



Fiscal Year 2013 Annual Report

Table of Contents

EXECUTIVE SUMMARY 1

BACKGROUND AND HISTORY 2

WELLMOBILE STATEWIDE IMPACT 4

FISCAL YEAR 2013 FUNDING..... 5

 FUNDING PARTNERS 6

WELLMOBILE PROGRAM SERVICE MODEL 7

FISCAL YEAR 2013 PERFORMANCE, IMPACT, AND PARTNERSHIPS 8

 OVERALL RECIPIENT IMPACT AND COST EFFECTIVENESS..... 9

 REGIONAL SERVICE AREAS 10

 Central Maryland Project and Report of Fiscal Year 2013 Activities 10

 Upper Eastern Shore Project and Report of Fiscal Year 2013 Activities 12

 TARGETED SERVICES IN RESPONSE TO COUNTIES, PARTNERS AND NEW INITIATIVES 14

 HEALTH DISPARITIES IMPACT 15

 EMERGENCY PREPAREDNESS 15

 COMMUNITY PARTNERS 16

EDUCATION AND SERVICE ACCOMPLISHMENTS 17

 COMMUNITY EDUCATION AND OUTREACH..... 17

 CLINICAL EDUCATION ACTIVITIES..... 18

 RESEARCH AND PROGRAM EVALUATION 19

 NATIONAL PRESENTATIONS AND PUBLICATIONS 20

PROGRAM ADMINISTRATION AND FUTURE STRATEGIC DIRECTIONS 21

 OPERATIONAL CHALLENGES 21

 REDESIGN OF WELLMOBILE FUNCTIONS IN RESPONSE TO HEALTH CARE REFORM..... 23

 FUNDING AND STRATEGIC SUSTAINABILITY INITIATIVES 25

 SUMMARY OF FISCAL YEAR 2013 AND FISCAL YEAR 2014 FUNDING STATUS AND INITIATIVES..... 27

 FISCAL YEAR 2014 PRIORITIES 27

APPENDIX A..... 30

FISCAL YEAR 2012 WELLMOBILE BUDGET 31

WELLMOBILE ADVISORY BOARD MEMBERS GOVERNOR’S WELLMOBILE PROGRAM FY 2013..... 32

PUBLIC RELATIONS 33

EXECUTIVE SUMMARY

For the past 19 years, the Governor's Wellmobile Program has been a community partnership model of mobile nurse-managed primary health care. In 2000, state statute (Health General §13-1301 et seq.) codified two dual Wellmobile missions: to provide primary and preventive health care services to geographically underserved communities and uninsured individuals across the state and to serve as principle training sites for the University of Maryland School of Nursing that will expand student learning opportunities in the care of underserved populations.

The Wellmobile Program's fiscal year 2013 impact focused on the following three categories of initiatives: primary care and clinical services at multiple sites in Prince George's and Montgomery counties; CareFirst BlueCross BlueShield of Maryland (CareFirst) funded primary care on Maryland's Upper Eastern Shore project; and, to the extent financial support was available, targeted services in response to individual counties, partners, and new initiatives. These services included county-sponsored homeless resource and veterans stand-down days and the Prince George's County Mobile Vans project. Using a "Bridge to Care Model," the Wellmobile filled the gap in the existing primary care infrastructure by managing patients who lacked access to community-based clinics and prioritizing transfer of acute and comorbid clients and those with insurance coverage to available patient-centered medical homes.

A major goal of fiscal year 2013 was re-activating an additional Wellmobile on the Upper Eastern Shore by implementing a formative and summative evaluation of the "Bridge to Care Model." The Wellmobile was re-activated in collaboration with a funder and institutional partners, creating a template for rebuilding the former statewide program and demonstrating the potential to create a statewide model responsive to health care reform initiatives in the state's most underserved areas. Driving principles of the model were redesign of a delivery system compatible with health care reform, funding and testing, strengthening care management, building collaboration with health delivery systems and community linkages for seamless care with patient-centered medical homes, and building partnerships for sustainability and billing in 2014. The Wellmobile Program director pursued partnerships and submitted funding proposals with health systems to collaboratively pilot innovative approaches for seeing clients shortly after hospital or emergency room discharge and linking them with a community-based primary care practice in communities from where they draw clients. Under this revised model, the Wellmobile Program can enhance the capacity of existing health delivery systems, specifically primary care and prevention initiatives, aimed at reducing health costs and health disparities, while improving primary care access.

In fiscal year 2013, the Wellmobile service model included nurse practitioner primary care, nurse care management, social work, and outreach work. Services were provided in six counties in Central Maryland and on the Eastern Shore. Service accomplishments include: 1,641 nurse practitioner, 129 nurse care manager, 1,169 social work, and 754 outreach worker visits; 745 medical assistance outreach, applications, and follow-up encounters; and 325 referrals to specialists and for diagnostic testing across all activities. Combined public/private funds of \$563,053 supported Wellmobile Program operations in fiscal year 2013.

GOVERNOR'S WELLMOBILE PROGRAM ANNUAL REPORT

UNIVERSITY OF MARYLAND SCHOOL OF NURSING

FISCAL YEAR 2013

The following report is prepared for the Maryland General Assembly to fulfill the requirement of providing an annual accounting of actual and planned program activities for the Governor's Wellmobile Program.

BACKGROUND AND HISTORY

The Governor's Wellmobile Program is a community partnership model of mobile nurse managed primary health care designed to serve uninsured and underserved populations throughout Maryland. The program was established in 1994 on the recommendation of registered nurse Delegate Marilyn Goldwater, who at the time was the executive assistant for health issues in the Governor's Office. Delegate Goldwater was responding to the 1993 *Primary Access Plan for the State of Maryland*, which directly linked socioeconomic status to poor health outcomes, inadequate access to health services, and unhealthy lifestyles. The program was designed around a mobile health unit that would travel throughout the state to provide health care services and education to underserved and uninsured populations. The University of Maryland School of Nursing (UMSON) was designated the institutional home of the program and lead community partners and private citizens in making the concept a reality.

Delegate Goldwater's vision called for a Wellmobile Advisory Board representing a broad cross-section of business supporters, health care professionals, community leaders, educators, communications experts, private citizens, and others. Advisory Board members are appointed by the Governor and include representatives from the House and Senate, who are appointed by the Speaker and President of these chambers respectively. The purpose of the board is to assist UMSON in overseeing the program, in cultivating community and business partnerships, and in raising necessary funds to complement state appropriations.

The Wellmobile Program has been in continuous operation under UMSON's management since 1994. UMSON raised the corporate and philanthropic donations to purchase the original mobile unit in 1994 and outfit it as a medical clinic. Between 1994 and 1998, this solo Wellmobile provided maternal and child health services and immunizations in Baltimore City and Baltimore, Prince George's, and Montgomery counties and responded to similar needs in migrant camps and schools on the Upper Eastern Shore.

In 1998, UMSON was awarded a Health Resources and Services Administration (HRSA) grant to purchase and operate a second mobile clinic to extend services to the Eastern Shore. This unit was to be dedicated to expanding access to maternal and child health services and to accelerate the start up of school-based health centers by providing an interim mobile step to establishing the stationary school-based health center clinics. The Eastern Shore Wellmobile was placed in operation in summer 1999 to serve counties on both the middle and lower Eastern

Shore in collaboration with Head Start migrant health programs, complementing academic year school-based health center services. Through collaboration with school-based health centers operated by Caroline County public schools and eventually assumed by Choptank Community Health Systems, Inc., a Federally Qualified Health Center (FQHC), this second Wellmobile served as a transitional school-based health center for two county schools until the FQHC received funding for permanent clinics. Changes in Maryland's health policy, including Medicaid expansion through the Children's Health Insurance Program (CHIP) in 1998, and the Medicaid Section 1115 waiver designed to improve funding and access, revealed gaps in health care among the adult population. Consequently, the program, by then comprised of two mobile units, shifted its emphasis to a largely adult population to address the unmet needs of those in the workforce for whom employment-based health benefits were unaffordable or not offered.

The success of the program in reaching medically underserved populations prompted health officers in Western Maryland and the three lower Eastern Shore counties to advocate for extension of services into their jurisdictions. From 1999 to 2002, the program grew from one unit to four, with funds from federal and state public and local private sources. In 2000, the Maryland General Assembly passed legislation codifying the Governor's Wellmobile Program. The statute (Health General §13-1301 et seq.) identified the following two missions: provide primary and preventive health care services to geographically underserved communities and uninsured individuals across the state, and provide principle training sites for UMSON that will expand student learning opportunities in the care of underserved populations.

A fiscal year 2001 state appropriation funded the replacement of the original Wellmobile, the purchase of a Lower Shore Wellmobile, and annual operating expenses for one Wellmobile. That same year, when UMSON's HRSA grant submission for a Western Maryland mobile unit was not funded, a private benefactor gifted a fourth mobile unit for that region and established the Connect Maryland, Inc. foundation to support operations by matching state appropriations dollar for dollar. UMSON raised funds necessary to close the gap in program operating expenses. By the end of fiscal year 2002, four Wellmobiles were operating in four regions of the state: Western Maryland, Central Maryland, Upper and Middle Eastern Shore, and Lower Eastern Shore. As each new unit joined the fleet, it was assigned a designated regional service area based upon funding source specifications; a community needs assessment that identified gaps, such as distribution and proximity of primary care sites for the underserved; and concurrent community asset assessment, including the availability and community partners and stakeholder commitment. In preparation for placing each of the four units into service, discussions occurred with local health officers, hospital officials, FQHCs, other health care providers, and local social service agencies, which became community partners. Between fiscal years 2002 and 2009, with four units operating, the program was conducting an average of 8,000 consultations annually.

The Wellmobile fleet consists of three 36-foot and one 37-foot long, fully-equipped mobile medical clinics, each with an intake area flanked by two exam rooms. Each mobile unit has the ability to travel wherever needed in Maryland. The core staffing model is comprised of a driver/outreach worker, a family nurse practitioner (FNP) on UMSON's faculty, FNP graduate students, and entry-level community health students. Additional personnel may be added to meet the cultural needs of the client population and to provide care coordination to facilitate access to local wrap around and enabling services. The program's mission complements UMSON's

educational mission by providing clinical education sites for graduate advanced practice and entry-level community health nursing students. Undergraduate social work students from the University of Maryland Baltimore County (UMBC), accompanied by a University of Maryland School of Social Work faculty, also gain clinical experience on the Wellmobile, contributing to mitigation of health care work force shortages in the state and region.

WELLMOBILE STATEWIDE IMPACT

The mobile feature of the Wellmobile Program allows for unique portability and flexibility in accessing underserved communities. With the exception of populations with access to FQHCs, communities with relatively large numbers of uninsured residents tend to have disproportionately fewer options for primary health care than their insured counterparts because they lack financial resources to compensate providers and/or they reside in more rural, isolated areas less likely to attract health professionals. Many of the sites served by the Wellmobile program are federally designated medically underserved areas, health professional shortage areas, or medically underserved populations. Moreover, even the FQHCs and FQHC look-alikes are unable to completely satisfy the demand for primary care in the communities they serve despite additional funding. In 2009 and 2011, Maryland's 15 FQHCs received an additional \$27,976,619 (based on number of enrollees with an enhancement for uninsured enrollees) from HRSA to support operating expenses with the goal of expanding services. In 2012, four of Maryland FQHCs received \$19,436,822 in additional HRSA funding for capital improvements and one FQHC received \$858,333 in new access point funding. Despite this expansion of services, the demand for care has not been met.

Services by the Wellmobile continue to be in high demand, and care managers report long wait times when patients are referred to FQHCs for follow up and enrollment in a patient-centered medical home. When patients who entered through the Wellmobile "front door" become eligible for Medicaid, Medicare, or private insurance, the "Bridge to Care" is accomplished with their transfer to an in-network care provider. Patients too complex for management by Wellmobile FNPs are prioritized for referral to medical homes. FQHCs represent the first choice for uninsured patients in this category.

Without the Wellmobile, many of the clients served would have experienced significantly more limited or no access to health care services and/or delays in treatment. Many would have resorted to hospital emergency departments as their only source of care. Wellmobile services played a key role in reducing inappropriate emergency department utilization, a costly practice that undermines continuity in preventive and primary care. The Wellmobile Program has fostered relationships with hospital emergency departments and urgent care centers that refer recently discharged patients to the Wellmobile for primary care. This "reverse referral" mechanism expands primary care access and offers clients an opportunity to benefit from additional trans-disciplinary interventions aimed at breaking the cycle of inappropriate emergency department use. The Wellmobile Program has successfully filled this role for the most vulnerable residents across the state for 19 years.

The Wellmobile Program has reconfigured its client services management approach to align with the increased demand for primary care services that accompanies the statewide

implementation of health care reform. Health care providers and organizations will be mandated to manage clients in the community and prevent and decrease emergency department visits, prolonged hospitalizations, and unnecessary readmissions. This approach necessitates increasing availability of primary care access points over a relatively short period of time. Additionally, the October 1 opening of Maryland Health Connection (the state's health benefit exchange), designed as a one-stop shop to facilitate a single entry point for coverage through Medicaid expansion and private health plan enrollment, will strain the health plan network by increasing the demand for primary care providers. The Wellmobile Program is actively pursuing partnerships with health systems to collaborate on innovative approaches of aligning client encounters with community-based primary care practices close to their facilities and in their communities. Under this revised model, the Wellmobile Program can enhance the capacity of existing health delivery systems, specifically primary care and prevention initiatives aimed at reducing health costs and health disparities.

FISCAL YEAR 2013 FUNDING

At the beginning of fiscal year 2010, four Wellmobiles served the state in four distinct regions: densely populated suburban Central Maryland (Prince George's and Montgomery counties), suburban Anne Arundel County, the rural Lower Eastern Shore, and rural Western Maryland. Three Wellmobile vans operated in nine counties four days a week, and one vehicle operated weekly. Because the program was conceived as a public-private partnership, during fiscal years 2007, 2008, and 2009, annual state appropriations of \$570,500 to the University of Maryland, Baltimore (UMB) through the Maryland Higher Education Commission (MHEC) were used to leverage additional private sector funding to support the program. During that time, the range of state funding that supported the partnership model that facilitated operation of the four units progressively decreased from 74 percent of the annual budget in fiscal year 2007 to 57 percent in fiscal year 2009, with federal funds and other government and private sector grants and contracts filling the gap. In those and subsequent years, level-state funding could not keep up with rising marketplace personnel and operating expenses. Following the 50 percent reduction of the fiscal year 2010 allocation to \$285,250, operations that were planned based on an expectation of continuation of level funding equivalent to previous years' core state budget allocation, supplemented by grants, service contracts, and additional contributions, could not be sustained at the projected fiscal year 2010 level. This drastic cutback could not be immediately offset by other UMSON fundraising activities. By the beginning of fiscal year 2010, the Wellmobile had experienced a shift in its funding profiles. For the previous nine years, the program received pass through reimbursement from the Center for Medicare and Medicaid Services (CMS) for outreach efforts related to case-finding and enrollment of eligible adults, pregnant women, and children in Medicaid, CHIP, and the Primary Adult Care (PAC) program, under a memorandum of understanding (MOU) with the Maryland Department of Health and Mental Hygiene (DHMH). The agreement expired in October 2008, resulting in reimbursement for only the first quarter of fiscal year 2009. A new agreement was not approved in fiscal year 2010.

This drastic decrease in funding resulted in the contraction of the fiscal year 2010 Wellmobile Program and suspension of Wellmobile services in Western Maryland (three sites), the Lower Eastern Shore (four sites), and Anne Arundel County (one site), and elimination of seven positions. Refer to **Appendix A** (Wellmobile Staffing Comparisons by Fiscal Year and

Post-Program Contraction) for Wellmobile staffing details. Central Maryland was selected as the sole remaining site because that region has the state's lowest ratio of FQHCs to underserved populations. In addition, the region benefits from strong community and newly developing institutional partnerships and easy access as a clinical education site for the greatest number of students due to its proximity to UMSON's Baltimore and Shady Grove locations.

The fiscal year 2013 legislative allocation of \$285,250, supplemented with UMB Foundation funding, allowed UMSON to sustain the Governor's Wellmobile Program at the previous year's level of operation in Central Maryland. Grant funding from CareFirst BlueCross BlueShield supported reactivation of one Wellmobile four days a week beginning July 5 on the Upper Eastern Shore. Due to reconfiguration of the Medicaid enrollment process into the Health Benefits Exchange, the DHMH MOU reimbursing a percentage of direct Medicaid outreach activities by outreach and social work staff was not renewed.

FUNDING PARTNERS

Consistent with the objective of attaining program fiscal sustainability, the Wellmobile administration actively pursued funded partnership and grant opportunities with entities committed to extending nurse-managed primary care services in alignment with community needs. The last installment of a six-year commitment from a commercial donor was received in early fiscal year 2013. A grant award from CareFirst in fiscal year 2012 is the sole funder for the three-year (2012-2015) Upper Eastern Shore Primary Care and Services Linkages project in partnership with two Eastern Shore University of Maryland Medical System hospitals. This project is redeploying a Wellmobile to the Upper Eastern Shore. Funds from this grant supported project planning and start-up expenditures incurred in the second half of fiscal year 2012 and are the sole funder for project implementation that began July 5, 2012.

In fiscal year 2013, Wellmobile-designated funds from the UMB Foundation, Inc., supplemented the gap between the legislative allocation and operating costs for the remaining core program and Homeless Resource Day activities. The Wellmobile is not supported by University funding; its funding is dependent upon the direct state budget allocation through MHEC, grants and contracts, and public and private sources in partnership with communities. The Governor's Wellmobile Program used funds from donations, partnerships, contracts, and sponsors totaling \$277,803 to complement the state budget appropriation so the Wellmobile Program could provide services in fiscal year 2013.

Reactivating additional Wellmobiles and rebuilding the statewide program remains a UMSON priority, because the Wellmobile Program serves as a clinical education site for nurse practitioner, community health, and social work students and is a faculty practice that enables nursing and social work faculty to maintain clinical competency. Clinically competent faculty model evidence-based and interprofessional collaborative practice to students during clinical practice and integrate clinical experiences into classroom education. This faculty practice model assures the transfer of clinical skills to the newest cohort of health care and human services providers that comprise the future Maryland workforce. UMSON's Office of Strategic Partnerships and Initiatives, the organizational home of the Wellmobile Program, supported the Wellmobile Program's development efforts in proposal- and grant-writing and partnership development activities, including memberships in professional organizations and travel to attend

meetings relevant to the impact of health reform policy on safety-net providers and nurse-managed health centers.

WELLMOBILE PROGRAM SERVICE MODEL

The Wellmobile Program provides a valuable service to Marylanders by filling the gap where services are inaccessible due to increased demand and/or scarcity of access points, particularly for the uninsured. The program serves as the “front door” for the uninsured and a “bridge to care,” with the goal of linking clients to a patient-centered medical home. The Wellmobile Program provides the following services:

1. Clinical care – FNPs conduct physical exams and screenings, diagnose, and treat common acute and chronic illnesses for adults and children. Examples of episodic and acute primary care services include diagnosis and treatment of sore throats, urinary tract infections, skin rashes, pink eye, upper respiratory infections, and other common ailments. Clients often display symptoms that are harbingers of chronic conditions such as diabetes and hypertension. Following screening and diagnosis, the FNP initiates treatment to stabilize the client, prescribing generic prescriptions and over-the-counter medications as indicated, and instructs the client on self-management, employing health education techniques and associated teaching materials. Nurse care managers, social workers, and bilingual outreach staff, assisted by community health nursing and social work students, identify community resources and agencies, including other local safety-net health providers willing to accept referrals as the permanent medical home. Priority is given to clients with chronic and unmanageable acute conditions and co-morbidities.

2. Health screenings – FNPs conduct school physicals, well-woman checkups, clinical exams (including breast exams, pap smears, and pregnancy tests), cardiovascular (lipid profiles) and cancer risk assessments (PSA tests), and identify and diagnose chronic health problems (including diabetes and hypertension) and acute health problems, within the context of a primary care encounter conducted at Wellmobile routine service sites. Funding permitting, additional screenings are conducted at local community events, sponsored by faith-based institutions, local health departments, and county local homeless resource days, primarily in communities served by the Wellmobile. Screenings target specific groups such as uninsured school-age children or uninsured adult populations in underserved communities. Some screenings are directly conducted by the FNP, assisted by FNP students, on the Wellmobile; others, including colonoscopies and mammograms, are performed by referral arrangements to local health departments, health centers, hospitals, and other community agencies with which the program has negotiated and established partnership agreements. The Wellmobile Program limits health screenings to communities where partnerships are established with health care facilities and providers who will accept client referrals for appointments and provide follow-up for clients who screen positive for the tested conditions. This practice is necessary to assure optimal quality and continuity of care. FNPs initiate treatment using evidence-based clinical guidelines and transition the client to a permanent medical provider by matching patient needs with available resources and reimbursement. Community partnerships are developed and maintained to provide essential follow-up services for clients who screen positive and require specialty diagnostics and follow-up care.

3. Health promotion – Educating clients about healthy living practices, disease prevention, developmentally specific immunization and screening thresholds, weight management, exercise, smoking cessation programs, and personal/family emergency preparedness is the cornerstone of nurse-managed health care. Entry-level community health nursing students and advanced practice FNP students assist nurse care managers and outreach workers in planning and delivering health promotion and disease prevention educational programs tailored to specific populations. In addition, patients with acute and chronic disease receive personal disease management guidance and health information from FNPs and nurse care managers. Students fulfill clinical course requirements by engaging in these experiences.

4. Care management and service linkages, referrals, and system navigation – Many clients require extensive care management, referrals to second-tier specialists for complex conditions and diagnostics, and assistance in accessing related enabling services (social services, food assistance, prescriptions, interpretation, etc.) essential to improving their health status and quality of life. The program takes the holistic approach to health care that is at the core of the nursing model of health. In Central Maryland, an academic partnership with the UMBC School of Social Work provides field experiences for undergraduate social work students under the guidance of a master's-prepared faculty field instructor. Likewise, UMSON community health nursing faculty members oversee entry-level community health nursing students. Under faculty guidance, the students provide a range of interventions that assist clients who need help with housing, food, medications, and specialty health care to locate and obtain local, state, and federal resources.

The Wellmobile health care team functions autonomously based on this service model, with the operational goal of maximizing efficiency and cost effectiveness. The units receive minimal administrative support from the program's central office for clerical and patient management functions. Team members handle all communications, including phone calls, referrals, faxing, consultation follow-ups, lab and x-ray reports, and medical record maintenance and filing. Safe and appropriate staffing levels are required to accomplish these duties in compliance with primary care, advanced practice nursing, and general nursing practice standards. The program director oversees the outreach staff and consults with the FNPs and care managers on care coordination and disposition issues. The central office, comprised of the director and part-time administrative assistant, assumes responsibility for program development, planning and evaluation, community partnerships, overall program administration, reports, policies and procedures, regulatory compliance and quality assurance, grant writing, fundraising, billing, and ordering and distributing office and medical equipment and supplies.

FISCAL YEAR 2013 PERFORMANCE, IMPACT, AND PARTNERSHIPS

The Wellmobile Program's impact in fiscal year 2013 focused on three areas: primary care and clinical services at multiple sites in Prince George's and Montgomery counties, the Upper Eastern Shore Program Primary Care and Services Linkages project (a new initiative), and, funding permitting, targeted services in response to individual counties and partners.

OVERALL RECIPIENT IMPACT AND COST EFFECTIVENESS

In fiscal year 2013, the program provided client encounters under the following categories: primary care, nurse care management, social work, and outreach work. Primary care visits include those conducted on the Wellmobile vehicles during five county homeless resource day events. Social work encounters ranged from assistance with applications for medical benefits, e.g., Medicaid, CHIP, PAC, Medical Care for Children Partnership, and Kaiser Bridge; emergency assistance; food stamps; and referrals to the state’s Breast and Cervical Cancer Treatment Program. Screenings included HIV testing in collaboration with the Prince George’s County Health Department and testing for health problems such as hypertension and diabetes at community venues.

Outreach targeting eligibility determination and enrolling uninsured in entitlement programs resulted in 970 outreach encounters, including encounters for CHIP, Medicaid, and PAC applications; other health coverage (local health departments); breast and cervical cancer screening programs; application follow-ups; and promotional and informational outreach encounters. The scope of Medicaid outreach services included the following efforts by bilingual outreach workers or social work students: campaigns to raise awareness of entitlement programs, screening for eligibility, assistance completing Medicaid applications, follow-up on eligibility determinations, and assistance to those accepted with selection of a managed care organization and a primary care provider. Clients eligible for entitlement programs continued to receive Wellmobile primary care services until they were officially enrolled in that program, were assigned a primary care provider, and confirmed their scheduled appointment for the initial visit with the patient-centered medical home for follow-up care. Undergraduate social work students, under the supervision of a UMBC social work faculty member, advised clients on eligibility for public benefits and services. Case management and outreach efforts generated an additional 434 referrals for food, housing, and smoking cessation programs. The social worker, nurse care managers, and outreach workers met with clients after the nurse practitioner primary care visit to provide additional case management, care coordination, and health care system navigation. Accompanied by students, the social worker conducted additional community-based encounters at the Catholic Community of Langley Park Outreach Center two half days a week. These encounters involved referrals to community agencies, internal medicine and surgery specialists, and diagnostic services; transfer of cases to permanent health care homes; and communication of results and modifications to treatment plans. The following table summarizes the above-described activities.

Fiscal Year 2013 Census, Clinical Encounters, and Referrals

Unduplicated Medical Patients	Primary Care	Nurse Care Management	Social Work	Outreach Work	Public and Private Insurance Applications and Assistance	Other Assistance
943	1,588 adults 53 children	129	1169	754	418 applications 17 information 310 follow-ups	275 food stamps 54 financial assistance 95 other applications

According to the 2010 Medical Expenditure Panel Survey, the average cost of an emergency department visit in the U.S. for an uninsured person under 65 was \$1,843, with a median expenditure of \$455 (<http://meps.ahrq.gov>), of which the uninsured person paid 37 percent out of pocket (Agency for Healthcare Research and Quality, 2011, <http://consumerhealthratings.com>). An ongoing survey of Wellmobile clients, initiated in fiscal year 2013, on their intent to use the emergency department in the event the Wellmobile vans were not available revealed that 15 percent of respondents would have sought help at the local emergency department if they did not have Wellmobile services that day. In fiscal year 2013, it is estimated that the program avoided approximately \$453,654 in emergency department visit expenditures (based only on FNP visits and using median expenditures). This does not include the additional costs incurred in the emergency department for tests and procedures.

The market value of the average professional encounter on the Wellmobile (primary care, nurse care management, and social work) was \$192. This amount reflects the allocation of fixed costs across only professional (nurse practitioner, nurse care manager, and social worker) visits, conducted with support of drivers/office assistants, bilingual outreach workers, and the Wellmobile Program office. These visits were more time intensive and thus costlier than outreach and health promotion visits, which, when combined with the professional encounters, reduced the fiscal year 2013 Wellmobile cost per visit to \$152. Fiscal year 2013 Wellmobile operating expenditures were allocated across a slightly larger visit volume than in fiscal years 2010 through 2012. The slightly lower cost per visit when compared with previous years is due to the initial lower visit volumes and start-up costs for the Eastern Shore. Additionally, visit volumes remained less than those of previous years, a consequence of curtailed operations and program contraction due to comparatively fewer available financial resources beginning in fiscal year 2010.

REGIONAL SERVICE AREAS

Central Maryland Project and Report of Fiscal Year 2013 Activities

The Wellmobile has been in continuous operation in central Maryland since the program started in 1994. Demand for and utilization of health care services in this area—the Maryland suburbs adjacent to Washington, D.C.—continued to grow in fiscal year 2013. With the opening of Mary’s Center FQHC at the Judy Hoyer Center, the Wellmobile relocated to the Langley Park Shopping Center in July 2012. The Central Maryland Wellmobile provided services four days per week at the following Prince George’s County sites: Langley Park Shopping Center (Langley Park), Bladensburg Elementary School (Bladensburg), Deerfield Run International School (Laurel), Buck Lodge Middle School (Adelphi), and Franklin Park at Greenbelt Metro Apartments (Greenbelt). In Montgomery County, the Wellmobile provided weekly services at the Seventh Day Adventist Church in Takoma Park.

Staff reassignment and associated salary reallocation to the Eastern Shore project implementation created the opportunity to increase services to weekly at Takoma Park. In June, the Central Maryland project added a part-time nurse care manager to enable the nurse practitioner to see more clients. The nurse manager will facilitate care coordination, link patients

to specialty care, and oversee clinic flow, including medical records, scheduling, and outreach efforts, and precept nursing students. Central Maryland clients included concentrated pockets of Latino and African populations, who are predominantly uninsured. Care management needs could be further addressed by increasing the nurse care manager to four days a week and filling the position with a bilingual nurse. Additional funding (other than that designated by CareFirst for the Upper Eastern Shore) was unavailable for additional nurse practitioner, nurse care manager and driver positions to support expansion to other vicinities both within Central Maryland or in other areas of the state where demand is high.

Partnerships with health systems and other community-based providers and organizations enabled the Wellmobile team to provide a comprehensive range of health care services by accepting specialty and diagnostic referrals. Uninsured clients accessed reduced-cost generic prescription drugs prescribed by the nurse practitioner at local supermarkets, Walmart, and Target. This resource has been an asset in providing maintenance medications for conditions such as diabetes, cardiovascular disease, and hypertension for Wellmobile clients. The social worker assisted clients requiring proprietary prescription drugs with applications to the respective pharmaceutical company's patient assistance programs.

In both Central Maryland and the Upper Eastern Shore, the Wellmobile remained a key provider of regional outreach and enrollment for Medicaid (including MCHP and PAC). The social worker, nurse care manager, bilingual outreach staff, and students worked with local health departments to screen each client and household members for eligibility for Medicaid programs. In Central Maryland, for the past five years, a part-time field instructor from the UMBC School of Social Work has provided continuity in this effort. The social work faculty member supervised bilingual undergraduate social work students who located community resources, screened for Medicaid eligibility, and worked with clients whose applications have been denied to determine the reason for denial and help them re-apply, if warranted. The demographics of this area would support the assumption that the majority of adult clients in this region would be ineligible for entitlement programs due to their immigration status. However, outreach efforts by social workers and outreach workers assisted numerous clients at Central Maryland access points with Medicaid (including PAC) applications. Most of the children screened for CHIP and Medicaid were either eligible for one of these programs or the Kaiser Bridge program, and staff assisted their parents with applications. Staff assisted Medicaid recipients who brought their determination letters to the Wellmobile with enrollment in a Medicaid Managed Care Organization (MCO) and selection of a primary care provider and with the required annual re-enrollment process.

The patient-centered medical home is an integral concept in the 2010 Patient Protection and Affordable Care Act. The Wellmobile Program served as the "front door" for many uninsured and underserved residents in the communities it served. Newly-insured clients and uninsured clients whose conditions were refractory to treatment and required complex management and specialty providers were prioritized for referral to a patient-centered medical home. Clients were stabilized and referred to a permanent medical home, utilizing available FQHCs, other clinics, and private providers.

Referring stabilized clients revealed that the waiting list for appointments for new clients at Greater Baden Medical Services, Inc., the FQHC site in Beltsville, and the FQHC site in Capital Heights exceeded three months, resulting in a backlog of clients who remained under the care of the Wellmobile FNP until they could be accepted into care. Community Clinics, Inc.'s Greenbelt clinic was open only three days a week. The newly renovated Takoma Park site has been open six days a week since May 2012. In spring 2012, Mary's Center opened a new clinic at the Judy Hoyer Center/Cool Spring Elementary School campus (Adelphi), primarily serving pregnant women and children. The Wellmobile Program referred clients to both Mary's Center's Silver Spring (Montgomery County) site and this new site. A waiting list for new clients persisted in fiscal year 2013. In spring 2013, the clinic sought to refer adult clients to the Wellmobile, due to the loss of an adult health provider. The Wellmobile continues providing primary care to these clients in fiscal year 2014, until that clinic is able to resume full operations.

The Wellmobile serves as the interim care provider, managing these newly insured clients until they are transferred to a patient-centered medical home. Stable clients and those amenable to Wellmobile intermittent management are retained on the Wellmobile panel. This array of services and demonstrated expertise in bridging the primary care gap is a valuable asset to communities and potential partners in the implementation of health care reform. Population data and the need to alleviate some of the backlog of primary care access in Prince George's and Montgomery counties continued to support the decision to retain Wellmobile services at these sites when program contraction took place in fiscal year 2010.

In January 2013, the Wellmobile Program submitted a HRSA Bureau of Nursing grant application to fund interprofessional practice and education using an "integrated care model" on the Central Maryland Wellmobile through the addition of a University of Maryland School of Medicine Department of Family and Community Medicine physician faculty member and a master's prepared nurse care manager. This proposal was approved, but due to insufficient federal funding, it was not funded.

Upper Eastern Shore Project and Report of Fiscal Year 2013 Activities

The Upper Eastern Shore Primary Care and Service Linkages Project addressed primary health care needs by reinstating Wellmobile Services – specifically FNP and nurse case management, health education, care coordination, and outreach services – four days per week to three underserved rural Upper Eastern Shore counties: Kent, Talbot, and Queen Anne's. Services focused two days per week in the communities of Rock Hall and Chestertown and two days per week in the Ruthsburg-Dixon (Sudlersville) area. Three key project components include: 1) case finding the uninsured 2) reverse referrals from Shore Health (Easton Memorial and Dorchester General) and Chester River Health System's inpatient and emergency departments and 3) subcontracting with Shore Health and Chester River Health Systems Physician Practices. In each community, a central location to park the Wellmobile was selected in collaboration with health system and community leaders; other health care providers; and the Kent, Queen Anne's, and Talbot counties health and social services departments to facilitate integration of primary care in the community and utilization of local resources. These rural Eastern Shore hospitals are participating in the Maryland Health Care Commissions hospital Total Patient Revenue Program, under which the hospital receives a capitated payment that covers all inpatient and outpatient

services provided by the hospital, based on the hospital's revenue from the prior fiscal year. If the hospital can increase efficiency, contain costs, and/or reduce avoidable admissions and readmissions, it will achieve financial savings. The hospital bears the financial risk if costs increase beyond the global budget amount, providing incentives to keep patients healthy and out of the hospital.

In fiscal year 2012, the Wellmobile Program administration engaged in partnership development and implementation planning for the Upper Eastern Shore Primary Care and Services Linkages project. Activities included stakeholder meetings with Chester River Health System, Kent County and Queen Anne's County health departments, the Judy Hoyer Center, and the Family Support Center in Sudlersville, with respective execution of required memoranda of understanding. Personnel were assigned and oriented to the community partners. Promotional materials were developed and distributed via outreach activities to community organizations in the targeted localities of Chestertown, Rock Hall, and Sudlersville. Other pre-implementation activities included developing clinic operations, creating referral mechanisms, and refining clinical documentation and information exchange processes with partners. The Wellmobile was reactivated on the Upper Eastern Shore July 5, 2012.

The Wellmobile Program collaborated with Chester River Health System in Chestertown, Shore Health System in Easton, and the local health and human services organizations to identify and divert uninsured clients and those without primary care providers to the Wellmobile, thereby decreasing their reliance on unnecessary readmissions and emergency room use. A business associate agreement with Chester River Health System facilitated exchange of medical information between the hospital and the Wellmobile providers for continuity of care of discharged patients. The health system provided Wellmobile patients access to the financial aid/sliding fee schedule eligibility process that enabled them to receive low cost diagnostics and labs. The Chester River Hospital Foundation provided financially eligible discharged patients with emergency funds to cover prescriptions.

In June 2013, Chester River Hospital Center formed a QUICK (Advocacy, Quality, Utilization, Improvement/Coordination Keystone) Huddle team with representation from diverse service lines, including case management, nursing leadership, social work, behavioral health, palliative care, patient advocacy, transitional care, inpatient units, emergency department (ED), hospitalist team, long-term care/rehabilitation, and home care and hospice. The QUICK team's goals are to identify, facilitate, and guide patients to the appropriate ambulatory care venues to receive the care that they need. Noting the trend of patients seeking care in the ED, they identified a subset of patients who could benefit from referral to the Wellmobile. The nurse care manager provided the transitional care coach with handouts and the Wellmobile referral form initially implemented with the ED staff and discharge planner. Next steps are for the health system to query its database for uninsured and those without a PCP who frequent the ED and to mail information about the Wellmobile to them, in addition to referring them to a post-ED or hospital inpatient visit. Both mechanisms have the potential to increase referrals in the upcoming fiscal year.

The Upper Eastern Shore continues to experience a shortage of primary care providers, particularly for the uninsured, but also for those residing in more remote isolated communities

without physicians. The Upper Eastern Shore Medicaid (PAC) primary care providers and specialists experienced unique challenges related to business and economic forces peculiar to rural environments. These include a limited pool of primary care physicians accepting PAC patients, because the majority of PAC patients are complex enough to require specialty consultation. In addition, the program does not reimburse specialists and diagnostics, resulting in providers being unwilling to assume liability for their management and reduced availability of specialists willing to provide uncompensated care and travel time.

As in Central Maryland, the Wellmobile served as the interim care provider, managing insured and complex clients until they could be transferred to a patient-centered medical home. This array of services and demonstrated expertise in bridging the primary care gap is a valuable asset in efforts to forge financially sustainable partnerships, including piloting the integration of the Wellmobile provider staff into a Shore Health System affiliated primary care practice. This affiliation would enable the nurse practitioner to integrate her patient panel, consisting of both simple and complex patients, into a primary care practice, providing them with additional resources of an interprofessional practice. Some of the currently uninsured members on the Wellmobile patient panel will be eligible for Medicaid coverage or will be able to purchase health insurance through the exchange beginning October 1, 2013, resulting in a cohort of newly insured. Since the Wellmobile is the primary care provider for these newly covered patients, there is incentive for a primary care practice to incorporate the Wellmobile FNP and her patient panel beginning in January 2014. The associated billing and collections would create a revenue stream for the Wellmobile. Shore Medical Group and the Chester River Hospital have been identified as potential primary care partners.

Chester River Health System and Shore Health System merged July 1, 2013, creating the following new entities: UM Shore Medical Center at Chestertown, UM Shore Medical Center at Easton, and UM Shore Medical Center at Dorchester. Personnel changes in discharge planning and unification of nursing services leadership, and key internal referral interfaces to the Wellmobile care manager, will necessitate new relationship-building. No announcements regarding unification dates for Easton, Dorchester, and Chestertown hospital medical staff or for incorporating Chestertown-affiliated physicians into Shore Medical Group practices have been made.

TARGETED SERVICES IN RESPONSE TO COUNTIES, PARTNERS, AND NEW INITIATIVES

The success of Anne Arundel County's Homeless Resource Day over the past six years prompted Governor O'Malley's request that each Maryland jurisdiction conduct a Homeless Resource Day in subsequent years. At each of these day-long events, UMSON faculty and nursing students and county medical volunteers provided primary care services. The Wellmobile Program participated in five such events between September and March.

- Baltimore City Homeless Resource Connect – August 2, 2012
- Carroll County Homeless Resource Day, Westminster – October 6, 2012
- Montgomery County Homeless Resource Day, Gaithersburg – November 15, 2012,
- Dorchester County Homeless Resource Day, Cambridge – November 29, 2012

- Anne Arundel County Homeless Resource Day, Glen Burnie – March 16, 2013 (2 Wellmobiles)

HEALTH DISPARITIES IMPACT

The Wellmobile Program has been at the forefront of responding to cultural and linguistic diversity and mitigating health disparities since its inception. The persistent immigrant population, however, with its language and customs challenges, continues to demand a considerable expenditure of time and personnel. The largest group served by the Wellmobile in Prince George's and Montgomery counties is the multinational Latino community for which Spanish is the primary language. African and Asian immigrants constitute the second and third largest immigrant client groups, respectively. These populations face complex medical and social challenges, are uninsured, experience delays in accessing an overburdened FQHC safety-net provider system, and have limited English language proficiency. All Wellmobile outreach staff members are bilingual in Spanish, with one also fluent in French, enabling them to work effectively with this population. Other challenges related to cultural diversity, particularly in immigrant populations, are health illiteracy and the inability to read and write in their native language and in English. The Wellmobile is often the provider of last resort for these populations.

A partnership with Prince George's County Health Department Communicable Disease Division to provide mobile HIV testing and counseling services twice a month in Seat Pleasant, a predominately African-American community, ended in September 2012. Clients testing positive on the mobile unit were referred to Dimensions Health Systems, which receives funding from the Ryan White program to treat HIV/AIDS. Clients requiring primary care services were referred to Greater Baden (FQHC) in Capital Heights. Resources from this service day were reallocated to initiating primary care at Buck Lodge Middle School.

In January 2012, Dr. Eun-Shim Nahm received a Designated Research Initiative Funds award from the UMSON Office of Research for development and testing of a mobile health website for mobile clinic patients. In fiscal year 2012, content was developed for the English-speaking population and adapted for the Spanish-speaking population in Central Maryland. Testing of the devices occurred in fall 2012, and clients were able to access diet and exercise information and techniques from the mHealth website using iPads during a Wellmobile clinic visit. Once implemented, through independent or guided use by bilingual outreach workers and students, users will receive culturally and linguistically appropriate health education. This encounter will provide underserved patients with the opportunity to be connected to the benefits of eHealth.

EMERGENCY PREPAREDNESS

Mobile medical units are valuable assets during times of disaster or large-scale emergencies. While they are not first responders, their mobile platforms allow deployment to specific areas in need of assistance and, therefore, they are incorporated into Maryland's surge capacity plan. In past years, the Wellmobiles were on standby to DHMH for weather emergencies. Their services were not required this year.

COMMUNITY PARTNERS

Throughout its existence, the Wellmobile Program has relied on the support and cooperation of a host of committed partners to deliver a comprehensive array of health care and human services to its clients. In each region of the state served by the Wellmobile, the program has carefully identified and accessed a set of community and health care organizations whose missions and strategic goals are aligned with its own. While these partners provide no direct monetary support, their in-kind services and collaborative relationships enable special populations to gain access to their facilities, medical professionals, and enabling personnel, who accept client referrals for additional services. Through these partnerships, the Wellmobiles becomes an integral part of the health care delivery system in each of the communities they serve.

In Central Maryland (Prince George's and Montgomery counties) the following community partners provided access to health services and accepted referrals for Wellmobile clients in fiscal year 2013:

- Prince George's County Health Department
- Prince George's County Department of Social Services
- Montgomery County Department of Health and Human Services
- Greater Baden Medical Services, Capital Heights, Prince George's County
- Associated Catholic Charities, Spanish Catholic Charities, and Spanish Catholic Center, Archdiocese of Washington, D.C.
- Community Clinic, Inc., Greenbelt, Prince George's County
- Mary's Center, Silver Spring, Montgomery County and Adelphi, Prince George's County
- Brentwood Senior Center/ Dimensions Health Systems, Prince George's County
- Holy Cross Hospital, Silver Spring, Montgomery County
- Quest Diagnostics
- Pregnancy Aid Center, College Park, Prince George's County
- Washington Adventist Hospital, Takoma Park, Montgomery County
- MobileMed (Mobile Medical Care, Inc.), Montgomery County
- Montgomery Cares, Montgomery County
- Spanish Catholic Center, Montgomery County

The following community partners provided Wellmobile parking and access to facilities:

- Buck Lodge Middle School, Adelphi, Prince George's County
- Catholic Community of Langley Park, St. Camillus Parish, Langley Park, Prince George's County
- Deerfield Run Elementary School, Laurel, Prince George's County
- Bladensburg Elementary School, Bladensburg, Prince George's County
- City of Seat Pleasant, Prince George's County
- Shining Star Missionary Church, Seat Pleasant, Prince George's County
- Franklin Park at Greenbelt Metro Apartments, Greenbelt, Prince George's County
- Seventh Day Adventist Church, Takoma Park, Montgomery County

- Langley Park Shopping Center, Langley Park, Prince George's County

On the Upper Eastern Shore, (Kent and Queen Anne's counties) the following community partners provided access to health services and accepted referrals for Wellmobile clients in fiscal year 2013:

- Kent County Health Department
- Kent County Department of Social Services
- Queen Anne's County Health Department
- Queen Anne's County Department of Social Services
- Chester River Hospital Center, Chestertown
- Galena Family Medicine, Kent County
- Shore Medical Center, Easton, Talbot County
- Townsend Clinic, Rock Hall, Kent County
- Millington Pharmacy, Kent County
- Family Support of Queen Anne's County, Sudlersville, Queen Anne's County
- Choptank Community Health System, Inc., Caroline County

The following community partners provided Wellmobile parking and access to facilities:

- Chester River Hospital center
- Queen Anne's County Public Schools
- Rock Hall Volunteer Fire Company

EDUCATION AND SERVICE ACCOMPLISHMENTS

COMMUNITY EDUCATION AND OUTREACH

Health education and outreach services are essential program components in communities served by the Wellmobile. Requests for participation in community health fairs are so frequent that the Wellmobiles could be engaged in these activities weekly throughout the year. In previous years, each Wellmobile team independently chose the health fairs in which they would participate. This level of response frequently resulted in commitments exceeding the weekly primary care schedule. Budget constraints, however, have limited the program's ability to support overtime pay for weekend work, severely reducing the program's availability for weekend community events. As an alternative, a routine primary care day was eliminated in favor of an event deemed strategically important and valuable to the Wellmobile mission and to the communities it serves. This approach was implemented on a limited basis, with the goal of maintaining clinical service commitments to existing clients, rather than initiating services in a new population for whom the Wellmobile does not have established follow-up service linkages.

In fiscal year 2013, persistent decreased funding for personnel continued to limit the capacity to respond to health fair requests and resulted in prioritizing responses to those requests within the geographic areas served by the Wellmobile Program. Within those jurisdictions, priority was given to events conducted in collaboration with operational partnerships and aligned with targeted service and educational missions of the Wellmobile Program, particularly

opportunities for nursing and student participation in fulfillment of clinical course requirements. In fiscal year 2013, community education and outreach occurred at homeless resource days, continuing the commitment to participate in these events when operationally and economically feasible.

In Central Maryland, the social work faculty member and her students conducted community outreach and provided consultations and assistance with human services applications at the Catholic Community of Langley Park's Langley Park Outreach Center. Langley Park is one of six Prince George's County "Transforming Neighborhoods Initiatives" (TNI), focused on uplifting six neighborhoods in the county that face significant economic, health, public safety, and educational challenges. Bladensburg, another community served by the Wellmobile, is also a TNI site. This additional space provided the social worker and her students with access to additional clients whose entry point to Wellmobile services were primarily social service needs.

CLINICAL EDUCATION ACTIVITIES

A major component of the Governor's Wellmobile mission is educating successive generations of nurse practitioners and community health nurses in primary care of the underserved. The significance of this educational mission is underscored by new federal health care reform legislation, which emphasizes prevention, public health, and enhancement of the primary care infrastructure. The Wellmobile Program accomplishes its clinical education mission by serving as a clinical education site for students in UMSON's undergraduate, graduate, and doctoral programs and UMBC's undergraduate social work program. Students' educational experiences are selected to provide mutual benefit to the target population and the students.

In fiscal year 2013, one bilingual registered nurse to Bachelor of Science in Nursing (RN-BSN) student completed an experiential Spanish medical terminology independent study on the Wellmobile and provided interpreter services for the mHealth iPad testing. Two students fulfilled community health nursing clinical practicum requirements on the Wellmobile. These students assisted the nurse practitioner by performing patient assessment, patient education, basic care coordination, outreach, and follow-up client contacts and by designing health promotion materials and conducting health education visits. They performed community-wide and service site assessments and developed and implemented programs in fulfillment of course requirements. They planned and participated in homeless resource day activities and conducted health promotion sessions with individuals and groups of clients. A community public health clinical faculty member supervised an additional eight RN-BSN community/public health students who planned interventions which they conducted at Anne Arundel County Homeless Resource Day. A master's prepared community health nurse completing a Teaching in Nursing and Health Professions certificate completed a practicum on culturally competent health promotion on the Wellmobile.

The Wellmobile Program director taught an undergraduate nursing rural health course, using an ecological framework to expose students to social, behavioral, environmental, and physical health issues impacting rural communities' health status. Through clinical rotations in rural communities, students identified health priorities and challenges impacting these communities and proposed evidenced-based interventions. These region-specific assessments

and approaches were incorporated into the CareFirst Eastern Shore grant implementation and are available as guidance for future Wellmobile Program grant submissions in Maryland's three respective rural regions.

Wellmobile FNPs precepted 10 FNP students and 13 adult/gerontological nurse practitioner students, who completed Wellmobile rotations to fulfill practicum requirements. Nurse practitioner students worked individually with the nurse practitioner to perform patient exams, diagnose, prescribe treatments and medications, and refer appropriate patients to specialists for consultation. The social worker precepted two UMBC undergraduate social work interns over the full academic year. These interns augmented the effort of the social work faculty member by providing preliminary screening for Medicaid eligibility; linking clients to services; organizing community resources; and revising the local community services directory of primary care, county breast and cervical cancer programs, and radiology providers. They created and maintained an updated active patient panel database.

RESEARCH AND PROGRAM EVALUATION

The Wellmobile Program offers a multitude of opportunities for research across diverse areas. In anticipation of a transition to an electronic health record (EHR), and to manage data required to generate invoices for DHMH to obtain CMS reimbursement for Medicaid outreach activities, administrative effort continued in fiscal year 2013 on refining data points, encounter-level data collection methodologies, and documentation adherence by Wellmobile staff who provided clinical and enabling services. Capturing all Wellmobile professional and allied health staff encounters is a priority to identify and quantify the multiple interventions and interveners needed to help clients obtain assistance and navigate the health care and social service systems. This important information also provides data for future grant submissions.

Two current projects initiated in fiscal year 2012 extended into fiscal year 2013: Development and Testing of a Mobile Health Website for Mobile Clinic Patients and the Upper Eastern Shore Primary Care and Services Linkages project. Process and impact outcomes from these projects respectively will address the following research questions:

- Can evidence-based health promotion programs be adapted to provide culturally and linguistically appropriate information for minority populations using mobile technology?
- How can vertical integration with health systems impact utilization of higher cost system resources, including emergency departments and hospitalization?
- Can a mobile health unit contribute to the statewide objective of integrating patient-centered medical homes into primary care practices?
- What would be the impact on health costs and client outcomes with a refocus of hospital community benefits funds to support Wellmobile services in communities targeted by respective hospitals' community assessments?

Through community collaborations, partnerships, and clinical documentation and care coordination activities, the Wellmobile Program provides a continuous source of data that can be used to determine policy directions for health care reform and provision of services for hard-to-

reach populations. Research questions generated by the program's experience with underserved groups that have potential for future investigation include:

- Can national evidenced-based practice guidelines and standards be translated into care provided to an uninsured population?
- Can a focus on disease management in a nurse-managed model improve outcomes for the uninsured?
- Are mobile health units effective and efficient in increasing access to primary care in uninsured and underserved populations?
- Can health promotion activities and routine physical assessments and screenings conducted among relatively healthy uninsured populations defer the onset of chronic diseases and/or improve early detection?

NATIONAL PRESENTATIONS AND PUBLICATIONS

As both a clinical and faculty practice site for UMSON, the Governor's Wellmobile Program is a valuable source of lessons learned and best practices. UMSON faculty members disseminate this knowledge by presenting their work at local, regional, national, and international meetings of nurses and other health professionals interested in exploring innovative programs consistent with the Wellmobile's missions.

Wellmobile staff presented the following at professional meetings in fiscal year 2013:

- Nahm, ES; Antol, SM; Plummer, L; Pinna, J; Brown, J; Rietschel, M; Kapustin, JF; Carter-Pokras, OD; & Zhang, D. "Development and Testing of a Mobile Health Website for Mobile Clinic Patients," presentation in Symposium 04 "The Use of Emergent Technology to Assess and Intervene with Multiple Health Behaviors in Racial/Ethnic Minority Populations," 3-20-2013, 34th Annual Meeting & Scientific Sessions of the Society of Behavioral Medicine, March 20-23, 2013, San Francisco, CA.
- Antol, S. "Analysis of Insurance Status of a Nurse Managed Rural Safety Net Clinic Patient Panel," poster presentation, April 4, 2013, University of Maryland College Park School of Public Health Public Health Research Day.

To date, Wellmobile administrators and faculty have delivered presentations on:

- Innovative approaches to enhancing health care access for the underserved
- Models of nurse-managed primary health care practice
- Community and interprofessional partnership development
- Rural and minority health care
- Innovative delivery mechanisms and task-shifting
- Deployment of outreach workers
- Health promotion and disease prevention in underserved communities
- Linguistic and cultural competence
- Opportunities and barriers to fiscal sustainability in the era of health reform

PROGRAM ADMINISTRATION AND FUTURE STRATEGIC DIRECTIONS

It is important for the Wellmobile Program director to keep abreast of state and federal policy changes pursuant to health care reform because of implications for program development and sustainability. Specifically, the director must be able to articulate the program's current and potential future contributions to primary care for the underserved and establish a role for the program in the rapidly evolving restructuring of health care delivery. The Wellmobile Program director participated in the DHMH Workforce Committee retreat and the Eastern Shore regional subcommittee. The director is a board member of the Maryland Assembly on School-based Health Care (MASBHC). MASBHC's mission is the promotion and advancement of school-based health care to ensure that children and youth have access to quality health care services in a setting that is uniquely tailored to meet the needs of the students and the community. As a provider of school-linked services to underserved populations of children and adults, the Wellmobile has expanded service capacity to schools without clinics and served as a transitional clinic for developing centers. In fiscal year 2013, the director was appointed to the Governor's School-based health Center Policy Advisory Council (PAC). The PAC's mission as outlined in section §7-4A-05 of the Education Article is "to coordinate the interagency effort to develop, sustain, and promote quality school-based health centers in Maryland. In consultation with appropriate State agencies and other interested organizations, including representatives from academic institutions, health care providers, and payers, the Council is responsible for multiple actions outlined in Section 7-4A-05(b) of the law." One function pertinent to the Governor's Wellmobile mission, is to "perform other activities identified that impact on the development, sustainability, or quality of school-based health care in Maryland. In fiscal year 2013, the PAC engaged in dialogue with Medicaid MCOs around increasing the role of School-based health centers to fill the primary care gap for school-age children, for which school-linked Wellmobiles could enhance capacity of existing school-based health centers.

OPERATIONAL CHALLENGES

Challenges in fiscal year 2013 continued to be: access to secondary referral services, including sub-specialties; linkages to patient-centered medical homes for primary care services; lack of an electronic health record; and maintaining the Wellmobile vans in the required operating condition to perform the program's legislatively designated missions.

One of the biggest challenges facing primary care providers continued to be securing second-level referral sources for laboratory tests, x-rays, diagnostic tests, and specialty services. Examples include oncologists to manage breast, cervical, and thyroid tumors; endocrinologists for management of complex diabetes; neurologists to rule out brain tumors and develop treatment plans for migraine headaches; orthopedic physicians for pain evaluation due to muscular-skeletal problems; urologists for kidney failure; and cardiologists for hypertension and heart failure. Other safety-net providers, including FQHCs, report the same challenges.

During fiscal year 2013, the Wellmobile Program director explored new contacts with health providers willing to accept referrals for newly covered and uninsured complex Wellmobile patients to fill the gap left by the Spanish Catholic Center, which relocated its Takoma Park office to Silver Spring in spring 2011. Clients willing to travel to Silver Spring

remained eligible for services on a case-available basis. The program continues to explore options and partnerships with existing health systems, including local hospitals, for second-level referrals.

Dimensions Health System (Prince George's Hospital Center and Greater Laurel Beltsville Hospital), a Prince George's County owned health system, continues to experience financial difficulty aggravated by uncompensated care and has not been a source of specialty and diagnostic resources. Opportunity exists to integrate the Wellmobile into the planned primary care infrastructure envisioned as part of the proposed partnership among the University of Maryland Medical System (UMMS), the University System of Maryland, and the state to construct a new health system, contingent on the funding of this enterprise. Washington Adventist Hospital plans to relocate to White Oak, Montgomery County and to develop a Village of Education, Health and Wellbeing, which will include primary care, on the current Takoma Park campus. Holy Cross Hospital in Montgomery County accepts specialty referrals. The Wellmobile Program will continue to seek out partnerships and refer clients to specialists and for diagnostic services affiliated with these facilities that accept sliding fee and pro-bono referrals.

In fiscal year 2011, the Wellmobile Program negotiated an array of reduced fee lab services with Quest Diagnostics and passed the reduced rates on to clients. Wellmobile staff members collected the fees during the Wellmobile visit and provided the client with a pre-paid lab slip. Clients went to the nearest Quest lab for the specimen collection and analysis. Quest invoiced the Wellmobile Program, which paid the bill from client collections. In fiscal year 2013, the Wellmobile Program passed on a two-percent increase in Quest Diagnostic laboratory fees to its clients.

Providing access to primary care services does not solve all of the problems of the uninsured and underserved. The Wellmobile client base is a population that has experienced delayed access to health care and often present advanced disease processes. Clients with unmet needs may average up to eight medical problems, demanding multiple referrals for diagnostic and specialty care. These more complex patients require extensive care management. Many clients have minimal literacy skills and require additional effort to ensure that they have a basic grasp of their health conditions and how to manage their day-to-day health.

Given this client profile, the Wellmobile Program included a budget line for a nurse care manager in its January 2013 HRSA grant submission and received funding from CareFirst for the position on the Upper Eastern Shore. All future proposal submissions will include a nurse care manager position in the line item budget. Full restoration of the bilingual nurse care manager role would enhance linkages of clients to secondary and tertiary care services. The addition of a nurse care manager to the clinic team provides entry-level community health and master's nursing students a preceptor, complementing the roles of the FNP with NP students and the social worker who, assisted by social work students, oversees outreach activities. Even when linkages can be located and established, the absence of insurance coverage for the more costly specialty and diagnostic services necessitates out-of-pocket payment, which, despite sliding-fee schedules, is often a deterrent to accessing the next level of care. For these clients, the emergency room provides an avenue to specialty care, an option to which clients may resort when other means fail.

Failure to procure an EHR in fiscal year 2013 continues to impede operations both at the direct-service and administrative levels. An EHR is central to attaining integration with patient-centered medical homes and for efficient operations, including care management and quality. Electronic scheduling systems link with client medical records, resulting in streamlined documentation and recordkeeping processes. Real-time access to the clinical record enhances continuity of care, saving time and effort in collating and filing paperwork. It eases transitions in care as clients are referred between health systems, an important part of partnership development required for subcontracts. An EHR provides an added level of assurance for scheduling and accurate data collection of client encounters. EHRs also facilitate reporting of an unduplicated patient census by linking all encounters within a case. Currently, all documentation, including schedules and encounters, are paper-based, which requires entry into a database to generate reports. The Wellmobile program has satisfied by implementing workarounds such as home-grown databases, hard copy scheduling, and documentation practices.

Compounded by budgetary constraints resulting from four consecutive years of a 50-percent state budget reduction, cessation of CMS reimbursement, fewer than expected donations and grants, and the need to provide equitable salaries and benefits to employees, the EHR project has been deferred for the fifth consecutive year. The Wellmobile Program will resume the process of EHR acquisition through grant writing, fundraising, and partnership development and will eventually resume the procurement process when these factors are aligned.

Fiscal year 2013 operating expenditures included maintenance of four Wellmobile vehicles, each requiring semiannual State of Maryland and Department of Transportation mandated vehicle inspections, ongoing preventive maintenance, and routine and unpredicted mechanical repairs. The vehicles were rotated in and out of service during fiscal year 2013 to sustain program operations while other vehicles were undergoing repairs and inspections. Routine generator maintenance was continued on a fixed schedule, as required, based on each vehicle's rate of auxiliary power utilization. Because the vehicles operate on generator power at community sites (unless the host site has installed a special electrical outlet to support shore power), generator service, repair, and replacement are major expenses. Generators were replaced on three vehicles as part of extensive generator battery and electrical system maintenance during fiscal year 2012. Fuel tanks were replaced on one vehicle in fiscal year 2013. These and other repairs to the aging fleet, as well as rising fuel costs, contributed to ever-increasing operational expenditures. The Wellmobile Program purchased fuel through the state of Maryland fuel program at State Highway Administration fueling stations and filed for tax rebates, which helped ameliorate fuel expenditures.

REDESIGN OF WELLMOBILE FUNCTIONS IN RESPONSE TO HEALTH CARE REFORM

In fiscal year 2009, the Wellmobile Program began a shift from its former role as a health care home serving as the "front door" for primary care services, to its new role of linking clients to a permanent community-based primary health care home. This policy shift was aimed at maximizing Wellmobile resources and extending access to Wellmobile services to a larger

section of the population. This strategy expanded the potential reach of this gap-filling service and was continued in the subsequent four fiscal years.

Advent of the patient-centered medical home model, an integral part of the Patient Protection and Affordable Care Act, and the increasing role of FQHCs in primary care for the underserved, reinforced the value of sustaining this direction in fiscal year 2013. Additionally, given the imminent coverage expansion via Medicaid expansion and implementation of health exchanges by 2014, the demand for primary care will continue to increase. Anticipating the potential role of the Wellmobile Program in expanding access to care, the program continued refining its “Bridge to Care” model during fiscal year 2013. A generous grant from CareFirst has allowed us to pilot an affiliation with a hospital system on the Eastern Shore. While the Wellmobile Program as a stand-alone entity cannot function as a medical home, this model of care (described below) is well-suited to assist FQHCs, medical practices, health systems, and other health institutions in meeting patient-centered medical home requirements. Additionally, nurse practitioner and community health nursing expertise, specifically care management, are assets in the patient-centered medical home model.

The “Bridge to Care” model has three components, each instrumental to the role of the Wellmobile Program as a gap-filling resource. These components are: increasing access, eligibility determination, and care management. **Increasing access** involves establishing the Wellmobile as the “front door,” providing accessibility in two ways. Wellmobile outreach workers locate uninsured and concentrations of underserved populations and publicize Wellmobile service availability in those communities. The front door is available to partners through the reverse referral mechanism. Community partners, such as hospitals (including their emergency departments and affiliated medical practices), urgent care centers, and health and human service agencies refer clients to the Wellmobile.

Eligibility determination is the second model component. To achieve the desired outcome of transferring eligible clients to a patient-centered medical home, outreach worker and social work efforts focus on determining eligibility for state and federal entitlement programs such as Medical Assistance (including CHIP and PAC) and Medicare. Outreach staff members assist clients in completing applications, facilitating Managed Care Organization enrollment, and selecting primary care providers. Once the client’s needs are assessed, immediate needs are treated, and the plan of care has been established, the Wellmobile care management process prioritizes transition of unstable, co-morbid individuals to a permanent patient-centered medical home, regardless of insurance status. Increasingly scarce reduced fee physician specialists, pro bono and sliding scale fee diagnostic services, and other wrap-around services, to which the Wellmobile historically referred clients in need of additional consultations and treatment, demand that these complex clients be transitioned to a permanent health care home. Medical homes used include FQHCs, outpatient clinics, and private physicians that accept the client’s newly-established health coverage or offer sliding scale fees for the uninsured.

Given that the average wait time for a new-patient appointment at clinics and practices accepting uninsured patients is typically two to three months, and clients who have undergone the eligibility determination process for entitlement programs are awaiting confirmation, the Wellmobile FNP continues to follow both potentially eligible and ineligible clients until they can

be safely transitioned to the appropriate clinical practice. During this **care management** phase, the Wellmobile program continues managing these clients and providing individualized physical and social assessments, blood work, treatment, and health education to stabilize their health problems. Clients are scheduled to receive follow-up medical care as needed, either on the Wellmobile or through referral arrangements with an available pro bono or sliding fee scale specialist, or diagnostics, to the extent they are available.

The contracted Wellmobile Program capitalized on the opportunity to transition both complex uninsured and newly insured clients to medical homes in local FQHCs made available by the fiscal year 2010 HRSA FQHC service expansion, funded under the 2009 American Recovery and Reinvestment Act. In Central Maryland, the process of transitioning complex co-morbid clients to health care homes remains protracted due to the extensive pent-up demand for primary care services for the uninsured. An overall shortage of primary care providers in both Central Maryland and on the upper eastern shore, including limited availability of those accepting Medicaid and PAC, also resulted in patients remaining under Wellmobile care. Both insured and uninsured clients awaiting referral remained primary patients of the Wellmobile for varying amounts of time. Factors influencing the duration that a client may continue under Wellmobile Program management include level of clinical stability, state or federal entitlement program eligibility, availability of a health care facility willing to accept the uninsured and newly insured Medicaid and PAC patients, and availability of an appointment slot in a patient-centered medical home.

The Wellmobile Program demonstrates value not only by addressing clients' immediate health problems and providing the bridge to primary care, but also by conducting preliminary work-ups, prescriptions, and treatments for clients pending transfer, who are then transitioned, along with a medical record, in a relatively more stable condition than if they had self-referred to the practice or were referred by an emergency department. This attention to stabilizing the client, including diagnosing and treating immediate conditions, and the accompanying clinical documentation facilitates client transfer and creates a climate of more willing acceptance by the receiving provider of these clients.

Experience with this level of nurse-managed patient care in the "Bridge to Care" model provides evidence that the Wellmobile Program has the capacity to fill a valuable role in the statewide health reform implementation. This asset can be tapped by community partners via contractual arrangements to assist them with medical home functions, including visits from advanced practice nurses and care managers, which are among the essential patient-centered medical home functions. Billing and collections obtained from the patient-centered medical home under this contractual model would form the groundwork for sustainability efforts. The Upper Eastern Shore strategy of forging partnerships between the Wellmobile and health system-affiliated primary care practices could be replicated with other UMMS network hospitals health to enhance fiscal sustainability concurrent with filling the gap in primary care practices.

FUNDING AND STRATEGIC SUSTAINABILITY INITIATIVES

The fiscal year 2010 goal was to configure a program of Wellmobile services aligned with available fiscal, human, and material resources. Once the annual service plan was mapped

out and subsequently contracted, attention was refocused on sustainability strategies, including identification of supplemental funding streams. This configuration was maintained in ensuing fiscal years 2011 through 2013. Although not a new model, the strategy required renewed and targeted efforts toward engaging a generation of new funders through grants, foundations, and business and community partnerships. When Wellmobile funding was robust, the expectation was that community partners would provide referrals, service sites, and in-kind services, and would leverage influence with existing health delivery systems to accept uninsured clients on either a pro bono or sliding fee basis. The Wellmobile Program brought a fully-funded service into their community without a local financial commitment to the service model. A shift away from this model of freely allocating Wellmobile services funded through legislative allocation and UMSON fundraising efforts to a community, county, or region was needed to accomplish reactivation of the full fleet. The new paradigm involved a stakeholder model whereby the local health and/or human services delivery system, local nonprofit agencies, or the beneficiary community itself would support the operation of this service. This included redefining the expected contribution of the community partnerships to include financial support, ranging from contractual service agreements or grant fund allocation to provide direct payments for services, to community-based collaborations committed to joint grant submissions with the Wellmobile Program. The aforementioned “Bridge to Care” provides the framework for the community partnership sub-contractual model, one potential sustainability strategy.

The CareFirst-funded partnership with Chester River and Shore Health Systems will expand implementation of the ‘Bridge to Care’ model to the upper Eastern Shore and pilot approaches to sustainability. The goal is to achieve a fiscally sustainable model by the conclusion of the third project year, fiscal year 2015, by integrating the Wellmobile into the Upper Eastern Shore primary care system through sub-contractual arrangements and eventual incorporation into the health system–related practices.

With the re-activation of a second Wellmobile on the Eastern Shore accomplished in July 2012, the ultimate goal of reactivating the remaining two Wellmobile vehicles remained foremost among the fiscal year 2013 priorities identified. The January 2012 HRSA Interprofessional Collaborative Practice grant proposal submission was designed to replicate the CareFirst proposal sustainability model. The proposal would pilot a sub-contractual arrangement between the University of Maryland School of Medicine Family Medicine and the Wellmobile, enabling retention of existing, newly insured, and complex patients. Through this partnership, eligible patients seen by the Wellmobile FNP and complex patients requiring physician consultation would be attributed to Family Medicine, which would bill and collect revenues on insured patients and reimburse the Wellmobile Program an agreed-upon portion of the proceeds. Funds generated through this arrangement would support program operations, freeing up a portion of the MHEC allocation for additional services.

While community and organizational partnerships are fundamental to procuring future Wellmobile funding, such partnerships must be of mutual value and advance the Wellmobile’s service and educational missions. To date, the Wellmobile has explored partnerships in the health, academic, and community organization sectors. Wellmobile Advisory Board members have been urged to identify corporate and community funders and to broker entry into the local health delivery systems to gain access to funding opportunities and community partnerships.

Examples of funded partnership exploration activities include FQHCs; rural and urban hospital systems, including UMMS; University System of Maryland academic institutions; local and state health departments; the Maryland State Department of Education and county school systems; and local community agencies and philanthropic organizations. The Wellmobile Program seeks partnerships with health delivery systems to develop and implement novel integrated interprofessional health service models that will add value to the evolving health services sector, including care transitions and primary care.

SUMMARY OF FISCAL YEAR 2013 AND FISCAL YEAR 2014 FUNDING STATUS AND INITIATIVES

The UMB Foundation, Inc. received donations to the Wellmobile from communities and individuals in fiscal year 2013, which have supplemented Wellmobile operations in accordance with donor specifications.

During fiscal year 2013, the Wellmobile Program submitted the following proposals to external funders:

- “Bridging Interprofessional Collaborative Practice with Integrated Care” (HRSA, Division of Nursing Nurse Education Practice Quality and Retention) not funded
- “Use of mHealth Technologies in Mobile Clinics for Underserved Populations.” TM&M Weight Management (TM&M-WM) program (R21 NIH) Eun-Shim Nahm (PI), Associate Professor, Department of Organizational Systems and Adult Health, not funded
- “EHR Adoption in a Mobile Faculty Nurse-Managed Clinic for the Uninsured and Underserved Populations in Maryland” (University of Maryland, Baltimore and UMBC SEED Grant) not funded

Fiscal year 2014 funding prospects include HRSA requests for proposals pending fiscal year 2014 federal appropriations.

FISCAL YEAR 2014 PRIORITIES

The challenge to raise external funds to support care of the uninsured will continue in fiscal year 2014. Affordable Care Act requirements placed on health insurers requiring them to invest no less than 80 percent of premiums in patient services restrict the availability of grants from those funders. Funders, including those to which the Wellmobile Program had previously submitted proposals, have reduced the number of requests for proposals, restricted the amount of funding per proposal, and limited the duration of funding commitment to one fiscal year. In the past, such grants were often renewable and involved multiple year commitments. Because fundraising remains an ongoing priority to sustain the work of the Wellmobile Program, proposals and presentations to potential partners and funders will require additional resources and responsibilities for the program’s administrative staff. Previously submitted grant proposals continue to undergo revision for resubmission to funders, emphasizing the potential value of a mobile clinical service provider to a partner with a stationary operation, particularly within the

context of health reform. The Wellmobile will enlist the assistance of UMSON's Office of Development in the preparation and submission of calls for proposals by foundations.

The Wellmobile Program will continue to pursue collaborative extramural funding opportunities with UMSON specialty program directors that provide faculty practice and service opportunities aligned with the mission of the Wellmobile Program. UMSON is collaborating with other UMB professional education programs. Wellmobiles outfitted as clinical exam rooms are well-suited for interprofessional collaborative practice. Potential availability of federal funding to support advanced practice nursing and clinical training offers an opportunity to reactivate Wellmobile units using newly created interprofessional teams implementing practice models that would establish the Wellmobiles as interprofessional clinical training sites.

The Wellmobile Program aspires to further capitalize on the opportunity to align its education mission with the Maryland State Office of Rural Health's "Grow Your Own" initiatives, which focus on recruitment, education, and retention of health professionals in rural areas of the state. This innovative plan requires both internal and external partnerships with other schools and health care systems, as well as local area health education centers to craft an alliance for a rural HRSA health professions training grant submission.

The Wellmobile Program has proposed to school-health specialists in the Student Services Division of the Maryland State Department of Education that the Wellmobile could enhance school-based health center capacity. This enhancement could be accomplished by establishing collaborative funded partnerships between school systems and the Wellmobile to provide nurse-managed primary care services through a school-linked health center model. Establishing this partnership would require designating the Wellmobile as a school-linked health center and creating billing capability through sub-contractual arrangements with local jurisdictions or health systems. Revenue would be generated through indirect or direct access to health care reimbursement streams. In July 2012, DHMH realigned the Office of School Health, the Office of Primary Care Access, and the Office of Community Health Centers under a newly-created Health Systems and Infrastructure Administration. Future discussions of a proposed Wellmobile school-linked health center model will include the Deputy Secretary of Public Health Services.

The Wellmobile is a state asset that could also be a subcontractor to entities funded under the proposed State Innovation Model Grant scheduled to be submitted in fall 2013 and to Health Enterprise Zone grantees seeking opportunities to access difficult to reach populations.

The development and implementation of an EHR remains a priority for fiscal year 2014. An EHR is fundamental to partnerships and subcontracts with health systems' primary care providers and FQHCs because it provides the secure platform for exchange of health information among partners of vertically integrated health systems. Assistance has been requested from the UMSON Office of Development to locate a funder specifically for the EHR project (hardware, software, and licensing fees). Possible funding sources include education grants in collaboration with UMSON's nursing informatics and advanced practice nursing educational programs, which would benefit both the Wellmobile service mission and UMSON's education mission. Doctoral students would benefit from access to de-identified data and outcomes for translational research.

During this time of statewide and national transition in the delivery of health care services, the Wellmobile Program will continue to seek out opportunities for continuing its tradition of innovation as both a provider of population-based, nurse-managed health care and as a clinical education site for the state's future health care providers.

APPENDIX A

GOVERNOR'S WELLMOBILE FISCAL YEAR 2013 ANNUAL REPORT

Wellmobile Staffing Comparisons by Fiscal Year and Post-Program Contraction

Fiscal Year	Nurse Practitioners	Nurse Care Coordinators	Social Workers	Outreach Workers	Drivers
FY 2009	3.2.0	2.0 (reduced to 1.5 1/1/2009)	.5	4*	3
FY 2010 (7/1-8/15)	2.8	1.5	.5	3*	3
FY 2010 (8/15-6/30)	.6	0	.5	2*	.8
FY 2011	.6	0	.5	1.8*	.75**-.1.0
FY 2012	.6 (increased to .8 4/1/12, 1.6 4/16/12)***	0	.5	1.8	1
FY 2013	1.6	1 (increased to 1.5 6/1/2013)	.5	1.8	1

This table illustrates the Wellmobile staffing model, representing numbers of positions by full time equivalents (FTEs) allocated across operations of four Wellmobiles for fiscal year (FY) 2009 and the first four weeks of FY 2010.

From August 15 to June 30, 2010, and for FY 2011 and FY 2012, these positions are allocated across operations of one core Wellmobile and a second Wellmobile fulfilling additional educational and programmatic functions.

In FY 2013, these positions are allocated across operations of two core Wellmobiles and a third Wellmobile fulfilling additional educational and programmatic functions.

Notes: *1 FTE outreach worker is also a driver.

** .75 driver represents base weekly scheduled hours, with additional hours during peak service weeks.

*** .8FTE Eastern Shore Nurse practitioner began orientation 4/16 for the Eastern Shore Wellmobile.

FISCAL YEAR 2012 WELLMOBILE BUDGET

Governor's Wellmobile Program - Financial Report
Fiscal Year 2013 (7/1/12-6/30/13)

Expenses:

Personnel	Salaries & Fringe Benefits	\$ 497,449
Operating		\$ 65,604
Total Expenditures		<u>\$ 563,053</u>

Revenues:

MHEC Funds	\$ 285,250
Other Sources	\$ 277,803
	<u>\$ 563,053</u>

**WELLMOBILE ADVISORY BOARD MEMBERS
GOVERNOR'S WELLMOBILE PROGRAM FY 2013**

MEMBER	AFFILIATION
Janet D. Allan, PhD, RN, FAAN (7-1-12-31-2012) Jane M. Kirschling, PhD, RN, FAAN (current)	Chair Dean, UMSON
Dr. Elmer T. Carreno	Physician, Prince George's County Health Dept.
Richard Gelfman	Owner, WCTR Broadcasting
Charles Brett Hofmann	MD, Princess Anne Family Practice
Joseline Pena-Melnyk	Maryland House of Delegates
Catherine Pugh	Maryland Senate
Gerard Walsh	Sr. Vice President/Chief Operating Officer, Shore Health Systems
Vacant	Business member
Vacant	Media member

PUBLIC RELATIONS

Mobile medical office visiting Kent County



DANIEL DIVILIO

Governor's Wellmobile

The Governor's Wellmobile can be found Mondays in front of the Rock Hall fire hall. On Wednesdays, it is parked at the Chester River Hospital Center in Chestertown.



Mobile medical office visiting Kent County By DANIEL DIVILIO Kent Editor

CHESTERTOWN — In an effort to get primary care for the uninsured, the University of Maryland has dispatched a roving doctor's office of sorts to Kent and Queen Anne's counties.

The university's school of nursing received a nearly \$1 million grant from Carefirst BlueCross BlueShield to bring the Governor's Wellmobile to the Upper Shore. It can be found on Mondays at the Rock Hall firehouse, Tuesdays and Thursdays at the former Sudlersville Middle School and Wednesdays in the Chester River Hospital Center's rear parking lot in Chestertown. It is open each day from 9 a.m. to 3 p.m.

"We're friendly in here," said nurse practitioner Deborah Campbell, who sees wellmobile patients.

Campbell can handle a variety of primary care needs, such as physicals or monitoring conditions like hypertension and diabetes, but she does not handle prenatal care. She said the program does have access to lab work.

She said appointments are preferred and can be scheduled by calling 866-228-9668. She said patients

also must be able to climb the short set of steps into the wellmobile — a converted RV.

"And we see people without insurance or we can see people with high deductibles. And also, we can see people with insurance but can't find a doctor to take them," Campbell said.

Susan Antol — an associate professor at the university and director of the wellmobile program — said at the end of the three-year grant, the wellmobile has to be sustainable. She does not expect to receive another \$1 million grant from the insurance company to keep it going.

She said the wellmobile also needs to work with pending health care reforms. She said the burden on the uninsured will get much bigger and this mobile office is one potential method of rapidly integrating them into the changing health care landscape.

"The myth is that they haven't been seeing doctors, but the truth is that they have," Antol said.

Chester River Hospital Center spokeswoman Julianna Vallecillo said some of the uninsured are coming to the hospital's emergency department for primary care, a situation not unique to Kent County.

Vallecillo said statistics show 15 percent of Kent County's population — about 3,000 people — have no health insurance. She said those people still need health care.

An issue in rural areas like Kent County is the lack of primary care physicians available, and Antol said the state is working on that. She said in the meantime, the wellmobile can be a primary care source.

"We think rural areas are great for wellmobiles," Antol said.

Antol said a simple goal of the wellmobile is to help people stay healthy and not let medical issues fester until they become much more serious. She said the program is about getting people primary care and preventing unnecessary hospital visits.

"The gap really is in the service — the primary care, who prescribes the medications, who manages the patient's care," she said.

For those with a primary care physician who are having difficulty getting an appointment, Antol said the wellmobile can be a bridge, getting people treatment when they need it. She said, though, she does not want to interrupt established doctor-patient relationships.

Antol said the wellmobile has two main sources of patients. She is asking for referrals from community organizations and taking patients recently discharged from the hospital and in need of follow-up visits with health care providers.

She said hospital officials here are working with the wellmobile program. She said they are asking wellmobile patients to register with the hospital for its reduced or no-cost health care programs.

"So if they need blood work or something, they're already in the computer. They already know ahead of time that they're going to get it at no cost .. or whether or not they're going to have to do a small fee, a co-pay," Antol said.

Antol and Vallecillo both said the future of health care lies in creating partnerships between hospitals and doctors and programs like the wellmobile.

"We're going to be here for the next three years. And we hope that we can get, you know, a steady flow of patients because we want to be useful to the community," Campbell said.

The Wellmobile Will See You Now

Mobile clinic brings health care to those who normally wouldn't get services

How do you get health care to those who never come to the hospital? For UM Shore Regional Health, the answer was easy: Bring health care to them.

The Governor's Wellmobile is a mobile health clinic that operates four days a week, providing primary health care to those who need it most. "It's for the working poor, the homeless, the unemployed and uninsured," explains Susan Antol, RN, Wellmobile and school-based programs director of strategic partnerships and initiatives at the University of Maryland School of Nursing. "Some folks have Medicaid, but they haven't been going to the doctor because of transportation. We bring the service to them."

The mobile clinic, which is nurse practitioner-managed, works closely with the hospital to find patients who would benefit from its services. They also refer patients who need additional or specialty care. The Wellmobile is "like a small RV," explains Antol. "It has an exam room and an office for a nurse care manager." Patients can receive physical exams and well-woman exams, or find help in managing minor, acute or chronic illnesses. Antol says the caregivers see mostly adults but are equipped to see children as well.

"Patients who normally would not be receiving services from a primary care physician are now getting care," says Antol. "It's helping them stay healthy, and keeping them from going to the ER." ♦



WELLMOBILE SCHEDULE

The Governor's Wellmobile can be found from 9 a.m. to 3 p.m. at the following locations:

- **Mondays:** Rock Hall Volunteer Fire Company, 21500 Rock Hall Ave.
- **Tuesdays and Thursdays:** The former Sudlersville Middle School, 201 N. Church St.
- **Wednesdays:** UM Shore Medical Center at Chestertown, 100 Brown St.

For more information or to schedule an appointment, call **866-228-9668**.

The Governor's Wellmobile is available in Kent and Queen Anne's Counties!

In partnership with CareFirst Blue Cross Blue Shield, Chester River Health and Shore Health, the Wellmobile is available at locations in Kent and Queen Anne's Counties:

- Mondays 9-3, Rock Hall Volunteer Fire Company, Inc. (21500 Rock Hall Road, Rock Hall)
- Wednesdays 9-3, **Chester River Hospital** (rear parking lot)
- Tuesdays and Thursdays 9-3, the former **Sudlersville Middle School** (201 North Church Street, Sudlersville)

The Governor's Wellmobile, a University of Maryland School of Nursing nurse-managed mobile health clinic, provides primary health care and care management to uninsured clients and those requiring linkages to health services. These services are funded by CareFirst. Patients can also be referred by inpatient discharge planners and emergency departments.



You are eligible for Wellmobile services if you:

- Do not have medical insurance
- Are not covered by Medicare or Medicaid
- Have insurance with limited coverage or a high deductible
- Do not qualify for other state and federal health care programs

The Wellmobile Nurse Practitioner performs:

- Initial assessments
- Physical exams and health maintenance for healthy young adults
- Well woman exams
- Management of minor, acute and chronic illnesses

The Wellmobile Nurse Case Manager:

- Works closely with the discharge planning manager at local hospitals to identify inpatients who could benefit from the Wellmobile's services
- Collaborates with health care providers in the region who are willing to accept referrals for clients requiring complex management

The Wellmobile Outreach Worker provides:

- Referrals for primary care facilities
- Assistance with applications for insurance and other governmental assistance
- Spanish interpreter services

For appointments or program information, please call toll-free 1-866-228-9668.

WELLMOBILE NOW AVAILABLE IN KENT & QUEEN ANNE'S COUNTIES

In partnership with CareFirst and Chester River Health, the University of Maryland School of Nursing Wellmobile is now available in Kent & Queen Anne's counties.

MONDAYS 9 A.M.-3 P.M.

Rock Hall Fire Department
21500 Rock Hall Avenue, Rock Hall, Md.

WEDNESDAYS 9 A.M.-3 P.M.

Chester River Hospital
100 Brown Street, Chestertown, Md.
Rear parking lot

TUESDAYS & THURSDAYS 9 A.M.-3 P.M.

Former Sudlersville Middle School
201 North Church Street, Sudlersville, Md.

The Governor's Wellmobile, a University of Maryland School of Nursing nurse-managed mobile health clinic, provides primary health care and care management to uninsured clients. Services performed by the Wellmobile's nurse practitioner include:

- Initial health assessments
- Physical exams and health maintenance for healthy young adults
- Well woman exams
- Management of minor, acute, and chronic illnesses

The Wellmobile also has an outreach worker who provides referrals for primary care facilities and assists with applications for insurance and other governmental assistance. Spanish interpreter services are available, too.



You are eligible for Wellmobile services if you:

- Do not have medical insurance
- Are not covered by Medicare or Medicaid
- Have insurance with limited coverage or a high deductible
- Do not qualify for other state and federal healthcare programs

For appointments or program information, please call toll-free 1-866-228-9668.



September 2012

Welcome to the September issue of *School of Nursing News*, an electronic newsletter designed to inform, engage, inspire, and connect with faculty members, staff, students, alumni, and other constituents of the University of Maryland School of Nursing (UMSON).

UMSON/Governor's Wellmobile to Participate in P.G. County "Convoy of Care"

An event held Sept. 12 at Buck Lodge Middle School in Landover, Md., launched a new partnership, "Convoy of Care," with Prince George's County Schools, Children's Medical Center, Mary's Center, UMSON Governor's Wellmobile program, the Deamonte Driver Dental Project, and SMILE Maryland that will provide free medical and dental care to students in 175 public schools throughout P.G. County. Leading the roster of speakers was Rushern L. Baker, III, P.G. county executive, who announced the partnership before a crowd of more than 100 students, guests, and community members. Kathryn Lothscheutz Montgomery, PhD, RN, NEA-BC, associate dean for strategic partnerships and initiatives, delivered remarks on behalf of UMSON and the Governor's Wellmobile program.





Baltimore Mayor's Weekly Newsletter
Rawlings-Blake Review

Better Schools. Safer Streets. Stronger Neighborhoods.

August 3, 2012

Dear Friends:

Yesterday, I was downtown to thank the organizers and the hundreds of volunteers taking part in the inaugural Baltimore Project Homeless Connect, a large one-day homeless outreach effort that took place at M&T Bank Stadium. The volunteers connected homeless individuals and families with medical and dental care, legal and benefit advice, and hosts of other services.



The homeless are our most vulnerable fellow residents. Life on the street—whether it lasts just one night or for more than a year—is fraught with risks. The effort to end homelessness is complicated, and City Hall cannot do it alone. To create meaningful change, we must bring together resources from private partners and advocates, and leverage the power of volunteers—like those who came together on Thursday.

Baltimore Project Homeless Connect is modeled after events that have taken place across the country since 2004. We are grateful that KMPG and Beta Alpha Psi partnered with the [Mayor's Office of Human Services](#) and the [United Way of Central Maryland](#) to build this excellent event.

One of our goals over the next ten years, embodied by [The Journey Home](#), is to make homelessness rare and brief. Increasing economic opportunity and housing options for everyone at a time of economic uncertainty is an enormous challenge, and government alone cannot get this job done. It will take partnerships like Baltimore Project Homeless Connect to leverage resources and volunteer power to lift up every resident as this city starts growing again.

As I have said many times before, the path to growing our city is a complex web of individual actions and collective sacrifice—a steely resolve to demand better, and a potent sense of urgency to act now, knowing that the yield of these labors is not-at-all immediate, but is, by far, the most important.

If you have any questions or concerns, please contact me at my [website](#) or by email at mayor@baltimorecity.gov. You can also follow the Mayor's Office and be a part of the conversation on [Facebook](#) or [Twitter](#).

Sincerely,

Stephanie Rawlings-Blake
Mayor, City of Baltimore

Prince George's bringing medical, dental services to more students

By Ovetta Wiggins, Published: September 12

As health practitioners spoke to students at G. James Ghoulson Middle School on Wednesday about the importance of health care, some could not finish their remarks without mentioning Deamonte Driver, the 12-year-old Prince George's County boy who died five years ago as a result of an infected tooth.

Deamonte's life might have been saved had he gotten a tooth extraction that costs less than \$100.

The boy's death spurred lawmakers to change Maryland's Medicaid dental program to increase reimbursement rates and allow dental hygienists in public health settings to provide more preventive care for patients in need.

Now the county is coordinating with Children's National Medical Center, Mary's Center, the University of Maryland School of Nursing Governor's Wellmobile, the Deamonte Driver Dental Project and Smile Maryland to make medical and dental services even more accessible to public school students and their parents.

"These units meet our kids where they are," said Verjeana Jacobs, chairwoman of the county school board. "We know every teacher in this school district can tell us that they have children who are sick, children who are hungry."

Mobile health units that offer the same type of services found in dentists' and primary care doctors' offices will travel to about 175 schools in the county this school year. The units — mostly offering dental services — were previously available at 108 schools, officials said.

"How fitting is it that this county that represented the worst of dental access is now representing the best of dental access," said Marcy Borofsky, co-founder of Smile Programs, which operates mobile dental units in Virginia and Baltimore as well as throughout the country.

Last year, Smile Maryland visited 90 schools. It will add 50 more schools to its stops this year. The Deamonte Driver Dental Project will double its outreach from 10 schools to 20 schools this year.

"Our goal is to ensure that no other child suffers because of a lack of services," said Debonny Hughes, the program chief of the county's dental-health service.

Joseph Wright, interim executive vice president of Children's National Medical Center, which began offering medical and dental services in the county in March, said the mobile units' mission is twofold: to provide access and to get children signed up for insurance coverage.

With 17 percent of its residents uninsured, Prince George's has the highest uninsured rate in Maryland. The state's average is 13 percent.

"When you look at the totality of health care in Prince George's County, where we are and most importantly where we are going, the mobile health units will play a vital role in closing some of the health disparity gaps that were identified in the University of Maryland School of Public Health's Impact Study by bringing primary medical and dental health care where it's needed most," County Executive Rushern L. Baker III (D) said in a statement.

A report prepared by RAND Health for the County Council in 2009 found that residents of Prince George's were more likely to be obese and diabetic than those elsewhere in Maryland as well as in the District. The county ranked lower than Baltimore and the District in the number of cases of hypertension but higher than the District in heart-disease cases.

The study also estimated that as many as 150,000 county residents lack health insurance or have insufficient coverage. It also found that county residents use emergency rooms more than residents of neighboring counties do; pediatric practices are largely in the county's most affluent areas; and some residents' access is limited because medical practices are not spread across the county.

Prince George's County News: County Executive Baker, Prince George's County Board of Education, Mobile Health Care Providers and NBC4 Announced Convoy of Care

Title County Executive Baker, Prince George's County Board of Education, Mobile Health Care Providers and NBC4 Announced Convoy of Care

SubTitle Coming to Public School Students

Publishdate 9/13/2012 8:00 AM

ContactName Christy A. Lipscomb

ContactPhone (240) 508-1989

Body

Upper Marlboro, MD – Today, standing before over 100 excited students and guests, Prince George's County Executive Rushern L. Baker, III announced a new partnership with Prince George's County Public Schools, Children's National Medical Center, Mary's Center, University of Maryland School of Nursing Governor's Wellmobile, the Deamonte Driver Dental Project, and SMILE Maryland, that will provide a convoy of free medical and dental care to students in 175 designated public schools throughout the County.

"This partnership with all the health care providers is indeed a win - win for our public school students. I also want to acknowledge NBC4 and NBC4 Prince George's County Bureau Chief Tracee Wilkins for all their support of today's event. When you look at the totality of health care in Prince George's County, where we are and most importantly where we are going, the mobile health units will play a vital role in closing some of the health disparity gaps that were identified in the University of Maryland School of Public Health's Impact Study by bringing primary medical and dental health care where it's needed most," said Baker. "We feel this convoy of care should be delivered directly to our students and without a doubt, mobile units are an effective way of implementing these services."

Baker concluded his Convoy of Care remarks with a pledge he asked all the students to join him in reciting. The students enthusiastically pledged to eat right, brush their teeth, take care of themselves, listen to their parents and do well in school.

"The launch of this program is monumental for our district," said Verjeana M. Jacobs, Esq., Chair of the Prince George's County Board of Education. "Through the mobile health units we are able to ensure that every child in our district in need of medical care has the opportunity to receive preventive care and treatment. The outpouring of support and services from our County Executive and community partners is just another example of the types of strong community partnerships that are needed to ensure the success of our students and the future of Prince George's County."

"Children's National has a rich history of providing the best pediatric care in the country. We are privileged to be able to work collaboratively with the Prince George's County Executive Office, Department of Health, and Prince George's County Public Schools in expanding our mobile health programs to the children who need the services most," said Dr. Kurt D. Newman, President and CEO at Children's National Medical Center. "This partnership highlights our commitment to the community; we go where we are needed so that children get the right care, at the right time, and in the right place."

For the 2012 - 2013 school year, the mobile units will rotate their coordinated services to select public schools located in the Transforming Neighborhoods Initiative (TNI) areas and Turn-Around and Title I schools.

"A crucial tier to the success of our efforts will be our parents/guardians, who

will be responsible for signing the consent waivers that will allow their children to receive dental and medical services," said Baker. "We are hoping that door to door services will alleviate stress for our parents who are trying their best to make ends meet, raise their families and tend to the health and well-being of their children."

"It is exciting to see how our efforts to expand access to medical and dental care in Prince George's County will have a greater impact through this partnership," stated Maria Gomez, President and CEO of Mary's Center. "Our Dental Cruiser, in particular, is on the road with the goal of promoting early detection, and providing dental education, prevention and treatment to more than 3,000 children in the first year. Our Mama and Baby Bus also will provide the best care to mothers and their children."

The Governor's Wellmobile program, administered by the University Of Maryland School Of Nursing, has a long history of supporting the health needs of Prince George's County citizens. "We are delighted to be able to work in partnership with Buck Lodge Middle School, their families, and the surrounding community by providing primary care and outreach services through this school-linked partnership," said Kathryn Lothschuetz Montgomery, PhD, RN, NEA-BC, Associate Dean, Strategic Partnerships & Initiatives, University of Maryland School of Nursing.

"We are proud to have provided professional and compassionate in-school dental care for the past 15 years," stated Dr. Solomon K. Pesis, Dental Director of Smile Maryland. "And we applaud the efforts of Rushern L. Baker, III who recognizes that it's not enough just to hope that kids get the care they need, but rather that medical and dental care should be brought to the children. We look forward to continuing our work in the state for many years to come, and doing our part to ensure that quality and compassionate healthcare is delivered to the children in Prince George's County."

"The Health Department is excited to spearhead and administer this important initiative that the County Executive envisioned. The new partnerships with the mobile units will allow our department to further maximize and enhance our outreach efforts. Most importantly, we will be delivering options and greatly needed primary care to our public school students," said Pamela Creekmur, Prince George's County Health Officer.

To Learn More About the "Convoy of Care" Providers (click links below):

-Children's National Medical Center

<http://www.childrensnational.org/departmentsandprograms/default.aspx?Id=6010&Type=Dept&Name=Mobile%20Health>

-Mary's Center

<http://www.maryscenter.org/event/mama-and-baby-bus-health-promotion>

-The Governor's Wellmobile

<http://nursing.umaryland.edu/collaborative-outreach/community-and-service>

-Deamonte Driver Dental Project/Colgate

<http://www.princegeorgescountymd.gov/government/agencyindex/health/index.asp>

-SMILE Maryland

http://www.mobiledentists.com/dental_homes.html