Pop-Up Clinic	
Assessment	<ul style="list-style-type: none"> ● Identify potential Community Partners: laboratories, pharmacies, community health centers, hospitals, universities, county and local disaster preparedness teams ● Conduct a Community Needs Assessment ● Assess the organization’s ability to take on the project
Planning	<ul style="list-style-type: none"> ● Follow a community-based framework ● Engage Stakeholders and Community Partners ● Set goals and determine criteria for success and sustainability ● Define model for services delivered ● Apply for licensing (CLIA, business license, specialized driver’s license). ● Establish a budget and apply for grants ● Consider the following: <ul style="list-style-type: none"> ○ Insurance (personal/professional, vehicle, business), risk management, ○ Policies and procedures (patient care, supply storage, specimen storage, etc..) ○ Supplies needed ○ Sites of operation ○ Advertising ○ Staff licensing and training ○ Interpreter services
Implementation	<ul style="list-style-type: none"> ● Identify team leader(s) for the day. ● Hold a team huddle at the start of the day and a debriefing at the end of the day. ● Triage area should be the first space clients enter prior to the seating area. ● Lunch area should be separate from the mobile set. Lunch breaks should be staggered so services are not interrupted. ● Ensure staff are compliant with competencies. ● Continue to advertise dates/times for the clinic. ● Track patient needs and make adjustments to services and supplies as needed. ● Continue to engage stakeholders and community partners.
Evaluation	<ul style="list-style-type: none"> ● Process Outcomes, Outcome Measures and Balance Measures ● Available resources found here: https://www.cdc.gov/publichealthgateway/performance/resources.html

Appendix B. Additional Resources

Resources	
AMA Foundation- Legal and Operations Guide for Free Medical Clinics	https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/public/ama-foundation/legal-operational-guide-free-medical-clinics.pdf
ASPPH- Interprofessional Collaborative Practice Model	https://www.aspph.org/teach-research/models/interprofessional-collaborative-practice/
CDC- Public Health Systems and Best Practices	https://www.cdc.gov/publichealthgateway/bestpractices/index.html
CDC- Federal Funding Programs	https://www.cdc.gov/publichealthgateway/federalprogramsandfunding/index.html
CDC- Mass Vaccine Clinic Checklist	https://www.cdc.gov/vaccines/hcp/admin/mass-clinic-activities/index.htm
CDC- Performance Evaluation Resources	https://www.cdc.gov/publichealthgateway/performance/resources.html
CDC- Vaccine Storage and Handling Toolkit	https://www.cdc.gov/vaccines/hcp/admin/storage/toolkit/index.html
CLIA Regulation	https://www.cms.gov/regulations-and-guidance/legislation/clia?redirect=/clia/
Community Emergency Response Team (CERT)	https://www.ready.gov/cert
Community Tool Box	https://ctb.ku.edu/en
Healthy People 2030	https://health.gov/healthypeople
Medical Reserve Corps	https://aspr.hhs.gov/MRC/Pages/index.aspx
Mobile Health Map	https://www.mobilehealthmap.org
National Healthcare for the Homeless Council	https://nhhc.org/
NHCHC Trauma Informed Care Toolkit	https://nhhc.org/research/publications/trauma-informed-organizations-change-package/trauma-informed-organizations2/
Rural Health Information Hub	https://www.ruralhealthinfo.org/
Rural Health Hub- Community Health Worker Model	https://www.ruralhealthinfo.org/toolkits/community-health-workers/2/program-models
United Way	https://www.unitedway.org/