

# GOVERNOR'S WELLMOBILE PROGRAM ANNUAL REPORT

Fiscal Year 2016



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## EXECUTIVE SUMMARY

For the past 22 years, the Governor's Wellmobile Program has been a community partnership model of mobile nurse-managed primary health care. In 2000, state statute (Health General §13-1301 et seq.) codified 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 for expanding student learning opportunities in caring for underserved populations.

During Fiscal Year 2016, the Wellmobile Program focused on three categories of initiatives: transforming primary care and clinical services at multiple sites in Prince George's and Montgomery counties to incorporate a Health Services Resources Administration (HRSA)-funded interprofessional collaborative practice (IPCP); transitioning CareFirst BlueCross BlueShield of Maryland (CareFirst)-funded primary care on Maryland's Upper Shore to a sustainable partnership model; and participating in Anne Arundel County's Homeless Resource Day. 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 health care homes. This approach involved prioritizing transfers of acute and complex patients and transferring patients with insurance coverage to available patient-centered medical homes (PCMH) and establishing an HRSA-funded "medical neighborhood" to retain patients who meet the eligibility criteria.

A major goal for FY16 was to assure the sustainability of the Upper Shore project and, in collaboration with a funder and institutional partners, to implement the "Bridge to Care" model to rebuild the former statewide program. These initiatives demonstrate the potential to create a statewide model responsive to health care reform initiatives in the most underserved areas. The driving principles of the model were redesigning a delivery system compatible with health care reform, testing a funding model, and strengthening care management. There were two major objectives.

The first was to build a collaboration with health delivery systems and community linkages for seamless care with patient-centered health homes, and secure an arrangement with a medical center to use technology infrastructure for sustainability and billing by the end of the project in 2015. Building on the outcomes attributed to CareFirst's funding, the Wellmobile Program pursued partnerships and submitted a funding proposal to a major health system to collaboratively develop and pilot innovative care transition approaches by having timely primary care appointments for newly discharged hospital or emergency department patients and then linking them with a community-based primary care practice in their communities. After months of planning, the hospital was unable to provide start-up financial support for the Wellmobile operation to build the billing and fee model while growing the program. The inability to secure a financial partner resulted in contraction of the Upper Shore Wellmobile program with reassignments and layoffs of the staff to the Prince George's County program. Dialogue continues with potential new partners in Prince George's County for FY17.

The second objective was to conduct a formative and summative evaluation of the "Bridge to Care" model in the context of health coverage expansion. The reverse referral process resulted in

128 cases of diverted emergency department visits. During FY16, more than 10 percent of the Upper Shore patient panel was insured by Medicare, Medicaid, commercial insurance, or qualified health plans. In FY16, the Wellmobile service model included nurse practitioner primary care, nurse care management, and outreach work, with added availability of a physician, pharmacist, and social worker in Central Maryland, which was funded by the HRSA grant to train health care professional students in the dynamics of an interprofessional practice model.

Service accomplishments include: 2,382 nurse practitioner, 323 nurse care manager, 1,006 social work, and 2,123 outreach worker visits; 526 specialty referrals to health care providers and facilities; assistance with 232 health care coverage applications; and 274 referrals for other health-related services across all activities. Combined federal, public, and private funds of \$980,594 supported Wellmobile Program operations in FY16. The Wellmobile Program's "Bridge to Care" model demonstrated the capacity to enhance the quality and reduce the cost of care for existing health delivery systems, including hospitals under the newly enacted waiver and primary care and prevention initiatives. These efforts are aimed at reducing health costs and health disparities while improving primary care access.

The Wellmobile Program requires sufficient state funding to leverage a meaningful partnership with a health care system, making it possible to have a partnership with the Wellmobile Program as an integrated component of the system's care model and financial capacity to build a sustainable model. To date, 29 percent of funding from the state has not been sufficient to solidify a financial partner. But we are committed to working toward building this model and finding a partner to impact health disparities and reduce the cost of care and to add needed services that contribute to improving population health.

# **GOVERNOR'S WELLMOBILE PROGRAM ANNUAL REPORT**

## **UNIVERSITY OF MARYLAND SCHOOL OF NURSING**

### **FISCAL YEAR 2016**

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 Delegate Marilyn Goldwater, a registered nurse, who was 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 is designed around a mobile health unit that travels throughout the state to provide health care services and education to underserved and uninsured populations. The University of Maryland School of Nursing (UMSON) is the institutional home of the program and leads 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 Maryland House and Senate who are appointed by the speaker and president of these chambers, respectively. The board's purpose is to assist UMSON in overseeing the program, cultivating community and business partnerships, and raising necessary funds to complement state appropriations.

UMSON began managing the Wellmobile Program in 1994 and raised the corporate and philanthropic donations to purchase the original mobile unit that same year, outfitting it as a medical clinic. Between 1994 and 1998, a single Wellmobile unit provided maternal and child health services and immunizations in Baltimore city and in 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, extending services to the Eastern Shore. This unit was dedicated to expanding access to maternal and child health services and to accelerating 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 went into operation in summer 1999 to serve counties on the middle and lower Eastern Shore in collaboration with migrant Head Start 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. (CCHS), a Federally Qualified Health Center (FQHC), this second Wellmobile served as a transitional school-based health center for two county schools until the FQHC's funding built 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 access among the adult population. Consequently, the program, then comprising 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 funding from federal and state public and 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.

An FY01 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 Connect Maryland, Inc., a 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 FY02, 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 funder 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 of 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, who became community partners. Between FY02 and 09, 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, 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 includes a driver/outreach worker, a family nurse practitioner (FNP) on UMSON's faculty, a nurse care manager, a social worker, FNP and Adult-Gerontology Nurse Practitioner (A/GNP) graduate students, and entry-level community health and social work 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. A HRSA

Cooperative Agreement, targeting student and faculty/staff education and interprofessional collaborative practice, funded the addition of a part-time University of Maryland School of Medicine (UMSOM) family medicine physician, a University of Maryland School of Pharmacy (SOP) clinical pharmacist, and a nurse care manager. 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 (UMSSW) faculty member, also gain clinical experience on the Wellmobile, contributing to a mitigation of health care workforce 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 the 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 FY16, Maryland's 17 FQHCs received more than \$4 million (\$4,451,803) to expand facilities and quality improvement initiatives to serve a projected 12,876 new patients. FQHCs were also awarded an additional \$1,092,985 for health information technology enhancements. These centers are able to bill those insured under Medicaid and Medicare at the cost-based rate. Comparatively, the Wellmobile provided care for 1,595 patients at a cost of \$791,144. Despite the expansion of FQHC services, the demand for primary care in the region has not been met.

Between Nov. 1, 2015, and Jan. 31, 2016, Maryland residents enrolled in both Medicaid and qualified health plans through the Maryland Health Connection and its website, Maryland Health Connection.gov, receiving enrollment assistance from grant-funded navigators and assistors. This created a third new cohort of newly insured beneficiaries, subsequent to those newly eligible effective Jan. 1, 2016. Wellmobile services continue to be in high demand, and care managers report long wait times when newly enrolled patients attempt to schedule an initial appointment with assigned primary care practices and FQHCs within the health plan network, which is their designated PCMH. Returning patients likewise report longer wait times when they attempt to schedule an appointment for a new health problem or following emergency department (ED) or hospital discharge. This is most likely attributed to increased demand by the newly insured for primary care providers (PCPs) in clinics and private practices. When patients who entered through the Wellmobile "front door" become eligible for Medicaid, Medicare, or private insurance, the "Bridge to Care" model is accomplished with their transfer to an in-network care provider or their designated PCP. Patients too complex for management by Wellmobile FNPs are prioritized for referral to PCMHs. FQHCs represent the first choice for uninsured patients in this category. A HRSA-funded on-site family medicine physician and



clinical pharmacist consultant has enabled the Wellmobile to continue to manage more complex uninsured patients, in concert with specialty referrals when indicated.

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 EDs as their only source of care. Wellmobile services played a key role in reducing inappropriate ED utilization, a costly practice that undermines continuity in preventive and primary care. This has become increasingly important since the Maryland All-Payer System Model Agreement model, effective Jan. 1, 2015, prospectively establishes a fixed annual revenue cap for each hospital. This methodology encourages hospitals to focus on population-based health management. On the Upper Shore, the Wellmobile Program has fostered relationships with hospital EDs 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 transdisciplinary interventions aimed at breaking the cycle of inappropriate ED use. The Wellmobile Program has successfully filled this role for the state’s most vulnerable residents for 22 years.

The Wellmobile Program has aligned its client services management approach to respond to the increased demand for primary care services that accompany the statewide implementation of health care reform. Health care providers and organizations are mandated to manage patients in the community to prevent and decrease prolonged and preventable hospitalizations, readmissions, and avoidable ED visits. This approach requires increased availability of primary care access points over a relatively short period of time. Additionally, the Nov. 1, 2016, reopening of the Maryland Health Connection, designed as a one-stop shop to facilitate a single-entry point for coverage through Medicaid expansion and private health plan enrollment, will put additional strain on health plan networks by increasing the demand for PCPs. 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 2016 FUNDING**

At the beginning of FY10, four Wellmobiles served the state in four distinct regions: densely populated suburban Central Maryland (Prince George’s and Montgomery counties), suburban Anne Arundel County, rural Lower Eastern Shore, and rural Western Maryland. Three Wellmobiles operated in nine counties four days each week, and one operated once a week. Because the program was conceived as a public-private partnership, during FY07, 08, and 09, 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 FY07 to 57 percent in FY09, 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 FY10's allocation to \$285,250, planned operations based on an expectation of continued level funding—supplemented by grants, service contracts—and additional contributions, could not be sustained. This drastic cutback could not be immediately offset by other UMSON fundraising activities. By the beginning of FY10, 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 Primary Adult Care Program (PAC) program, under a memorandum of understanding with the Maryland Department of Health and Mental Hygiene (DHMH). The final renegotiated agreement was effective in FY11. Reconfiguration of the Medicaid enrollment process into Maryland Health Connection has rendered this reimbursement unavailable.

This drastic decrease in funding resulted in the contraction of the FY10 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 (Appendix A) 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, Laurel College Center, and Universities at Shady Grove (Rockville) locations.

The FY16 legislative allocation of \$285,000 composed 29 percent of the FY16 Wellmobile budget. The state's allocation, supplemented by University of Maryland Baltimore Foundation, Inc. (UMBF) and HRSA IPCP funding, allowed UMSON to sustain the Central Maryland Governor's Wellmobile Program at the previous year's level of operation. Bridge funding from CareFirst underwrote exploration of a partnership with a new institutional partner and partially funded the transition of Upper Shore patients to local health providers. In early 2016, Wellmobile services on the Upper Shore were decreased from four days a week to one until the program was closed in March.

### ***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 FY13. A grant award from CareFirst in FY12 was the sole funder for the three-year (2012-15) Upper Eastern Shore Primary Care and Services Linkages Project, in partnership with University of Maryland (UM) Shore Medical Center at Chestertown, one of three UM Shore Regional Health hospitals. This project successfully redeployed a Wellmobile to the Upper Shore. Funds from this grant supported project planning and start-up expenditures incurred in the second half of FY12 and project implementation that ran July 5, 2012, to June 30, 2015. Realizing the value of the program and the effectiveness of a hospital-linked mobile clinic,

in fall 2015, CareFirst funded the exploration of a partnership with an alternate health system in an effort to sustain its investment in the Upper Shore “Bridge to Care” model. Building on the outcomes attributed to CareFirst’s funding, the Wellmobile Program submitted a funding proposal to a major health system to collaboratively develop and pilot innovative care transition approaches by having timely primary care appointments for newly discharged hospital or ED patients and then linking them with a community-based primary care practice in their communities. After months of planning, the hospital was unable to provide start-up financial support for the Wellmobile operation to build a billing and fee model while growing the program.

In FY16 Wellmobile-designated funds from UMBF supplemented the gap between the legislative allocation and operating costs for the remaining core program. Anne Arundel County Department of Social Services funded Homeless Resource Day activities. The Wellmobile is not supported by University funding; its funding is dependent upon 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 \$695,593, to complement the state budget appropriation to provide services in FY16. Additional funding was unavailable for additional nurse practitioner, nurse care manager, and driver positions to support continuation of Upper Shore services or expansion to other vicinities in Central Maryland or in other areas of the state where demand is high.

Reactivating additional Wellmobiles and rebuilding the statewide program remains a UMSON priority because the Wellmobile Program serves as an interprofessional clinical education site for nurse practitioner, community health, medical, pharmacy, 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 compose Maryland’s future workforce. UMSON’s Office of Partnerships, Professional Education, and Practice, 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 PCMH. The program provides the following services:

1. Clinical care – FNPs conduct physical exams and age-specific screenings and 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. The FNP initiates treatment based on assessment and diagnosis to stabilize the patient, orders diagnostic tests, prescribes generic prescriptions and over-the-counter medications as indicated, and initiates specialty referrals. FNPs refer complex patients to the family medicine physician and clinical pharmacist interprofessional team members for consultation.

2. Life-cycle specific screenings – FNPs conduct school physicals, well-woman (including breast exams, pap smears, and pregnancy tests) and clinical exams, 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. As funding permits, additional screenings are conducted at county local homeless resource days, primarily in communities served by the Wellmobile. Screenings target specific groups such as uninsured adult populations in underserved communities. Some screenings are conducted on the Wellmobile by the FNP, assisted by FNP and A/GNP students. 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 provides these services in 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 clients who require treatment beyond the scope of the nurse practitioner to an appropriate medical provider by matching patient needs with available resources and reimbursement. This is particularly important for the uninsured, who are eligibility tested to qualify for sliding-fee and pro-bono arrangements.

3. 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. The social worker and bilingual outreach staff, assisted by social work students, identify community resources and agencies, including other local safety-net health providers willing to accept specialty referrals and transfers to a permanent medical home. Priority is given to patients with chronic and unmanageable acute conditions and co-morbidities. 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.

4. 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. Nurse

care managers, assisted by community health nursing students, instruct patients on self-management, employing health education techniques and associated teaching materials. Entry-level and graduate community health nursing students and advanced practice FNP and A/GNP students assist nurse care managers and bilingual (Spanish) 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 individualized disease management guidance and health information from FNPs and nurse care managers. Students fulfill clinical course requirements by engaging in these experiences.

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 radiology 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 on care coordination and disposition issues during weekly interprofessional team case conferences. The central office, composed of the director and a 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 2016 PERFORMANCE, IMPACT, AND PARTNERSHIPS**

The Wellmobile Program's impact in FY16 focused on three areas: interprofessional primary care and clinical services at multiple sites in Prince George's and Montgomery counties, sustainability of the Upper Eastern Shore Program Primary Care and Services Linkages Project, and an Anne Arundel County-funded Homeless Resource Day.

### ***OVERALL RECIPIENT IMPACT AND COST EFFECTIVENESS***

In FY16, the program provided FNP and physician primary care, nurse care management, pharmacy consultation, social work, and outreach work. Primary care visits include those conducted on the Wellmobile during the county Homeless Resource Day event. Social work encounters ranged from assistance with applications for medical benefits (e.g., Medicaid, CHIP, Medical Care for Children Partnership, Kaiser Bridge, and county Breast and Cervical Cancer Treatment Programs [BCCP]) to referrals for emergency assistance and food stamps.

The social worker, nurse care managers, and outreach workers met with patients after the nurse practitioner primary care visit to provide additional case management, care coordination, and health care system navigation. Undergraduate social work students, under the supervision of a UMSSW faculty member, advised patients on eligibility for public benefits and services. Outreach targeting eligibility determination and enrolling uninsured patients in entitlement programs resulted in 232 Medicaid/CHIP and other health coverage applications and follow-ups and referrals to Maryland Health Connection navigators. The scope of social work and student

outreach included campaigns to raise awareness of entitlement programs, screenings for eligibility, assistance in completing applications and with selection of a managed care organization or plan and a PCP, and follow-up on pending eligibility determinations. Patients eligible for entitlement programs continued to receive Wellmobile primary care services until they were officially enrolled in that program, were assigned a PCP, and had confirmed their scheduled appointment for the initial visit with the PCMH for follow-up care.

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 (CCLP) Outreach Center two half-days each week. These encounters involved 526 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 274 referrals for food, housing, and smoking cessation programs. The following table summarizes the above-described activities.

**Fiscal Year 2016 Census and Clinical Encounters and Referrals**

Unduplicated Medical/SW only Patients	Primary Care Encounters	Nurse Care Management Encounters	Social Work Encounters	Outreach Work
885/710	2,439	323	1,009	2,123

In FY16, 585 new and 400 established patients received 2,439 primary care FNP and family medicine visits and 323 nurse care manager visits. The social worker and students provided 1,009 visits to Wellmobile medical patients and an additional 710 social work-only patients. The latter category of patients received both health- and non-health-related assistance. The program provided 3,771 total professional visits in FY16, an increase from 3,342 and 2,811 in FY15 and 14, respectively. This represents an increase despite contraction of the Upper Shore project in early 2016.

**Fiscal Year 2016 Assistance and Referrals**

Health Insurance applications and food stamps	Health Care Provider and Diagnostic Referrals	Referrals for Other Health Related Services	Other Non-health Related Assistance and Referrals
232	526	274	491

According to the 2014 Agency for Healthcare Research and Quality (AHRQ) Medical Expenditure Panel Survey (<http://meps.ahrq.gov>), the average cost of an ED visit in the United States for uninsured people aged 18-44 was \$1,572, rising to \$2,176 for ages 45-64, with median expenditures of \$809 and \$987, respectively. Patients paid nine-10.5 percent of these expenses out of pocket. Previous survey results from Wellmobile patients revealed that 14-17 percent of respondents would instead have sought out an ED or urgent care center in the event the Wellmobiles were not available. Based on an estimated 15 percent utilization, we estimate that the program avoided between \$296,094 and \$361,242 in ED visit expenditures (based only on FNP and physician visits and median expenditures from the two age groups). This does not include the additional costs incurred in the ED for tests and procedures. Thus, the estimated cost

avoidance benefitted the hospital systems in the communities served by the Wellmobile Program and relevant Maryland all-payer model and other safety-net providers, including the FQHCs serving the Upper Shore and Montgomery and Prince George's counties.

The average cost per patient of a medical visit in 2014 (AHRQ Medical Expenditure Panel Survey) was \$390 for patients 18-44 and \$737 for those 45-64, with median expenditures of \$1,121 and \$1,889, respectively. As a result, the uninsured paid an average of 20.1 percent and 15.6 percent out of pocket (AHRQ, 2017). The average cost of a primary care visit to an FQHC was \$104 (National Nurse-Led Care Consortium [NNCC], personal communication). The market value of the average professional encounter on the Wellmobile (primary care, nurse care management, and social work) was \$226, compared with \$197 and \$225 in FY15 and 14, respectively. This amount reflects the allocation of all fixed costs across only professional (family medicine, nurse practitioner, nurse care manager, and social work) visits, conducted with the support of drivers/office assistants, bilingual outreach workers, and the Wellmobile Program office. These visits were more time intensive and thus costlier than outreach, interpreter, and health promotion visits, which when combined with the professional encounters, reduced the FY16 Wellmobile cost per visit to \$144, compared to \$136 and \$196 in FY15 and 14, respectively.

The increase in cost per visit from the previous fiscal year is attributable to faculty and staff salary increases and higher fringe rates. The higher salary for the family medicine provider also contributed to the additional costs. For 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. In upcoming fiscal years, we anticipate continued salary and fringe benefit 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). Additionally, overall visit volumes remained less than the 4,762 FNP visits in FY09, the last year of full Wellmobile operations, a consequence of curtailed operations and program contraction due to comparatively fewer available financial resources beginning in FY10.

## ***REGIONAL SERVICE AREAS***

### **Central Maryland Project and Report of Fiscal Year 2016 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 FY16. The Central Maryland Wellmobile provided services three days per week at these Prince George's County sites: Langley Park Shopping Center (Langley Park), Bladensburg Elementary School (Bladensburg), Deerfield Run International School (Laurel), and Franklin Park at Greenbelt Metro Apartments (Greenbelt). In Montgomery County, the Wellmobile provided services one day each week at the Seventh Day Adventist Church in Takoma Park.

Since June 2013, the Central Maryland program's nurse care manager has led care management and health education efforts, enabling the nurse practitioner to conduct more visits. The care

manager position was increased to full time in January 2014 to address care management needs of this population more effectively. 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.

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 that the nurse practitioners and physician prescribed 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. The social worker assisted patients requiring proprietary prescription drugs with applications to the respective pharmaceutical company's patient assistance programs. The clinical pharmacist and pharmacy students assist with formulary adjustments to ensure optimal cost savings.

Both in Central Maryland and on the Upper Shore, the Wellmobile continued to provide key regional outreach and enrollment guidance to patients for Medicaid and Medicare and to direct patients to Maryland Health Connection for enrollment and further assistance. The social worker, nurse care manager, bilingual outreach staff, and students worked with local health departments to screen clients and household members for eligibility for Medicaid programs. Over the past seven years, a part-time field instructor from the UMSSW has provided continuity in this effort in Central Maryland. 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 reapply, if warranted. Central Maryland demographics would support the assumption that the majority of adult clients in this region would be ineligible for enrollment in Medicare, Medicaid, and health insurance plans, due to citizenship status; however, social workers and outreach workers assisted numerous clients with applications at both Central Maryland and Upper Shore access points. Children were screened for CHIP, Medicaid, 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), selection of a PCP, and the required annual re-enrollment process.

The PCMH 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 stabilized and prioritized for referral to a PCMH, utilizing available FQHCs, other clinics, and private providers.

The average wait time for an appointment at Prince George's and Montgomery county FQHCs was 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's (CCI) Franklin Park clinic in Greenbelt (Prince George's County) and Takoma Park clinic (Montgomery County). Both sites are open five days each week, and the Takoma Park site is open on Saturday. The Wellmobile Program referred clients to



the Mary's Center Silver Spring (Montgomery County) and Langley Park (Prince George's County) sites. As a result of the persistence of waiting lists for new clients in FY16, the Wellmobile served as the interim-care provider, managing these newly insured patients until they were transferred to a PCMH. Stable patients and those amenable to Wellmobile intermittent management were 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 FY10.

The trend of longevity and increasing numbers of complex patients on the Central Maryland Wellmobile panel provided evidence of the need for more accessible physician consultation. In February 2014, the Wellmobile Program submitted an HRSA Bureau of Nursing Cooperative Agreement application to fund interprofessional collaborative practice and education using an "integrated care model" on the Central Maryland Wellmobile by adding a UMSOM Department of Family and Community Medicine physician faculty member and a School of Pharmacy clinical pharmacist. While this proposal was approved, federal funding was insufficient to extend the award for FY15 implementation. In FY15, HRSA elected to consider this approved category for grants for FY16 implementation. On July 2, 2015, UMSOM was notified that the proposal "Bridging Interprofessional Practice and Education with Integrated Care through a Medical Neighborhood" was funded for these additional disciplines and expanded bilingual outreach worker effort, effective July 1, 2016, through the end of FY18. After a six-month planning period, the interprofessional clinic was launched on Jan. 11, 2016.

The goals of this project are to retain patients previously referred to PCMHs by establishing an advanced primary care interprofessional collaborative practice in the Wellmobile clinic that integrates a family medicine physician, a clinical pharmacist, and a bilingual outreach worker into the existing nurse-managed (FNP, nurse care manager, and social work) faculty practice. The IPCP identifies and manages complex patients who require advanced interprofessional care. A partnership with the Archdiocese of Washington D.C.'s Catholic Charities Health Care Network (CCHN) provides access to specialty care. An IPCP team that retains a nurse-managed identity uses patient-centered interprofessional collaborative team processes and a patient-centered approach to care. Student IPCP competencies are advanced through clinical rotations and by collaborating with faculty and students from multiple disciplines to improve patient outcomes. The HRSA cooperative agreement project also funds research efforts to track and document provider, student, and patient outcomes related to IPCP activities to meet federal mandatory reporting requirements.

### **Upper Eastern Shore Project and Report of Fiscal Year 2016 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 each week to two underserved rural Upper Eastern Shore counties: Kent and Queen Anne's. Services focused two

days per week in the communities of Rock Hall and Chestertown and two days per week in the Ruthsburg-Dixon (Sudlersville) area. Three key project components included: 1) case finding the uninsured; 2) reverse referrals from UM Shore Regional Health at Chestertown's inpatient and emergency departments; and 3) subcontracting with Shore Medical Group physician practices. In each community, a central parking location for 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. Through the end of calendar year 2014, UM Shore Regional Health hospitals participated in the Maryland Health Services Cost Review Commission's hospital Total Patient Revenue Program, under which each hospital received 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. Effective January 2015, this model transitioned to the CMS waiver global payment system, Maryland's All-Payer System Model.

In FY12, the Wellmobile Program developed partnerships and planned implementation with Chester River Health System, Kent County and Queen Anne's County health departments, the Judy Hoyer Center, the Family Support Center in Sudlersville, and the Rock Hall Volunteer Fire Co. and executed memoranda of understanding. Upon completion of pre-implementation activities, which 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 Regional Health's hospital in Chestertown, UM Shore Medical Center at Easton leadership, and local health and human services organizations to identify and divert uninsured patients and those without PCPs to the Wellmobile. This decreased their reliance on avoidable readmissions and ED use. Over the three-year grant period, 128 cases were diverted from the ED as a result of using the Wellmobile for primary care. 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 demonstrated proof of insurance application and sought pro bono or sliding-fee-scale laboratory, diagnostic, and other services from Shore Regional Health affiliates were 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. A key aim of the CareFirst grant was to case-find the uninsured. These patients composed the majority of the patient panel. During the funding period, expansion of eligibility for entitlement programs and access to qualified health plans through Maryland Health Connection increased access to coverage for the uninsured. Financial services personnel met with uninsured patients and connected them with the Seedco navigators and assistors.

The Wellmobile Program accepted referrals from UM Shore Medical Center at Chestertown's A QUICK (Advocacy, Quality, and Utilization Improvement Coordination Keystone) huddle team.

Team members represented diverse service lines, including case management, nursing leadership, social work, behavioral health, palliative care, patient advocacy, transitional care, inpatient units, ED, hospitalist team, long-term care/rehabilitation, and home care and hospice. A QUICK huddle aimed to identify, facilitate, and guide patients to the appropriate ambulatory care venues to receive the care they need. To address the trend of patients seeking care in the ED, they identified a subset of patients who could benefit from referral to the Wellmobile. Key care transitions personnel completed referrals telephonically, electronically, or via fax to schedule patients for bridge primary care.

The Upper Eastern Shore continues to experience a shortage of PCPs for the uninsured and also for those insured residing in more remote, isolated communities without physicians. Upper Eastern Shore Medicaid PCPs and specialists experienced unique challenges related to business and economic forces particular to rural environments. These already scarce resources were exacerbated by the PPACA's Medicaid expansion, including the conversion of PAC enrollees into Medicaid. The already limited pool of primary care physicians accepting Medicaid patients was overwhelmed with new enrollees assigned to their practices. Patients seeking appointments with a limited pool of providers further exacerbated the health professional shortage on the upper shore, since MCOs serving the region empaneled the same limited number of available Medicaid providers, creating even more competition. Thus, both existing and newly insured patients on the Upper Shore experienced delays in obtaining new and recurring appointments with assigned PCPs. This phenomenon was particularly acute in the rural communities served by the Wellmobile, which filled the gap by addressing the primary care needs of these patients.

As in Central Maryland, the Wellmobile served as the interim health care home, managing insured and complex clients until they could be transferred to a PCMH. 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 the proposed integration of the Wellmobile provider staff into a UM Shore Regional Health affiliated primary care practice. Such an affiliation would integrate the FNP's patient panel, consisting of both routine and complex patients, into a primary care practice, providing additional resources and interprofessional practice opportunities. Many members of 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 exchanges between 2012 and 2016, resulting in a cohort of newly insured. Based on a cross-sectional analysis, more than 10 percent of the Upper Shore patient panel was insured with Medicaid, commercial or qualified health plans, or Medicare.

In the three years subsequent to the July 1, 2013, consolidation of Chester River Health System into UM Shore Regional Health, several sustainability proposals were presented to the executive leadership. Data regarding the Wellmobile's impact as the PCP for newly insured patients over three years illustrated the opportunity for a UM Shore Regional Health-affiliated primary care practice to incorporate the Wellmobile FNP and patient panel during the course of this project. The associated billing and collections were anticipated to create a revenue stream to partially support integrating the Wellmobile in the health system's service area, supplemented by additional funding to extend services to the uninsured. While Shore Medical Group and UM Shore Regional Health were identified as potential primary care partners, efforts to formalize a partnership agreement by the end of FY 2016 resulted in program contraction beginning Oct. 1,

2016, a systematic decrease in service days, and referral of approximately 245 patients to Eastern Shore providers.

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

The success of Anne Arundel County's Homeless Resource Day over the past nine years resulted in replication of this event in jurisdictions across the state. Resource limitations permitted the Wellmobile to participate only in the Anne Arundel County event. During these daylong events, UMSON faculty and nursing students and county medical volunteers provided primary care services.

- Anne Arundel County Homeless Resource Day, Glen Burnie – April 9, 2016 (two 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. However, the immigrant population, 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. The Upper Shore population consists of similar Latino settled-out migrant populations. These populations face complex medical and social challenges, are uninsured, and experience delays in accessing an overburdened FQHC safety-net provider system. Other challenges related to cultural diversity include limited English language proficiency; overall generic literacy deficits, such as the inability to read and write in their native language and in English; and health literacy deficits. All Wellmobile outreach staff members and a nurse care manager are bilingual (English and Spanish), enabling them to work effectively with this immigrant population and their associated health literacy challenges. The Wellmobile is often the health care provider of last resort for these populations. Employing prevention, early detection, and treatment of chronic and acute illnesses keeps these patients out of the hospitals and decreases expenditures in the all-payer model.

### ***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 Wellmobile Program has become an integral part of the health care delivery system in the communities it serves.

In Central Maryland (Montgomery and Prince George's counties), the following community partners provided Wellmobile parking and access to facilities:

- Bladensburg Elementary School, Bladensburg, Prince George's County
- Catholic Community of Langley Park, Langley Park, Prince George's County, an outreach site of 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

Also in Central Maryland, the following community partners provided access to health services and accepted referrals for Wellmobile clients in FY16:

- Brentwood Senior Center/Dimensions Health Systems, Prince George's County
- CCHCN, Washington, D.C.
- CCI, Greenbelt, Prince George's County
- Community Radiology Associates
- Doctors Community Hospital, Lanham, Prince George's County
- 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 of Maryland College Park SAFE Center

On the Upper Eastern Shore (Kent and Queen Anne's counties), the following community partners provided Wellmobile parking and access to facilities:

- Kent County Health Department
- Queen Anne's County Public Schools
- Rock Hall Volunteer Fire Co.
- UM Shore Medical Center at Chestertown

On the Upper Eastern Shore, the following community partners provided access to health services and accepted referrals for Wellmobile clients in FY16:

- CCHS, Caroline County
- The Family Center 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 Regional Health-Medical Center at Chestertown, Kent County, and Easton, Talbot County

## **EDUCATION AND SERVICE ACCOMPLISHMENTS**

### ***COMMUNITY EDUCATION AND OUTREACH***

Health education and outreach services are essential components of the Wellmobile primary care delivery model. Requests for participation in community health fairs are so frequent that the Wellmobiles could be engaged in these community-based activities at least monthly throughout the year. In previous years, a more robust funding profile permitted Wellmobile participation in regional community-based events sponsored by local health and social services and community-based and faith-based organizations. Since this level of response resulted in commitments exceeding the weekly primary care schedule, budget constraints have prevented the program’s ability to support overtime pay for weekend work, severely reducing the program’s availability for weekend community events. As an alternative, in jurisdictions served by the program, 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. The Wellmobile Program did not take this approach in FY16, given 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. Additionally, the HRSA funding stream supports a primary care interprofessional practice and education model, consistent with the Wellmobile’s legislative charge.

In both Central Maryland and the Upper Shore, community education and outreach services were available on the mobile unit and at the CCLP’s Langley Park Outreach Center, continuing the commitment to provide these services in a more economically feasible manner. Social work faculty and students conducted community outreach and provided consultations and assistance with human services applications at CCLP. 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. 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.

### ***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 HRSA interprofessional collaborative practice cooperative agreement funding 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 designed to provide mutual benefit to the target population and to the students.

In FY16, a Community/Public Health Nursing master's student and five RN-to-BSN students completed semester-long clinical rotations on the Wellmobile, directed by the nurse care manager. The FNP's precepted one A/GNP and three FNP students. The family medicine physician precepted 10 medical students. These students were in the exam room with the family medicine physician to perform patient exams, diagnose, prescribe treatments and medications, and refer appropriate patients to specialists for consultation. Two PharmD students rotated onto the Wellmobile. The social work faculty 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 transitioning to an electronic health record (EHR) and to manage data required to generate invoices for projected primary care partnerships and ongoing reports, we continued to focus administrative effort in FY16 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.

The increasing importance of patient self-management skills in improving chronic disease outcomes prompted the Wellmobile Program director to investigate the self-management capacity of the Wellmobile patients for her PhD dissertation. The significant finding of *Predictors of Patient Activation among Underserved Patients in a Nurse-managed Health Center* was that autonomy support of the nurse practitioner was the sole independent predictor of patient activation in this underserved patient population.



Process and impact outcomes from overarching Wellmobile services, the Upper Eastern Shore Primary Care and Services Linkages project, and the HRSA IPCP cooperative agreement 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 PCMHs into primary care practices?
- Can an interprofessional collaborative practice-based team model and integration with a medical neighborhood improve patient outcomes?
- What is the perceived impact of an interprofessional practice model on Wellmobile providers and student learners?
- What would be the impact on health costs and client outcomes with a refocus of Maryland all-payer model 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 populations 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 for learning and applying 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. To date, Wellmobile administrators and faculty have delivered presentations on:

- innovative approaches to enhancing health care access for the underserved
- models of nurse-managed and team-based 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.

In FY16, the Network Adequacy and Essential Community Providers Standing Advisory Committee of the Maryland Health Benefits Exchange recommended expansion of the definition of Essential Community Providers beyond the federal definition to include local health departments, mental health and substance use disorder providers licensed by DHMH as programs or facilities, and school-based health centers. Wellmobiles could enhance the capacity of existing school-based health centers. In June 2015, Wellmobile Advisory Board members endorsed the recommendation of Delegate Pena Melnick to convene a meeting with the MCOs to discuss reimbursement for primary care visits to covered patients who were unable to receive care in a timely manner from their assigned PCPs. The program has begun the State Medicaid provider application and credentialing processes with each of the interested MCOs.

## ***OPERATIONAL CHALLENGES***

The program's overarching challenges continue to be securing fiscal partners for regional programs, fulfilling the public-private partnership mandate, and providing a measure of fiscal sustainability that can be obtained through billing insured patients. Generating revenue is essential to offsetting personnel and health-delivery costs. Increasingly, insured patients seek care on the Wellmobile due to increased primary care demand as a result of increased coverage. Challenges in FY16 continued to be access to secondary referral services, including sub-specialties; linkages to PCMHs for primary care services; lack of an EHR; and maintaining the Wellmobile vans in the required operating condition to perform the program's legislatively designated missions.

One of the biggest challenges facing PCPs of uninsured patients 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 to manage complex diabetes; neurologists to rule out brain tumors and develop treatment plans for migraine headaches; orthopedic physicians to evaluate pain 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 FY16, the Wellmobile care managers and social worker 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 FQHCs that predominantly serve Medicaid patients and the insured and 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. Adding the physician to the interprofessional collaborative practice on the Wellmobile in January 2016 served as the initial step in the primary care referral process and further validated the need for specialty referrals.

Dimensions Health System (Prince George's Hospital Center and Greater Laurel Beltsville Hospital), a Prince George's County-owned health system, continues to experience financial difficulty aggravated by uncompensated care and has not been a source of specialty and diagnostic resources. 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 completion of this enterprise. Washington Adventist Hospital has contracted clinic space to an FQHC (CCI) on the Takoma Park campus. Prince George's County Health Department transitioned the BCCP program to Doctors Community Hospital. To extend the medical neighborhood for IPCP patients, we executed a Memorandum of Understanding with CCHCN for second-level referrals for Prince George's and Montgomery counties. Holy Cross Hospital in Montgomery County accepts specialty referrals from CCHCN and provides specialty care on a sliding-fee basis to eligible patients. The Wellmobile Program will continue to seek out partnerships and refer patients to specialists and diagnostic services affiliated with these facilities that accept sliding-fee and pro-bono referrals.

In FY11, 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 FY14 and 15, the Wellmobile Program passed on a 2 percent increase in laboratory fees to its patients. Faced with a further increase in FY16, the Quest representative provided a lower fee schedule for a number of frequently accessed tests.

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 presents advanced disease processes. Patients with unmet needs may average as many as eight medical problems, demanding multiple referrals for diagnostic and specialty care. These more complex patients require extensive care management. Those with low literacy skills 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 budgeted a nurse care manager in an unfunded January 2013 HRSA grant submission and has funded this position in Central

Maryland with funds raised through UMBF. CareFirst funded this position on the Upper Eastern Shore over the last three years. In recognition of the value of care management and the need to educate future nurse care managers, future proposal submissions will include a nurse care manager position in the line item budget. Full restoration of the bilingual nurse care manager role has enhanced linkages of clients to secondary and tertiary care services, complementing the efforts of social work and the outreach worker. As an interprofessional clinical team member, the nurse care manager precepts entry-level community health and master's nursing students and oversees outreach and scheduling 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 ED provides an avenue to specialty care, an option to which patients may resort when other means fail.

The inability to procure an EHR in FY16 continues to impede operations at both the administrative and direct-service levels. An EHR is central to attaining integration with patient-centered health homes and for efficient operations, including care management and quality. Electronic scheduling systems link with patient medical records, resulting in streamlined documentation and record-keeping 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 assures concise 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 manual 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, at the expense of valuable nurse care manager effort.

Compounded by budgetary constraints resulting from eight 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 eighth consecutive year. The Wellmobile Program will resume the process of EHR acquisition through partnership development, grant writing, and fundraising and will eventually resume the procurement process when these factors align.

FY16 operating expenditures included maintenance of four Wellmobile vehicles, each requiring semiannual State of Maryland- and Department of Transportation-mandated vehicle inspections; ongoing preventive maintenance for safety; and routine and unpredictable mechanical repairs. The vehicles were rotated in and out of service during FY16 to sustain program operations while other vehicles were undergoing repairs and inspections and to maintain functionality. Routine generator maintenance was continued on a schedule based on each vehicle's rate of auxiliary power utilization. The vehicles operate on generator power at community sites (installation of a special electrical outlet by the host site supports "shore power"; therefore, 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 FY12. Fuel tanks were replaced on one vehicle each in FY13 and 15. Repairing and refurbishing mechanical and clinic

equipment is ongoing. Maintenance costs of two vehicles that remained in the repair shop at the end of the fiscal year are not represented in this report and will be reflected in the 2017 report. These and other repairs to the aging fleet contributed to ever-increasing operational expenditures. UMB funded a “refresh” of two of the three larger Wellmobiles, upgrading their logos with a “wrap” to reflect the campus’ health professions education mission. 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 FY09, 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 six fiscal years.

Advent of the patient-centered health home model, an integral part of the PPACA, and the increasing role of FQHCs in primary care for the underserved reinforced the value of sustaining this direction as recently as FY15. Nevertheless, 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 FY16 in conjunction with the HRSA IPCP cooperative agreement. A generous grant from CareFirst allowed the program to pilot an affiliation with a hospital system on the Upper Shore. While the Wellmobile Program as a stand-alone entity cannot function as a health care home, this model of care (described below) is well suited to assist FQHCs, medical practices, health systems, and other health institutions in meeting PCMH 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 PCMH 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 concentrations of uninsured and 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 EDs 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 transfer insured clients effectively to a patient-centered health home, outreach worker and social work efforts focus on health

insurance plan enrollment and determining eligibility for state and federal entitlement programs such as Medical Assistance and Medicare. Outreach staff assist patients in completing applications, facilitating MCO enrollment, and selecting PCPs. Social work and outreach staff also disseminate information on how to access the navigators and assistors for enrollment through Maryland Health Connection. Once the Wellmobile staff has assessed the patient's needs, treated immediate needs, and established the plan of care, the Wellmobile care management process prioritizes transition of unstable, co-morbid individuals to a permanent PCMH, 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 health home. These health homes include FQHCs, outpatient clinics, and private physicians that accept the patient's newly established health coverage or offer sliding-scale fees for the uninsured. Making physician and clinical pharmacist consultation available on the Wellmobile and building access to a medical neighborhood has enabled the program to retain a number of complex patients with the addition of an advanced primary care interprofessional model.

**Care management** is the third model component. 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 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 these 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 that the FY10 HRSA FQHC service expansion made available, funded under the American Recovery and Reinvestment Act of 2009. 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 newly insured, further displacing the uninsured. An overall shortage of PCPs in both Central Maryland and on the Upper Shore, including limited availability of those accepting Medicaid, 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 health 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 ED. This attention to stabilizing the patient, including diagnosing and treating immediate conditions, and to the accompanying clinical documentation facilitates patient transfer and creates a climate of more willing acceptance by the receiving provider.

The increased numbers of unduplicated patients demonstrates the trend towards a more sustained patient empanelment in Central Maryland, driven by both health system forces and resources available under the HRSA funding stream. 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 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 PCMH functions. Billing and collections obtained from the PCMH under this contractual model would form the groundwork for sustainability efforts. The Upper Shore strategy of forging partnerships between the Wellmobile and health system-affiliated primary care practices could be replicated with other UMMS network hospitals and expanded statewide to enhance fiscal sustainability concurrent with filling the gap in primary care practices.

### ***FUNDING AND STRATEGIC SUSTAINABILITY INITIATIVES***

The FY10 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 FY11-16. 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 that they 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 unconditionally allocating Wellmobile services funded publicly and through 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” model provides the framework for the community partnership subcontractual model, one potential sustainability strategy.

The CareFirst-funded partnership with Chester River Health System/UM Shore Regional Health expanded implementation of the “Bridge to Care” model to the Upper Shore and piloted an approach to sustainability. The goal was to achieve a fiscally sustainable model by the conclusion of the third project year, FY15, by integrating the Wellmobile into the Upper Shore



primary care system through subcontractual arrangements and potential incorporation into the health system-affiliated practices.

With the reactivation of a second Wellmobile on the Upper Shore, accomplished in July 2012, the ultimate goal of reactivating the remaining two Wellmobile vehicles remained foremost among the priorities identified for FY16. The February 2014 HRSA IPCP grant proposal submission, funded for FY16-18, was designed to replicate the CareFirst proposal sustainability model in Central Maryland. Implementing an IPCP by adding a family medicine physician and clinical pharmacist to the team facilitates the primary aim: retaining existing, newly insured, and complex patients on the Wellmobile panel. A long-range objective is to attribute Wellmobile patient panels, including complex patients requiring a physician, to a primary care practice where revenues generated 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 are working 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 are 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 2016 AND FISCAL YEAR 2017 FUNDING STATUS AND INITIATIVES***

UMBF received donations to the Wellmobile in FY16 from communities and individuals, which have supplemented Wellmobile operations in accordance with donor specifications.

During FY16, the Wellmobile Program submitted the following proposals to external funders:

- Maryland Agricultural Education and Rural Develop Assistance Fund, "Utilizing Nursing Care Management to Facilitate Transition of Insured Patients to Patient-Centered Health Homes," July 10, 2015 (not funded)
- Anne Arundel Health System (AAHS) Partnership Health System Partnership, Sept. 15, 2015 (CareFirst/AAHS, preliminary funding)

FY17 funding prospects include:

- Community Health Resources Commission, "A Patient-Centric Innovation to Care: Meeting Patients Where They Live," a collaborative UMB submission, Dec. 19, 2016

## ***FISCAL YEAR 2017 PRIORITIES***

The challenge to raise external funds to support care of the uninsured will continue in FY17. The HRSA grant for Central Maryland requires maintenance of effort-continuation funding for baseline services provided prior to grant receipt. Hence, it only supports new activities and personnel. The program is dependent on supplemental funds to sustain pre-existing personnel and operational fiscal obligations, which in past years have been supported by dedicated fundraising in UMBF accounts; however, these funds will be depleted by the end of FY17. Furthermore, if the program is unable to garner sufficient funding from the state and other sources, UMSON will not be able to fund year three of the HRSA cooperative agreement sufficiently and will have no other option but to decline year three of the federal funding and initiate further program contraction. Wellmobile leadership is actively pursuing a partnership with a health delivery system to create sustainability.

PPACA 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 these 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 partner with a stationary operation, particularly within the context of health reform. The Wellmobile will enlist the assistance of UMSON's Office of Development and Alumni Relations to prepare and submit 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 with clinical exam rooms are well suited for interprofessional collaborative practice. Federal and local funding priorities, such as the HRSA IPCP cooperative agreement implemented in Central Maryland in January 2016, that support advanced practice nursing and clinical training offer additional opportunities 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 capitalize further on the opportunity to align its education mission with state initiatives that focus on recruitment, education, and retention of health professionals in rural areas. This innovative plan requires both internal and external partnerships with other schools and health care systems, as well as with 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 systems seeking opportunities to access difficult-to-reach populations.

The development and implementation of an EHR remains a priority for FY17. An EHR is fundamental to partnerships and subcontracts with PCPs and FQHCs because it provides the secure platform for exchange of health information among partners of vertically integrated health systems. We have requested assistance from the UMSON Office of Development and Alumni Relations 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 maintaining 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
FY09	3.2	2.0 (reduced to 1.5 1/1/2009)	.5	4*	3
FY10 (7/1-8/15)	2.8	1.5	.5	3*	3
FY10 (8/15-6/30)	.6	0	.5	2*	.8
FY11	.6	0	.5	1.8*	.75** -1.0
FY12	.6 (increased to .8 4/1/12, 1.6 4/16/12)***	0	.5	1.8	1
FY13	1.6	1 (increased to 1.5 6/1/2013)	.5	1.8	1
FY14	1.6	1.5 (increased to 1.8 1/16/2014)	.5	1.8	1
FY15	1.6	1.8	.5	1.8	1
FY16	1.65 (decreased to .85 7/16.	1.8, decreased to 1.3 7/16	.5	1.8, decreased to 1.2 5/16	1

This table illustrates the Wellmobile staffing model, representing number of positions by FTEs allocated across the operation of four Wellmobiles for FY09 and the first four weeks of FY10.

From Aug. 15 to June 30, 2010, and for FY11 and 12, these positions were allocated across operations of one core Wellmobile and a second Wellmobile fulfilling additional educational and programmatic functions.

In FY13, 14, and 15, these positions were allocated across the operation of two Wellmobiles.

In FY16, due to program contraction with the decrease in operations to only one Wellmobile, FTEs were reduced.

Notes:

\*One FTE outreach worker is also a driver.

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

\*\*\* .8 FTE Upper Eastern Shore nurse practitioner began orientation April 16, 2012.

**APPENDIX B: FISCAL YEAR 2016 WELLMOBILE BUDGET**

Governor’s Wellmobile Program - Financial Report  
 FY16 (7/1/15-6/30/16)

Expenses:

Personnel		
	Salaries	\$ 709,949.43
	Fringe	
	Benefits	\$ 210,647.93
	Total	
	Personnel	\$ 920,597.36
Operating		\$ 59,396.30
	Total Expenditures	<u>\$ 980,593.66</u>

Revenues:

	MHEC Funds	\$ 285,000.00
	Other Sources	\$ 695,593.66
		<u>\$ 980,593.66</u>

Note: \$105,926.11 in salaries and \$23,527.29 in fringe related to program development, data collection, and evaluation for mandatory HRSA NEPQR interprofessional collaborative practice cooperative agreement reports are included in the total budget. The salaries and fringe are excluded from the cost per visit calculation. Direct services salaries and fringe total equal \$791,143.96.

**APPENDIX C: WELLMOBILE ADVISORY BOARD MEMBERS**

**WELLMOBILE ADVISORY BOARD MEMBERS  
GOVERNOR'S WELLMOBILE PROGRAM FY16**

MEMBER	AFFILIATION
Jane M. Kirschling, PhD, RN, FAAN	Chair Dean and Professor, UMSON
Vacant	health member
Elmer T. Carreno, MD	Physician, Prince George's County Health Department
Vacant	media member
Christopher King, PhD	Georgetown University School of Nursing and Health Studies
Joselina Pena-Melnyk	Maryland House of Delegates
Dottie Tiejien Li	TransPacific Communications
Catherine Pugh	Maryland Senate
Vacant	business member

## APPENDIX D: PUBLIC RELATIONS

- Press release and web article: “Wellmobile to Provide Interprofessional Care,” July 16, 2015 (re: Susan Antol’s \$1,007,076 HRSA grant to fund “Interprofessional Collaborative Practice and Education with Integrated Care through a Medical Neighborhood”)  
<https://www.umaryland.edu/news/archived-news/july-2015/newspressreleaseshottopics/wellmobile-grant.php>
- Web article: “Congressional Focus on Community Outreach,” July 20, 2015 (Wellmobile mentioned)  
<http://www.umaryland.edu/news/archived-news/july-2015/newspressreleaseshottopics/ruppersberger-visit.php>
- Op-ed by UMB President Jay A. Perman in *The Baltimore Sun*, “Community Engagement is a Critical UMB Mission,” Aug. 4, 2015 (Wellmobile mentioned)  
<http://www.baltimoresun.com/news/opinion/oped/bs-ed-umb-perman-20150804-story.html>
- *nursing for/um* magazine article, “Antol Awarded Grant for Interprofessional Practice Project,” winter 2015 edition, p. 8 (mentions how grant funding will help implement an interprofessional collaborative practice for providing care to residents served by the Wellmobile)  
<http://digital-editions.todaymediacustom.com/um-school-of-nursing/nursing-forum/winter-2016/#p=10>
- Web article: Governor’s Wellmobile Provides Services to SAFE Center for Human Trafficking Victims,” May 17, 2016  
<https://www.nursing.umaryland.edu/news-events/news/wellmobile-safe-center.php>