Carteret Health Care
Healthcare Beyond the Clinic

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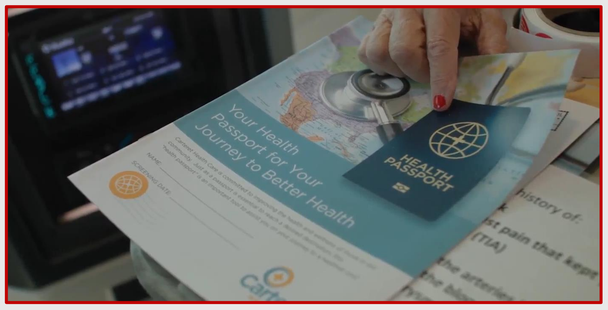
Background

Carteret Health Care serves a largely rural community with barriers to accessing consistent care. To meet patients where they are, the team leverages a Mobile Medical Unit and strong community partnerships to expand access, improve outreach, and connect patients to essential services.



Methods

- ✓ Conducted community health screenings using a Medical Mobile Unit in high-traffic areas.
- ✓ Collected key health metrics (blood pressure, blood glucose, total cholesterol).
- ✓ Identified high-risk individuals based on clinical markers and access-to-care gaps (no PCP, medication non-adherence).
- ✓ Provided real-time education on primary care, medication adherence, and follow-up needs.
- ✓ Referred high-risk participants to appropriate care resources and follow-up services.
- ✓ Tracked and recorded screening outcomes for analysis and program evaluation.

Smart Goal

Provide blood pressure cuffs and education to patients with BP >140/90, followed by telehealth consults within two weeks to monitor BP accuracy and statin adherence, with the goal of improving overall community health.

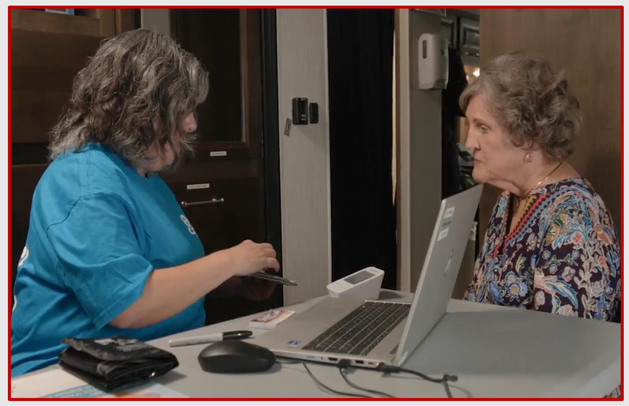
Drivers

- ➢ **Targeted Outreach:** Leveraging a Medical Mobile Unit to engage community members in high-traffic areas.
- ➢ **High-Risk Identification:** Rapid screening for elevated BP (>140/90), blood glucose, cholesterol, statin non-adherence, and lack of primary care.
- ➢ **Engagement & Education:** Promoting primary care access, medication adherence, and follow-up to support ongoing management.

Results

Conducted **79** community health screenings (June 2025 – March 2026)

- ✓ High-Risk → **72%**
- ✓ Hypertension (>140/90) → **35%**
- ✓ High Cholesterol (>240) → **24%**
- ✓ No PCP (past 12 months) → **18%**
- ✓ Statin Non-Adherence → **31%** (10 of 32 on statins)



Conclusions

1) Findings highlight a high burden of unmanaged cardiovascular risk and clear gaps in access to care and medication adherence.
2) Strong engagement: 50 participants with abnormal results agreed to follow-up.
3) Demonstrates high receptiveness to care when services are delivered in trusted community settings.
4) Reinforces the need and impact of community-based mobile health interventions.

Future Directions

- ➢ Integrate **HgbA1C** checks, and an improved diabetes screening into MMU operations.
- ➢ **Expand the Mobile Medical Unit's routes** to reach a broader demographic.
- ➢ Utilize the scheduled **follow-up call data** to track blood pressure reduction, statin adherence, and blood glucose management for the high-risk participants.
- ➢ Utilize a provider for telehealth provider coverage until the participant is fully **bridged** to primary care.