UNIVERSITY of MARYLAND
SCHOOL OF NURSING

wellMobile The Governor's Wellmobile Program

FISCAL YEAR 2014
ANNUAL REPORT

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EXECUTIVE SUMMARY

For the past 20 years, the Governor's Wellmobile Program has been a community partnership model of mobile nurse-managed primary health care. In 2000, state statue (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 2014 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; 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 patients and those with insurance coverage to available patient-centered medical homes.

A major goal of fiscal year 2014 was further development of the Upper Eastern Shore project, and in collaboration with a funder and institutional partners, implementing the 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 the 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 with an associated technology infrastructure for sustainability and billing by the end of the project in 2015. Another goal was to conduct a formative and summative evaluation of the "Bridge to Care Model," in the context of health coverage expansion. The Wellmobile Program Director pursued partnerships and submitted funding proposals with health systems to collaboratively pilot innovative approaches for seeing patients shortly after hospital or emergency department discharge and linking them with a community-based primary care practice in communities from where they draw patients. 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 2014, 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 two on the Eastern Shore. Service accomplishments include: 1,318 nurse practitioner, 233 nurse care manager, 1,240 social work, and 414 outreach worker visits; 389 referrals to health care providers and facilities, assistance with 737 health care coverage applications, and 363 referrals for other health related services across all activities.

Combined public/private funds of $632,117 supported Wellmobile Program operations in fiscal year 2014.

GOVERNOR'S WELLMOBILE PROGRAM ANNUAL REPORT

UNIVERSITY OF MARYLAND SCHOOL OF NURSING

FISCAL YEAR 2014

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, 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 and Adult-Gerontology Nurse Practitioner (A/GNP) graduate students, and entry-level community health students. Additional personnel may be added to meet the cultural, health, and social services needs of the patient 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 member, 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 fiscal year 2014, Maryland's 14 FQHC's received more than $37 million to fund operations. Despite the expansion of services, the demand for care has not been met.

During fall 2013, Maryland residents began to enroll in both Medicaid and qualified health plans through the Maryland Health Benefit Exchange and its website, Maryland Health Connection.gov, and received enrollment assistance from grant funded navigators and assistors. Enrollment in Medicaid programs is continuous, while qualified health plan enrollment officially ended in December 2013. This created a new cohort of newly insured, including new Medicaid beneficiaries and previous Medicaid Primary Adult Care (PAC) recipients who became eligible for full Medicaid, effective January 1, 2014. Wellmobile services continue to be in high demand, and care managers report long wait times when patients are referred to FQHCs for follow up and/or enrollment in a patient-centered medical home. This is most likely attributed to increased demand for primary care providers in these clinics and other private practices due to an increase in the newly insured. 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 patient-centered medical homes. FQHCs represent the first choice for uninsured patients in this category.

Without the Wellmobile, many of the patients who were served would have experienced significantly 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 state's most vulnerable residents for 20 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 patients 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 anticipated November 15, 2014 re-opening of the Maryland Health Benefits Exchange, designed as a one-stop shop to facilitate a single entry point for coverage through Medicaid expansion and private health plan enrollment, will further strain the health plan networks 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 patient 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 2014 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 Wellmobiles operated in nine counties four days a week, and one operated one day a week. 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 Wellmobile 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 Program 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 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. The final renegotiated agreement was approved in fiscal year

2011. 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.

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 the elimination of seven positions. Refer to the Wellmobile Staffing Comparisons by Fiscal Year 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 2014 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 and the Kent County Health Department, targeting smoking cessation, continued to support reactivation of one Wellmobile four days a week beginning July 2012 on the Upper Eastern Shore.

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 UM Shore Health System at Chestertown, which became one of three hospitals in the UM Shore Health System, effective July 1, 2013. 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 continue to fund ongoing project implementation that began July 5, 2012.

Using Maryland DHMH funding that targets smoking cessation in households of women of childbearing age, the Kent County Health Department funded training and smoking cessation supplies and associated patient education in conjunction with Wellmobile primary care visits at two county sites.

In fiscal year 2014, 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 $346,867, to complement the state budget appropriation so it could provide services in fiscal year 2014.

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 members to maintain clinical competency. Clinically competent faculty members 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 who will comprise the future Maryland workforce. UMSON's Office of Strategic Partnerships and Initiatives, the organizational home of the Wellmobile Program, supported the 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 patients to a patient-centered medical home. The 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. Patients 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 patient, prescribing generic prescriptions and over-the-counter medications as indicated, and instructs the patient 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 patients 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), 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. If funding permits, 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 and A/GNP 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 patient 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.

3. Health promotion – Educating patients about healthy living practices, disease prevention, developmentally specific immunization and screening thresholds, and personal/family emergency preparedness is the cornerstone of nurse-managed health care. Entry-level and graduate community health nursing students and advanced practice FNP and A/GNP 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 patients 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 bilingual social work students under the guidance of a master's-prepared faculty field instructor. Likewise, UMSON community health nursing faculty members oversee entry-level and masters community health nursing students. Under faculty guidance, the students provide a range of interventions that assist those 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 2014 PERFORMANCE, IMPACT, AND PARTNERSHIPS

The Wellmobile Program's impact in fiscal year 2014 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, and as funding permitted, targeted services in response to individual counties and partners.

OVERALL RECIPIENT IMPACT AND COST EFFECTIVENESS

In fiscal year 2014, the program provided patient encounters under the following categories: NP primary care, nurse care management, social work, and outreach work. Primary care visits include those conducted on the Wellmobile vehicles during four 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 to emergency assistance, food stamps, and referrals to the state's Breast and Cervical Cancer Treatment Program.

The social worker, nurse care managers, and outreach workers meet with patients after the nurse practitioner primary care visit to provide additional case management, care coordination, and health care system navigation. These actions generated 389 referrals to primary care providers, specialists, and local health departments for breast and cervical cancer screening and other public health services, and to health systems and other providers for diagnostics. Outreach targeting eligibility determination and enrolling uninsured patients in entitlement programs resulted in 737 Medicaid (CHIP and PAC) and other health coverage applications and follow-ups and referrals to Maryland Health Benefit Exchange navigators. 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 in 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. Patients 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 had 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 University of Maryland School of Social Work (UMSSW) faculty member, advised patients on eligibility for public benefits and services. In addition to social work interventions conducted on the Wellmobile, the social work team 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, including legal; 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. Case management and outreach efforts generated an additional

825 referrals for food, housing, and smoking cessation programs. The following table summarizes the above-described activities.

Fiscal Year 2014 Census and Clinical Encounters, and Referrals

Unduplicated Medical Patients	Primary Care	Nurse Care Management	Social Work	Outreach Work
1,189	1,318 Adults 20 Children	233	1,240	414

Fiscal Year 2014 Assistance and Referrals

Public and Private Insurance Applications and Assistance	Health Care Provider and Diagnostic Referrals	Referrals for Other Health Related Services	Other Non-health Related Assistance and Referrals
737 Applications 192 Information/follow-ups	389	296 Food Stamps 67 Other	97 Financial Assistance 365 Other

According to the 2011 Agency for Healthcare Quality and Research (AHRQ) Medical Expenditure Panel Survey, the average cost of an emergency department visit in the U.S. for an uninsured person under 65 was $1,257, with a median expenditure of $610 (http://meps.ahrq.gov), of which the uninsured person paid 27 percent out of pocket (Agency for Healthcare Research and Quality, 2011). Fiscal year 2014 data from an ongoing satisfaction survey of Wellmobile patients, on their intent to use the emergency department in the event the Wellmobile vans were not available revealed that 14 percent of respondents would have sought help at the local emergency department if they did not have Wellmobile services that day. This represents a slight decrease from 15 percent in fiscal year 2013. Another three percent would have accessed an urgent care center. In fiscal year 2014, it is estimated that the program avoided approximately $114,265 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 $225. This amount reflects the allocation of all fixed costs across only professional (nurse practitioner, nurse care manager, and social work) 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 2014 Wellmobile cost per visit to $196. Of note is that in the non-English speaking population, bilingual outreach workers provide interpretation during the entire primary care visit, including intake, care by the nurse practitioner, and post-visit health teaching and care management. The higher cost per visit is attributable to salary increases as a result of state cost of living increases and merit adjustments, which had not been given to faculty and staff in previous years. In upcoming fiscal years, we anticipate continued salary and fringe benefits increases due

to the ongoing demand for health care providers as the health care industry continues the implementation of the Patient Protection and Affordable Care Act (PPACA). The percentage of fringe benefits relative to base salary has also increased. Fiscal year 2014 Wellmobile operating expenditures were allocated across a slightly larger visit volume than in fiscal years 2010 through 2013. 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 2014 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 2014. The Central Maryland Wellmobile provided services three 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 services one day a week at the Seventh Day Adventist Church in Takoma Park.

In June 2013, the Central Maryland project added a part-time nurse care manager, who assumed care management and health education responsibilities, enabling the nurse practitioner to conduct more visits. Acknowledging the need to more thoroughly address care management needs, the care manager position was increased to full-time in January 2014. The nurse care manager facilitates care coordination, links patients to specialty care, precepts nursing students, and oversees clinic flow, including medical records, scheduling, and outreach efforts. Central Maryland clients included concentrated pockets of Latino and African populations, who are predominantly uninsured. 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 in 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 patients 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 patients. The social worker assisted patients 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 CHIP 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 six 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 patients 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 (and PAC, through the end of December) 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 PPACA. The Wellmobile Program served as the "front door" for many uninsured and underserved residents in the communities it served. Newly-insured patients and uninsured patients whose conditions were refractory to treatment and required complex management and specialty providers were prioritized for referral to a patient-centered medical home. Patients were stabilized and referred to a permanent medical home, utilizing available FQHCs, other clinics, and private providers.

Referring stabilized patients 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 Capitol Heights exceeded three months, resulting in a backlog of patients who remained under the care of the Wellmobile FNP until they could be accepted into care. The Wellmobile Program referred patients to Community Clinic, Inc.'s Franklin Park clinic in Greenbelt (Prince George's County) and the Takoma Park (Montgomery County) clinic. Both sites are open five days a week; the Takoma Park site is also open on Saturday. The Wellmobile Program referred clients to both Mary's Center's Silver Spring (Montgomery County) site and the Langley Park (Prince George's County) site. A waiting list for new clients persisted in FY 2014. In spring 2013, the clinic sought to refer adult clients to the Wellmobile, due to the loss of an adult health provider. The Wellmobile continued providing primary care to these patients in fiscal year 2014, until that clinic was able to resume full operations.

The Wellmobile serves as the interim care provider, managing these newly insured patients until they are transferred to a patient-centered medical home. Stable patients 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 February 2014, the Wellmobile Program submitted a HRSA Bureau of Nursing grant application to fund interprofessional collaborative 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 2014 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, Queen Anne's, and Talbot. 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 University of Maryland (UM) System at Chestertown Medical Center at Chestertown's inpatient and emergency departments; and 3) subcontracting with Shore Health and Chester River Health Systems Physician Practices. In each community, a central location for parking 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. UM Shore Health System hospitals are participating in the Maryland Health Care Commission's 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 UM Shore Health System, specifically, UM Shore Medical Center at Chestertown and its leadership at UM Shore Medical Center at Easton, and the local health and human services organizations, to identify and divert uninsured patients and those without primary care providers to the Wellmobile. This decreased their reliance on

unnecessary readmissions and emergency room use. A business associate agreement with UM Shore Medical Center at Chestertown facilitated exchange of medical information between the hospital and the Wellmobile providers for continuity of care of discharged patients. Uninsured patients who demonstrate proof of insurance application and who seek pro bono or sliding fee scale laboratory, diagnostic, and other services from Shore Health System affiliates are referred to the hospital's financial assistance office to complete applications. 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. Financial services personnel from UM Shore Medical Center at Chestertown met with uninsured patients and connected them with the SEEDCO navigators and assistors.

In June 2013, Chester River Hospital Center formed the A QUICK (Advocacy, Quality, and 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 goals of A QUICK huddle are to identify, facilitate, and guide patients to the appropriate ambulatory care venues to receive the care 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 were for the health system to query its database for uninsured patients and those without a PCP who frequent the ED, and mail information about the Wellmobile to them, in addition to referring them to a post-ED or hospital inpatient visit. Both mechanisms resulted in increased referrals in this 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 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 who accepted PAC patients until they became full Medicaid January 1, 2014, because the majority were complex enough to require specialty consultation. In addition, the program did 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. Many of members on the Wellmobile patient panel who were uninsured at the beginning of the fiscal year became eligible for Medicaid coverage or were able to purchase health insurance through the exchange beginning October 1, 2013, resulting in a cohort of newly insured.

Chester River Health System and Shore Health System merged July 1, 2013, creating the following new entities under Shore regional Health System: 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, have necessitated new relationship-building. Unification of Easton, Dorchester, and Chestertown hospital medical staff and community based primary care providers and Shore Medical Group practices were initiated in fiscal year 2014, but remain incomplete. Since the Wellmobile is the primary care provider for newly insured covered patients, there was 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 UM Shore Medical Center at Chestertown have been identified as potential primary care partners. Several meetings occurred in this FY, however, reorganization of management and a new structure at Shore Health System has delayed progress.

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

The success of Anne Arundel County's Homeless Resource Day over the past seven years prompted Governor O'Malley to 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 four such events between November and March.

- Prince George's County Homeless Resource Day and Veteran's Stand Down, Landover – November 2, 2013
- Montgomery County Homeless Resource Day, Gaithersburg – November 6, 2013
- Dorchester County Homeless Resource Day, Cambridge – December 9, 2013
- Anne Arundel County Homeless Resource Day, Glen Burnie – March 29, 2014 (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 (speak English and Spanish), 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.

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 become an integral part of the health care delivery system in 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 2014:

- Associated Catholic Charities, Archdiocese of Washington, D.C.
- Brentwood Senior Center/Dimensions Health Systems, Prince George's County
- Community Clinic, Inc., Greenbelt, Prince George's County
- Community Radiology Associates
- Family Crisis Center of Prince George's County
- Greater Baden Medical Services, Capitol Heights, Prince George's County
- Holy Cross Hospital, Silver Spring, Montgomery County
- Langley Park Walk-In Medical Clinic, Prince George's County
- Mary's Center, Silver Spring, Montgomery County and Adelphi, Prince George's County
- MobileMed (Mobile Medical Care, Inc.), Montgomery County
- Montgomery Cares, Montgomery County
- Montgomery County Department of Health and Human Services
- Planned Parenthood Federation of America, Montgomery County
- Pregnancy Aid Center, College Park, Prince George's County
- Prince George's County Department of Social Services
- Prince George's County Health Department
- Quest Diagnostics
- Riverdale Radiology

- University Imaging
- Washington Adventist Hospital, Takoma Park, Montgomery County

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

- Bladensburg Elementary School, Bladensburg, Prince George's County
- Buck Lodge Middle School, Adelphi, Prince George's County
- Catholic Community of Langley Park, , Langley Park, Prince George's County and St. Camillus Parish, Silver Spring, Montgomery County
- Deerfield Run Elementary School, Laurel, Prince George's County
- Franklin Park at Greenbelt Metro Apartments, Greenbelt, Prince George's County
- Langley Park Shopping Center, Langley Park, Prince George's County
- Seventh Day Adventist Church, Takoma Park, Montgomery 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 2014:

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

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

- Rock Hall Volunteer Fire Company
- Queen Anne's County Public Schools
- UM Shore Medical Center at Chestertown

EDUCATION AND SERVICE ACCOMPLISHMENTS

COMMUNITY EDUCATION AND OUTREACH

Health education and outreach services are essential components in communities served by the Wellmobile Program. 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 patients, rather than initiating services in a new population for whom the Wellmobile does not have established follow-up service linkages.

In fiscal year 2014, 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 2014, 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 2014, a Clinical Nurse Leader (CNL) master's student and a Community Public Health Program Planning and Evaluation master's student fulfilled community health nursing clinical practicum requirements on the Wellmobile. These students assisted the nurse practitioner by conducting patient assessments, 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, including conducting health promotion sessions with individuals and groups of patients.

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 health status in rural communities. 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 five FNP students and 23 A/GNP 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 patients to services; organizing community resources; and revising the local community services directory of primary care, county breast and cervical cancer programs, and radiology providers.

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 projected primary care partnerships, administrative effort continued in fiscal year 2014 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 reports and future grant submissions.

Process and impact outcomes from two current projects, the Upper Eastern Shore Primary Care and Services Linkages project initiated in fiscal year 2012 and the Kent County PATCH smoking cessation project, will address the following research questions:

- Can evidence-based health promotion programs be adapted to provide culturally and linguistically appropriate information for minority populations?
- 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 2014:

- Nahm, E.S; Resnick, B.; Rietschel, M.; & Antol, S.M. Dissemination of Health Information to the Older Adults Residing in Community: Use of Technologies (Symposium: Innovative Approaches to Dissemination and Implementation of Evidenced Based Interventions). November 22, 2013. Gerontological Society of America Annual Meeting, November 20-23, 2013, New Orleans, LA.
- Antol, S. Creating a Sustainable Nurse Managed Mobile Primary Care Clinic as an Extension of a Rural Health Delivery System. UMB/UMCP SPH Research Day, April 8, 2014. Poster presentation.
- Antol, S. Self-Management Tips For Patient Centered Medical Homes. Webinar presented to the Maryland Patient Centered Medical Homes Learning Collaborative, April 22, 2014.
- Antol, S. & Collins, C.S. Creating A Sustainable Nurse Managed Mobile Primary Care Clinic As an Extension of a Rural Health Delivery System. Workshop. Nurse Managed Health Centers: Turning the Affordable Care Act into Action, National Nursing Centers Consortium, 11th Annual Conference, Alexandria, VA, June 9, 2014.

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 was a member of the Maryland Health Care Commission Maryland Rural Health Delivery Task Force June 2013-December 2013. 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 2014, 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 2014 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 2014, 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. Patients willing to travel to Silver Spring remained eligible for services on a case-available basis. The program director is exploring an opportunity to enroll as a partner with the newly reconfigured Archdiocesan Health Care Network (Washington, D.C.), for second-level referrals for the Central Maryland project.

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. An 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 of Maryland to construct a new health system, contingent on the funding of this enterprise. Washington Adventist Hospital plans to expand to White Oak, Montgomery County, and develop a Village of Education, Health, and Well-being, 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 patients 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 patient with a pre-paid lab slip. Clients went to the nearest Quest Diagnostics laboratory for the specimen collection and analysis. Quest invoiced the Wellmobile Program, which paid the bill from patient collections. In fiscal year 2014, as in the previous fiscal year, the Wellmobile Program passed on a two-percent increase in Quest Diagnostics laboratory fees to its patients.

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. Patients 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 have low 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 patient profile, the Wellmobile Program included a budget line for a nurse care manager in its January 2013 and February 2014 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 a preceptor for entry-level community health and master's nursing students, 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 patients, the emergency room provides an avenue to specialty care, an option to which patients may resort when other means fail.

Failure to procure an electronic health record (EHR) in fiscal year 2014 continues to impede operations at both 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 patient 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 patients 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 this need by implementing workarounds such as home-grown databases, hard copy scheduling, and conventional paper documentation practices.

Compounded by budgetary constraints resulting from five 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 sixth 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 2014 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 2014 to sustain program operations while other vehicles were undergoing repairs and inspections and to maintain functionality. 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 patients 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 five 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 2014. Additionally, subsequent to the implementation of health exchanges in October 2013, Medicaid expansion and the availability of qualified health plans and subsidies, which boosted enrollment and insurance coverage, the demand for primary care continued 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 2014. A generous grant from CareFirst has allowed the program 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 of accrediting agencies and network adequacy requirements of insurers. 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 include increasing access, eligibility determination, and care management. **Increasing access** involves the establishment of 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 patients 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) and Medicare. Outreach staff members assist patients in completing applications, facilitating Managed Care Organization enrollment, and selecting primary care providers. Social work and outreach staff also disseminate information on how to access the navigators and assistors for enrollment through the Maryland Health Benefit

Exchange. Once the patient'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 patients in need of additional consultations and treatment, demand that these complex clients be transitioned to a permanent medical home. Medical homes used include FQHCs, outpatient clinics, and private physicians that accept the patient'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 patients who have undergone the eligibility determination process for entitlement programs are awaiting confirmation, the Wellmobile FNP continues to follow both potentially eligible and ineligible patients until they can be safely transitioned to the appropriate clinical practice. During this **care management** phase, the Wellmobile Program continues managing these patients and providing individualized physical and social assessments, blood work, treatment, and health education to stabilize their health problems. Patients 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 patients 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 patients to medical 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 patients awaiting referral remained primary patients of the Wellmobile for varying amounts of time. Factors influencing the duration that a patient 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 qualified health plan patients; and availability of an appointment slot in a patient-centered medical home.

The Wellmobile Program demonstrates value not only by addressing patients' immediate health problems and providing the bridge to primary care, but also by conducting preliminary work-ups, prescriptions, and treatments for patients 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 patient, including diagnosing and treating immediate conditions, and the accompanying clinical documentation facilitates patient transfer and creates a climate of more willing acceptance by the receiving provider of these patients.

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 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 2014. Although it was 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 is expanding implementation of the "Bridge to Care" model to the Upper Eastern Shore and piloting 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 priorities identified for fiscal year 2014. The February 2014 HRSA Interprofessional Collaborative Practice grant proposal submission was designed to replicate the

CareFirst proposal sustainability model. The proposal would have piloted a sub-contractual arrangement between the University of Maryland School of Medicine Department of 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 2014 AND FISCAL YEAR 2015 FUNDING STATUS AND INITIATIVES

The UMB Foundation, Inc., received donations to the Wellmobile from communities and individuals in fiscal year 2014, which have supplemented Wellmobile operations in accordance with donor specifications.

During fiscal year 2014, the Wellmobile Program submitted the following proposals to external funders:

- Maryland Community Health Resource Commission, University of Maryland School of Nursing Safety Net Clinic Electronic Health Record and Billing Infrastructure Development, December 3, 2013 (not funded)
- HRSA, Division of Nursing, Nurse Education Practice Quality and Retention (NEPQR) Bridging Interprofessional Collaborative Practice and Education with Integrated Care through a Medical Neighborhood, February 8, 2014 (not funded)

Fiscal year 2015 funding prospects include HRSA requests for proposals pending fiscal year 2015 federal appropriations.

FISCAL YEAR 2015 PRIORITIES

The challenge to raise external funds to support care of the uninsured will continue in fiscal year 2015. 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 is a state asset that could also be a subcontractor to Health Enterprise Zone entities seeking opportunities to access difficult to reach populations.

The Wellmobile Program has proposed to the school-health specialist 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, the 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 development and implementation of an EHR remains a priority for fiscal year 2015. 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 opportunities for continuing its tradition of innovation as 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: WELLMOBILE STAFFING

WELLMOBILE STAFFING COMPARISONS BY FISCAL YEAR

Fiscal Year	Nurse Practitioners	Nurse Care Managers	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
FY 2014	1.6	1.5 (increased to 2 1/16/2014)	.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 were allocated across operations of one core Wellmobile and a second Wellmobile fulfilling additional educational and programmatic functions.

In FY 2013 and FY 2014, these positions were 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 4/16/2012 for the Eastern Shore Wellmobile.

APPENDIX B: FISCAL YEAR 2014 WELLMOBILE BUDGET

Governor's Wellmobile Program - Financial Report
Fiscal Year 2014 (7/1/13-6/30/14)

Expenses:			
	Personnel		
		Salaries	$ 503,002
		Fringe Benefits	$ 80,877
		Total Personnel	$ 583,879
	Operating		$ 48,238
	Total Expenditures		$ 632,117
Revenues:			
		MHEC Funds	$ 285,250
		Other Sources	$ 346,867
			$ 632,117

APPENDIX C: WELLMOBILE ADVISORY BOARD MEMBERS

WELLMOBILE ADVISORY BOARD MEMBERS
GOVERNOR'S WELLMOBILE PROGRAM FY 2014

MEMBER	AFFILIATION
Jane M. Kirschling	Chair, Dean, UMSON
Elizabeth Arcia-Hird	Family Health Centers of Baltimore
Dr. Elmer T. Carreno	Physician, Prince George's County Health Dept.
Richard Gelfman	Owner, WCTR Broadcasting
Christopher King, PhD	MedStar Health System
Joselina 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

APPENDIX D: PUBLIC RELATIONS

Full page article with photo, “The Wellmobile Will See You Now,” UM Shore Regional Health’s *Maryland on a Mission* magazine, Fall 2013, p. 15.

Full page article with photo, “On the Road to Financial Sustainability,” University of Maryland School of Nursing’s *NURSING* magazine, Fall/Winter 2013, p. 18.

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**.

On the Road to Financial Sustainability

SINCE ITS INCEPTION IN 1994, the Governor's Wellmobile Program has focused on two priorities: offering the underserved and uninsured access to health care while educating students from the University of Maryland Schools of Nursing and Social Work.

Four years ago, however, state budget cuts caused all but one of the School of Nursing's four Wellmobile services to shut down.

Susan Antol, MS '79, RN, director of Wellmobile and School-Based Programs, knew she was going to have to change the business plan if she wanted more of the traveling health clinics back on the street. So Antol began thinking about alliances that could rebuild the Wellmobile program and improve the well-being of Marylanders.

"We went in with the agenda of making this service sustainable and moving toward a partnership that was more than just 'Hi, we'll let you park on our parking lot,' which is what it was about before," says Antol, an assistant professor at the School of Nursing.

Susan Antol knew she was going to have to change the business plan if she wanted more of the traveling health clinics back on the street.

Consequently, she came up with an innovative plan: Use a Wellmobile to help University of Maryland Shore Regional Health System hospitals run more efficiently by taking direct referrals from their physicians and discharge staff for primary care patients transitioning out of hospital care on the Upper and Middle Eastern Shore.

The idea is to direct repeat emergency room and inpatient hospital users without insurance or regular primary care providers to the Wellmobile, thereby helping to lower the number of hospitals' repeat visitors. Those patients benefit from the Wellmobile's convenient scheduling and proximity while hospitals save money on avoidable readmissions.

The initiative is funded by CareFirst BlueCross BlueShield for three years, and services began in July 2012. In partnership with the University of Maryland Shore Medical Center at Chestertown and the University of Maryland Shore Medical Center at Easton, a single Wellmobile is providing primary care services to the medically underserved counties of Kent and Queen Anne's. Antol expects Talbot County to be added.

In the Eastern Shore project's first fiscal year, 279 patients visited the Wellmobile. Most were uninsured; however, 66 patients who were covered by Primary Adult Care, Medicaid, Medicare, or other health insurance plans had their care transferred to primary care providers.

Eventually, Antol hopes to negotiate partnerships with Shore primary care groups and have the Wellmobile act as their "remote arm" in areas where people struggle to access health care. The Wellmobile would see new patients and could refer insured ones to the partnering groups.

"One thing we've discovered is that even the patients who were insured through [the state's] Primary Adult Care couldn't find primary care providers who were taking new patients," says Wellmobile nurse care manager Carole Staley Collins, PhD, PHCNS-BC.

The timing of this Shore Wellmobile Program couldn't be better: A surge of Americans who are newly insured under the Patient Protection and Affordable Care Act (PPACA) are expected to need primary health care yet will struggle to find it.

Susan Antol poses beside the Eastern Shore Wellmobile.

An additional strategy of the program is educating uninsured clients on how to get coverage through the new Maryland Health Connection. If the Wellmobile can hold on to some of those newly insured patients under this new model, Antol says it could begin a path to financial sustainability in 2014.

"My gut feeling is that a lot of patients are going to qualify for the expansion," says Antol. —**Sarah Richards**