Governor's Wellmobile Program
Fiscal Year 2019
Annual Report

EXECUTIVE SUMMARY

For the past 25 years, the Governor's Wellmobile Program has operated as a community partnership model of mobile nurse-managed primary health care. In 2000, a state statute (Health General §13-1301 et seq.) codified dual Wellmobile missions:

1. to provide primary and preventive health care services to geographically underserved communities and uninsured individuals across the state
2. to serve as principle training sites for the University of Maryland School of Nursing (UMSON) for expanding student learning opportunities in caring for underserved populations

During FY19, the Wellmobile Program implemented a modified interprofessional collaborative practice (IPCP), having completed year three of the Health Services Resources Administration (HRSA)–funded cooperative agreement in FY18. This required allocating other funding sources to sustain program operations at a sufficient level to meet the needs of the patient panel. Using a Bridge to Care model, the Wellmobile filled the gap in Prince George's and Montgomery counties' primary care infrastructure by managing patients who lacked access to community-based clinics and health care homes. In the effort to transform primary care and enhance clinical services, this approach entailed accessing the medical neighborhood to retain patients with complex health problems by coordinating advanced diagnostic services and coordinating intermittent specialty consultation. Patients who could not be safely managed in this model and those with insurance were referred to available patient-centered medical homes (PCMHs). HRSA funds designated for completion of the electronic health record project facilitated continuity of implementation and system optimization.

The Wellmobile Program continued its collaboration with the University of Maryland School of Pharmacy's (UMSOP) Maryland Community Health Resources Commission–funded *A Patient-Centric Innovation to Care: Meeting Patients Where They Live* initiative. This patient-centric, team-based model provided transition-of-care services to patients with ambulatory care sensitive conditions who were discharged from University of Maryland Capital Region Health and at risk for hospital or emergency department readmission.

Sustaining the nurse-managed collaborative interprofessional practice, an enhancement of the Bridge to Care model, demonstrated the feasibility of creating a statewide prototype 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
- exploring funded health system partners
- implementing interprofessional care tailored to community partner needs
- strengthening care management

Efforts continued to assure sustainability of the Wellmobile Program by securing a collaboration with funding and institutional partners to rebuild the former statewide program. Wellmobile Program leadership conducted exploratory meetings with health system executives to build

partnerships and community linkages for seamless care with PCMHs and to secure an arrangement with a medical center to collaborate on technology infrastructure for sustainability and billing. Dialogue continues with potential new partners in Prince George's County for FY20.

In FY19, the core Wellmobile service model included nurse practitioner (NP) primary care, nurse care management, outreach work, and social work to train health care professional students in the dynamics of an interprofessional practice model.

Service accomplishments include: 1,488 NP, 371 nurse care manager, and 531 social work visits. The team facilitated specialty referrals to health care providers and facilities, assistance with health care coverage applications, and referrals for other health-related services across all activities. Combined federal, public, and private funds of $646,582.40 supported Wellmobile Program operations in FY19, including $5,234.21 to support electronic health record implementation. The Wellmobile Program's Bridge to Care and IPCP models demonstrated the capacity to enhance the quality and reduce the cost of care for existing health delivery systems, including hospitals under the Centers for Medicare & Medicaid Services 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, to establish the Wellmobile Program as an integrated component of the system's care model, and to augment financial capacity to build a sustainable model. To date, 44% of funding from the state has not been sufficient to perform services and solidify a financial partner. However, we are committed to working toward building this model and finding a partner to impact health disparities, reduce the cost of care, and add needed services that contribute to improving population health among the underserved.

GOVERNOR'S WELLMOBILE PROGRAM ANNUAL REPORT

UNIVERSITY OF MARYLAND SCHOOL OF NURSING

FISCAL YEAR 2019

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

PARTNERSHIP MODEL

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 the executive assistant for health issues in the Governor's Office. Delegate Goldwater was responding to the 1993 *Primary Access Plan for the State of Maryland*, which directly linked socioeconomic status to poor health outcomes, inadequate access to health services, and unhealthy lifestyles.

The Wellmobile 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, cultivate community and business partnerships, and raise 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. The unit also 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.

STATE OF MARYLAND SUPPORT FOR PROGRAM EXPANSION

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, with its two mobile units, shifted its emphasis to a mostly 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. 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
- provide principle training sites for UMSON to expand student learning opportunities in the care of underserved populations

A FY01 state appropriation funded the replacement of the original Wellmobile, the purchase of a Lower Eastern 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. From 1999 to 2002, the program grew from one unit to four, in four distinct regions of the state, with funding from federal and state public and private sources. Between FY02 and FY09, with four units operating in densely populated Central Maryland, Upper and Middle Eastern Shore, suburban Anne Arundel County, rural Western Maryland, and rural Lower Eastern Shore, the program was conducting an average of 8,000 consultations annually.

As each new unit joined the fleet, it was assigned a designated regional service area based on:

- funder specifications
- a community-needs assessment that identified gaps, such as distribution and proximity of primary care sites for the underserved

- a concurrent community-asset assessment, including the availability of community partners and stakeholder commitment

Before 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.

FISCAL YEAR 2010 PROGRAM CONTRACTION

Because the program was conceived as a public-private partnership, during FY07, FY08, and FY09 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% of the annual budget in FY07 to 57% in FY09. Federal funds and other government and private-sector grants and contracts filled the gap.

In those and subsequent years, level state funding could not keep up with rising marketplace personnel and operating expenses. Following the 50% reduction of FY10's allocation to $285,250, planned operations based on an expectation of continued level funding — supplemented by grants and 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, with four Wellmobiles operating in four regions of the state, the Wellmobile Program had experienced a shift in its funding profiles. For the previous nine years, the program received pass-through reimbursement from the Centers for Medicare & Medicaid Services 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, 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 and Universities at Shady Grove (Rockville) locations.

FISCAL YEAR 2012 CAREFIRST FUNDING

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 BlueCross BlueShield 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 Eastern Shore. Funds from this grant supported project planning, start-up expenditures, and implementation through June 30, 2015.

FISCAL YEAR 2016 HRSA COOPERATIVE AGREEMENT

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 consultations. In February 2014, the Wellmobile Program submitted a HRSA Bureau of Nursing Cooperative Agreement application to fund interprofessional collaborative practice (IPCP) and education using an integrated care model on the Wellmobile by adding a University of Maryland School of Medicine (UMSOM) Department of Family and Community Medicine physician faculty member and a University of Maryland School of Pharmacy (UMSOP) clinical pharmacist. While this proposal was approved, federal funding was insufficient to extend the award for FY15 implementation.

Upon HRSA's consideration of this approved category of grants for FY16 implementation, UMSON was notified on July 2, 2015, that the proposal "Bridging Interprofessional Practice and Education with Integrated Care Through a Medical Neighborhood" was funded to add these additional disciplines and expand a bilingual outreach worker effort, effective July 1, 2016, through the end of FY18. This three-year HRSA Cooperative Agreement, targeting student and faculty/staff education in an IPCP, funded the addition of a part-time UMSOM family medicine physician, an UMSOP clinical pharmacist, and an embedded bilingual nurse care manager. The program's mission complemented UMSON's educational mission by providing clinical education sites for graduate advanced practice nurse practitioner (NP) and entry-level community health nursing students, third year medical students, and doctoral pharmacy 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 gained clinical experience on the Wellmobile, contributing to a mitigation of health care workforce shortages in the state and region.

The goals of this project were to retain patients previously referred to patient-centered medical homes (PCMHs) by establishing an advanced primary care IPCP in the Wellmobile clinic that integrates a family medicine physician, a clinical pharmacist, and additional bilingual outreach workers into the existing nurse-managed (family nurse practitioner [FNP], nurse care manager, and social work) faculty practice. The IPCP identified and managed complex patients who

required advanced interprofessional interventions. A partnership with the Archdiocese of Washington D.C.'s Catholic Charities Health Care Network (CCHCN) provided access to specialty care. The IPCP team retained a nurse-managed identity utilizing patient-centered interprofessional collaborative team processes and a patient-centered approach to care. Student IPCP competencies were advanced through clinical rotations and by collaborations with faculty and students from multiple disciplines to improve patient outcomes. The HRSA Cooperative Agreement also funded research efforts to track and document provider, student, and patient outcomes related to IPCP activities to meet federal mandatory reporting requirements.

After a six-month planning period, the interprofessional clinic was launched on Jan. 11, 2016. This grant was not eligible for renewal, and the program completed its final year of HRSA-funded clinical implementation of the project in FY18.

WELLMOBILE PROGRAM SERVICE MODEL

The Wellmobile fleet consists of three 36-foot fully equipped mobile medical clinics, each with a reception area flanked by two exam rooms. Each mobile unit can travel wherever needed in Maryland. The core staffing model includes a driver/outreach worker, an 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 nursing and social work students.

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. More 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 wraparound and enabling services. This additional workforce can vary with project scope and funding availability.

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 across the lifespan. Examples of episodic and acute primary care services include diagnosis and treatment of sore throats, urinary tract infections, skin rashes, upper respiratory infections, and other common ailments. An increasingly aging population receive care for chronic conditions such as diabetes, hypertension, and hyperlipidemia.

   The FNPs initiate treatment based on assessment and diagnosis to stabilize the patient, order diagnostic tests, prescribe generic prescriptions and over-the-counter medications as indicated, and initiate specialty referrals. FNPs refer complex patients to the social work faculty interprofessional team member for consultation. The team coordinates referrals for patients requiring diagnostic and specialty consultation to providers available

through the medical neighborhood established under the HRSA IPCP cooperative agreement.

2. **Life-cycle specific screenings** — FNPs conduct physicals, well-woman exams (e.g., breast exams, cervical cancer screenings, and pregnancy tests), and clinical exams and identify and diagnose chronic and acute health problems within the context of a primary care encounter conducted at Wellmobile routine service sites. Some screenings are conducted on the Wellmobile by the FNP, assisted by FNP 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 it serves 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 assures optimal quality and continuity of care. FNPs initiate treatment using evidence-based clinical guidelines and transition clients who require treatment beyond their scope of practice to an appropriate medical provider by matching patient needs with available resources and reimbursement. This is particularly important for the uninsured, whom providers test to determine eligibility for sliding-fee and pro-bono arrangements.

3. **Care management and service linkages, referrals, and system navigation** — The number of patients requiring 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.) remains increased, since they were enrolled in care under the IPCP model. As these resources are essential to improving patient 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.

The social worker, bilingual nurse care manager, and outreach staff, assisted by RN-BSN nursing and bilingual 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 patients who need housing, food, medications, and specialty health care to locate and obtain local, state, and federal resources.

4. **Health promotion** — Educating patients in health promotion, disease prevention, developmentally specific immunization and screening thresholds, and personal/family emergency preparedness is the cornerstone of nurse-managed health care. The bilingual nurse care manager, assisted by community health nursing students, instructs patients on self-management, employing health education techniques and associated teaching materials. Patients with acute and chronic disease receive individualized disease management guidance and health information from FNPs and the nurse care manager. Students fulfill clinical practicum course requirements by engaging in these experiences.

The Wellmobile health care team functions collaboratively, maximizing efficiency and cost effectiveness. The program's central office provides administrative support for scheduling, patient management and referral, and clerical functions, including faxing, medical record maintenance and filing, and ordering and distributing office and medical equipment and supplies. Team members handle all communications, including phone calls, referrals, consultations, and lab and radiology report follow-up.

Safe and appropriate staffing levels are required to accomplish these duties in compliance with primary care, advanced practice, and general nursing practice standards. The program director oversees the outreach staff and consults on care coordination and disposition issues during interprofessional team case conferences. The central office, composed of the director and a part-time administrative assistant, is responsible for overall program administration, including:

- program development
- planning and evaluation
- community partnership development
- fundraising and grant writing
- reports
- policies and procedures
- regulatory compliance and quality assurance
- staffing
- billing

WELLMOBILE STATEWIDE IMPACT

The mobile feature of the Wellmobile Program allows for unique portability and flexibility in accessing underserved communities. Except for 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 FY19, HRSA awarded 16 Maryland FQHCs $1,253,853 in Quality Improvement grants, of which $50,000 targeted enhanced access and $102,000 targeted reduction in health disparities. Fifteen health centers received a total of $2,481,232 to provide Integrated Behavioral Health Services. These awards did not sufficiently expand primary care services and were insufficient to ameliorate the demand for primary care in the region.

Between Nov. 1 and Dec. 15, 2018, Maryland residents could enroll in both Medicaid and qualified health plans through the Maryland Health Connection and its website,

marylanhdhealthconnection.gov, with enrollment assistance from grant-funded navigators and assistors. This created the fifth cohort of newly insured beneficiaries, effective Jan. 1, 2019.

Wellmobile services continue to be in high demand, based on the nurse care manager's report of long wait times when newly enrolled patients attempted 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 reported longer wait times when they attempted to schedule an appointment for a new health problem or following emergency department or hospital discharge. This is may reflect sustained 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 facilitates their transfer to an in-network care provider or their designated PCP. Uninsured patients too complex for management by Wellmobile FNPs are likewise prioritized for referral to PCMHs. FQHCs represent the first choice for uninsured patients. Access to specialty referrals and diagnostics, through CCHCN and other networks, have enabled the Wellmobile to continue to manage more complex uninsured patients.

Without the Wellmobile, many of the patients who were served would have experienced significantly limited or no access to health care services and/or delays in treatment. Many would have resorted to hospital emergency departments as their only source of care. Wellmobile services played a key role in reducing inappropriate emergency department utilization, a costly practice that undermines continuity in preventive and primary care. The Wellmobile Program has successfully filled this role for the state's most vulnerable residents for 25 years. This has become increasingly important since the Maryland All-Payer System Model Agreement model, effective Jan. 1, 2015, prospectively established a fixed annual revenue cap for each hospital. This methodology encourages hospitals to focus on population-based health management.

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 emergency department visits. This approach requires increased availability of primary care access points over a relatively short period of time. Additionally, the Nov. 1, 2019, 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 further strain 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 proposed 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 2019 FUNDING

The FY19 legislative allocation of $285,000 composed 44% of the FY19 Wellmobile budget. Funding from the Maryland Community Health Resources Commission (CHRC) through the Interprofessional Care Transitions Clinic (ICTC) partnership and HRSA electronic health record funding supplemented the state's allocation. While this allowed UMSON to sustain the Central Maryland Governor's Wellmobile Program at the previous year's level of operation, it did so without the family medicine and pharmacy consultants. UMSON allocated funding to sustain the Wellmobile Program at the existing level through the end of FY19 when UMB declined further CHRC funding because it was contingent on significant ICTC project revision and stringent metrics. The revised model did not include funding for the Wellmobile.

FUNDING PARTNERS

The Wellmobile Program is not supported by University funding; its funding is dependent upon direct state budget allocation to UMB, grants and contracts, and public and private sources in partnership with communities. The Governor's Wellmobile Program used Wellmobile-designated funds from state and federal grants, including the CHRC and HRSA, totaling $646,582.40 to complement the state budget appropriation to provide services and fund operating costs in FY19. Sufficient funding was unavailable for additional NP, nurse care manager, and driver positions to support reactivation of Upper Eastern 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 NP, community health nursing, pharmacy, and social work students and is a faculty practice that enables nursing, social work, and potentially additional faculty from the other health professions to maintain professional certification, simultaneous with providing clinical education for future health professionals. 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 Department 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.

FISCAL YEAR 2019 PERFORMANCE, IMPACT, AND PARTNERSHIPS

The Wellmobile Program's impact in FY19 focused on maintaining an interprofessional primary care model of clinical services at five community sites in Prince George's and Montgomery counties. This required a team-based approach primarily, but not exclusively, with the subset of the Wellmobile panel with complex health needs who required extensive case management and

access to the medical neighborhood to provide specialty care that cannot be met exclusively by the Wellmobile care team. No Cost Extension Funds from the HRSA IPCP cooperative agreement under the Nurse Education, Practice, Quality, and Retention program supported electric health record system optimization.

The Wellmobile continued to reserve appointment times for new-patient assessments for patients referred from University of Maryland Capital Region Health's (UMCRH) Cheverly and Laurel Regional Hospital sites to the ICTC. This clinic, located on the premises of UM Capital Region Health in Cheverly, Maryland, was designed to expand access and continuity of care for Medicare, Medicaid, and newly insured patients who lacked timely access to a primary care provider by addressing that gap after their hospital or emergency department discharge. A team comprised of an FNP, a social worker, and a clinical pharmacist used an interprofessional approach to reinforce discharge instructions and address social determinants of health to prevent rehospitalization. As a partner, the role of the Wellmobile was to provide alternative clinic sites to accommodate patients on days when the ICTC was not open and for patients residing in communities where the Wellmobile had a presence. As a consequence of a low overall referral rate and patient no-shows, the Wellmobile did not serve any clients.

OVERALL RECIPIENT IMPACT AND COST EFFECTIVENESS

In FY19, the program provided FNP primary care, nurse care management, social work, and outreach work. Social work encounters ranged from assistance with applications for medical benefits (e.g., Medicaid, CHIP, Medical Care for Children Partnership, Kaiser Bridge, and county-specific Breast and Cervical Cancer Treatment Programs [BCCP]) to referrals for emergency assistance, social programs, and food stamps.

In FY19, 161 new and 408 established patients received 1,488 primary care FNP visits and 371 nurse care manager visits. The social worker and students provided 212 visits to Wellmobile patients and an additional 319 encounters to social work–only patients. The latter category of patients received both health- and non-health-related assistance. The 2,390 total professional visits in FY19 represents a decrease from 2,742 in FY18. This decrease in visits was attributable to increased complexity of patient encounters and utilization of bilingual outreach workers as interpreters for Spanish-speaking patients.

The social worker, nurse care manager, and outreach workers met with patients after the FNP primary care visit to provide additional case management, care coordination, and health care system navigation assistance based on individualized needs. Undergraduate social work students, under faculty supervision, advised patients on eligibility for public benefits and services.

The scope of social work and student outreach included campaigns to raise awareness of entitlement programs, screenings for eligibility, assistance in completing applications and selecting a managed care 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 coverage, were assigned a PCP, and provided confirmation of a scheduled appointment for the initial visit with the PCMH for follow-up care. Social work

students completed applications for enrollment in the CCHCN's specialty provider programs and the BCCP as well as specialty programs from area health systems.

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 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 additional referrals for food, housing, and smoking cessation programs. The following tables summarize the above-described activities.

FISCAL YEAR 2019 CENSUS AND CLINICAL ENCOUNTERS AND REFERRALS

Unduplicated Medical Patients	Primary Care Encounters	Nurse Care Management Encounters	Medical Social Work Encounters	Social Work Only Encounters
569	1,488	371	212	319

FISCAL YEAR 2019 ASSISTANCE AND REFERRALS

Health Care Provider, Diagnostic Referrals, Health Insurance, and Food Stamp Applications for Active Patients	Community-wide Assistance with Care Provider Referrals, Health Insurance, and Food Stamp Applications	Other Non-health-related Assistance and Referrals
159	149	171

According to the Kaiser Family Foundation (KHN Morning Briefing, 2019)[1], the average cost of an emergency department visit in the United States was $2,032, compared with an average of $167 for a physician visit. Previous survey results from Wellmobile patients revealed that 14-17% of respondents would instead have sought out an emergency department or urgent care center in the event the Wellmobiles were not available. Based on 15% utilization and FNP visits, we estimate that the program avoided $453,542 in emergency department visit expenditures. 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 Prince George's and Montgomery counties.

Also per the KHN Morning Briefing, the average cost per patient of a medical visit in 2017 was $167. The average cost of a primary care visit to an FQHC in 2015 was $109 (www.sciencedaily.com). The market value of the average professional encounter on the Wellmobile (primary care, nurse care management, and social work) in FY19 was $260,

[1] See the July 25, 2019 KHN Morning Briefing at https://khn.org/morning-breakout/the-cost-of-unwarranted-er-visits-32-billion-a-year/

compared with $220, $244, $226, $197, and $225 in FY18, FY17, FY16, FY15 and FY14, respectively. This amount reflects the allocation of all fixed costs across only professional (FNP, nurse care manager, and social work) visits, conducted with the support of drivers and office assistants, bilingual outreach workers, and the Wellmobile Program office. These visits were more time and cost intensive due to inclusion of outreach staff performing interpretation.

The increase in FY19 cost per visit from the previous fiscal year is attributable to increased faculty and staff salary increases and higher fringe rates. We anticipate continued salary and fringe benefit increases in upcoming fiscal years due to the ongoing demand for PCPs with continued implementation of the Patient Protection and Affordable Care Act (PPACA). Bilingual outreach workers interpret for the non-English-speaking population throughout the entire primary care visit, inclusive of intake, the NP and physician encounters, and post-visit health teaching and care management. Additionally, program contraction due to comparatively fewer available financial resources since FY10 resulted in allocation of administrative costs across lower visit volumes than the 4,762 FNP visits in FY09.

REGIONAL SERVICE AREA

Central Maryland Project and Report of Fiscal Year 2019 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 FY19. 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)
- 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 NP to conduct more visits. The care manager position was increased to full time in January 2014 to address this population's care management needs 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 at local supermarkets, warehouses, 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.

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. Over the past 12 years, a part-time field instructor from UMSSW has provided continuity in this effort. This faculty member decreased her effort to two days a week, effective Jan. 20, 2019.

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 most 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. 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 was 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 stayed 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. In anticipation of decreased funding in FY20, the nurse care manager and social worker began referring complex patients residing in Montgomery County to Montgomery Cares, which facilitated access to clinics in its network for eligible community residents, where they could receive continuity of specialty care. These patients may be transferred to these clinics in FY20.

Because of the persistence of waiting lists for new clients in FY19, 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 an 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.

Electronic Health Record Implementation

An electronic health record provides the secure platform for exchange of health information among partners of vertically integrated health systems, including patient-centered health homes. By easing transitions in care as patients are referred between health systems, an electronic health record is essential for partnerships and subcontracts with PCPs and FQHCs. In addition, concurrent access to the clinical record enhances continuity of care, saving time and effort in collating and filing paperwork.

An electronic health record:

- facilitates efficient operations, care management and quality assurance, and confidential patient, team, and referral communication and messaging
- links with patient medical records, resulting in streamlined documentation and record-keeping processes
- assures concise scheduling and accurate data collection of client encounters
- facilitates reporting of an unduplicated patient census by linking all encounters within a case

In FY18, the Wellmobile Program designated the HRSA-funded administrative supplement to engage two consultants from the National Nurse-led Care Consortium who provided expertise in electronic health record acquisition, implementation, and system optimization. Since funding did not support hardware, software, and licensing fees, other HRSA funds were rebudgeted to procure these items. Successful implementation of the newly acquired electronic health record required revising patient management and direct-service workflows to focus documentation and assure timely access to scheduling and clinical information. The electronic health record was implemented on May 1, 2018.

Since the work was not all completed, UMSON requested and HRSA granted a no-cost extension for FY19 to utilize the remaining administrative supplement to fund system optimization. The consultants tailored the electronic health record's scheduling and documentation features to meet the needs of an interprofessional nurse-managed collaborative practice. The NPs completed training on electronic prescribing. The consultants developed referral documents linked to the nurse practitioner encounters to capture orders for diagnostic testing and referrals to specialists, streamlining communication. The consultants customized nurse care manager and social work visit notes forms to conform to clinical documentation requirements. This enabled capture of discipline-specific actions for these encounters. All staff were trained on documentation of phone calls and secure messaging internal to the electronic record. Retraining occurred in group and individual sessions to assure adoption of additional features as they were created.

All FY19 documentation was captured in the electronic health record, facilitating more efficient operations. While documentation of schedules and encounters prior to May 1, 2018, remain paper-based, this information is now more readily accessible from the patient management and clinical documentation components of the electronic health record, facilitating more accurate and timely reporting.

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.

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 marginal health literacy.

The bilingual (English and Spanish) nurse care manager, outreach workers, and social work students work effectively with this multinational Latino community 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 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. The Wellmobile, through the ICTC partnership, continued to collaborate with UMCRH in FY19.

In 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

- CCLP, Langley Park, Prince George's County (an outreach site of 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

The following community partners provided access to health services and accepted referrals for Wellmobile clients:

- Brentwood Senior Center/UMCRH, Prince George's County
- CCHCN, Washington, D.C.
- CCI, Greenbelt, Prince George's County and Takoma Park, Montgomery County
- Community Radiology Associates, Montgomery and Prince George's counties
- Doctors Community Hospital, Lanham, Prince George's County
- Family Crisis Center of 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, Montgomery and Prince George's counties
- University of Maryland College Park Support, Advocacy, Freedom, and Empowerment Center, Prince George's 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 outside 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.

In FY19, 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, the Wellmobile declined participation in community events. Additionally, the Wellmobile Program remained committed to the established complex patient panel, who remained dependent on the Wellmobile providers for their usual source of care. Maintaining these patients, who received services under the recently completed HRSA IPCP that supported a primary care interprofessional practice and education model, is consistent with the Wellmobile's legislative charge.

Central Maryland 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 gave the social work faculty and students access to additional clients whose entry point to Wellmobile services were primarily social service needs. Langley Park and Bladensburg are two of six Prince George's County Transforming Neighborhoods Initiatives focused on uplifting six neighborhoods in the county that face significant economic, health, public safety, and educational challenges.

CLINICAL EDUCATION ACTIVITIES

A major component of the Governor's Wellmobile mission is educating successive generations of NPs 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 IPCP cooperative agreement funding facilitated the Wellmobile Program's accomplishment of 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 FY19, three RN-to-BSN students completed semester-long clinical rotations on the Wellmobile, directed by the nurse care manager. Twenty-three FNP/Doctor of Nursing Practice students assisted the FNPs in the exam room, conducting patient exams, diagnosing health problems, prescribing treatments and medications, and referring appropriate patients to specialists for consultation. Four doctor of pharmacy (PharmD) students and one post-graduate PharmD student rotated onto the Wellmobile. A second Pharm D student completed her capstone research requirements using data generated by the HRSA IPCP cooperative agreement. The nurse care manager continued to provide a practicum experience for the pharmacy students since the clinical pharmacist could no longer be supported once HRSA funding was no longer available.

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 conducting 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. Two clinical nurse leader students collaborated on a quality improvement project focusing on editing the electronic health record user manual and implementation of electronic referrals and orders.

RESEARCH AND PROGRAM EVALUATION

The Wellmobile Program offers a multitude of opportunities for research across diverse areas. While transitioning to the electronic health record and to manage the data required to generate invoices for projected primary care partnerships and ongoing reports, focus continued on the administrative effort in FY19 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 from and navigate the health care and social service systems. This important information also provides data for reports and future grant submissions. Program evaluation was completed as part of the HRSA Annual Performance, the Uniform Data System, and the Final Project reports.

Process and impact outcomes from overarching Wellmobile services and the HRSA IPCP cooperative agreement address the following research questions:

- 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?
- What is the effect of vertical integration with health systems' 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 IPCP-based team model and integration with a medical neighborhood improve patient outcomes?
- Can evidence-based health promotion programs be adapted to provide culturally and linguistically appropriate information for minority populations?
- 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 provided 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 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?
- 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?

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 disseminated 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:

- models of nurse-managed and team-based primary health care practice
- the role of the nurse in primary care
- innovative approaches to enhancing health care access for the underserved
- innovative delivery mechanisms and task-shifting
- health promotion and disease prevention in underserved communities
- cultural and linguistic competence
- patient activation
- deployment of outreach workers
- community and interprofessional partnership development
- rural and minority health care
- opportunities and barriers to fiscal sustainability in the era of health reform

In FY19, the Wellmobile program director and faculty delivered the following presentations at state and national conferences:

- Slaby, M., Pincus, K., Storr, C., Antol, S. Impact of interprofessional collaboration on diabetes care on the Governor's Wellmobile. Poster presented at: American Society of Health-System Pharmacists Midyear 2018 Clinical Meeting; 2018 Dec. 2-6: Anaheim, CA.
- Antol, S., Pincus, K., Storr, C. Fostering interprofessional team member collaboration to improve outcomes of complex nurse-managed health center mobile clinic patients. Poster presented at: Primary Care Annual Retreat; 2019 April 5; Baltimore, MD.
- Antol, S., Collins, C.S. An exploration of practice structure and registered nurses' roles and related skills and expertise in primary care practices in Maryland. Paper presented at: Proceedings of the 41st Association of Community Health Nurse Educators Annual

Institute on Culture of Health: Equity Thrives on Diversity; 2019 May 30-June1; Phoenix, AZ.

Other grant awards supported research, conference registrations, travel, and accommodations. Wellmobile faculty co-authored the following capstone paper submitted for publication in April 2019, by a PharmD student.

- Slaby, M., Pincus, K., Storr, C., Antol, S. Impact of an interprofessional collaborative practice model on processes of care in a safety-net clinic. *Journal of Interprofessional Care*.

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 Provider* 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. This supports designating the Wellmobile Program as an Essential Community Provider since it enhances the capacity of other health system providers.

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 coverage expansion.

Fiscal Partners

One of the biggest challenges facing the Wellmobile Program in FY19 continued to be securing second-level referral sources for specialty care and diagnostic services. More external consults were necessary due to the conclusion of HRSA funding, which previously supported pharmacy and family medicine consultation from FY16 to FY18. Other safety-net providers, including FQHCs and other providers treating the uninsured, access the same pool of resources and report the similar challenges. These include:

- linkages to PCMHs for primary care services

- access to secondary referral services, including sub-specialties such as:
    - 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 and to treat injuries
    - nephrologists and urologists to evaluate for urinary dysfunction
    - cardiologists for hypertension and heart failure
- affordable laboratory, imaging, and other diagnostic tests

During FY19, the Wellmobile care manager and social worker explored new contacts with health systems and clinics whose providers were willing to accept referrals for newly covered and uninsured complex Wellmobile patients. The intention was to fill the gap left by the FQHCs that predominantly serve Medicaid patients and the insured and left by the Spanish Catholic Center, which relocated its Takoma Park office to Silver Spring in 2011. Patients willing to travel to Silver Spring remained eligible for services on a case-available basis.

Despite receiving six referrals from the partnership with UMCRH ICTC, no patients kept their appointments in FY19. Hence, this partnership did not contribute to the Wellmobile's overall productivity. Due to low overall referral volume and lack of appointment adherence, UMB and UMCRH, after informing the Community Health Resources Commission, suspended the ICTC project in October 2019. UMCRH remained focused on reorganization and ongoing leadership restructuring and managing ongoing challenges related to uncompensated care and has not been a source of specialty and diagnostic resources. An opportunity exists to integrate the Wellmobile into the existing and future primary care infrastructure once the health system becomes operational at the new Largo facility.

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 to Doctors Community Hospital. To extend the medical neighborhood for IPCP patients, we renewed the Memorandum of Understanding with CCHCN for second-level referrals for Prince George's and Montgomery county residents. 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 Diagnostics invoiced the Wellmobile Program, which paid the bill from patient collections. Quest Diagnostics routinely reassesses and increases these fees annually, which the Wellmobile Program passes on to its patients.

Nurse Care Manager Position

Providing access to primary care services does not solve all 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, the urgency of continued primary care follow-up, the importance of following through with diagnostic and specialty referrals, and daily management of their overall health.

Given this patient profile, the Wellmobile Program budgeted a nurse care manager in an unfunded January 2013 HRSA grant submission and supplemented funding for this position in Central Maryland with funds raised through the University of Maryland Baltimore Foundation, Inc. (UMBF), based on availability. Recognizing 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 embedded on the Wellmobile 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 pharmacy 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 emergency department provides an avenue to specialty care, an option to which patients may resort when other means fail.

Fleet Maintenance

Maintaining the aging fleet of Wellmobile vans in the required operating condition to perform the program's legislatively designated missions remains an ongoing challenge. FY19 operating expenditures included maintenance of three Wellmobile vehicles, each requiring semiannual State of Maryland– and annual Federal Department of Transportation–mandated vehicle inspections, ongoing preventive maintenance for safety, and routine and unpredictable electrical and mechanical repairs. Three of the four vehicles were rotated in and out of service during FY19 to maintain functionality and sustain program operations while others were undergoing repairs and inspections. The 37-foot unit, purchased with HRSA funds in 1998, was excessed from the fleet in FY19 after 20 years of service. It was non-operational and require extensive repairs.

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 since the host sites have not installed the special electrical outlet to provide 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 FY15. Repairing and refurbishing mechanical and clinic equipment is ongoing. Minor repairs are made to maintain the interior clinic area infrastructure, secure, storage areas, and clinic equipment. These and other repairs to the aging fleet contributed to ever-increasing operational expenditures. The Wellmobile Program purchased fuel through the state of Maryland fuel program at State Highway Administration fueling stations and filed for tax rebates, which helped ameliorate fuel expenditures.

REDESIGN OF WELLMOBILE FUNCTIONS IN RESPONSE TO HEALTH CARE REFORM

In 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 seven fiscal years.

The 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 through December 2015. 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 refined its Bridge to Care model in January 2016 to incorporate an integrated primary care model implemented with an HRSA-funded IPCP cooperative agreement. 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, the interprofessional team 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** establishes 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 emergency departments and affiliated medical practices), urgent care centers, and health and human service agencies refer patients to the Wellmobile.

Eligibility determination creates a cohort of insured clients that can be referred to a patient-centered health home. Outreach work and social work efforts focus on health insurance plan enrollment and eligibility determination for state and federal entitlement programs such as Medical Assistance and Medicare. Social work and outreach staff also disseminate information on how to access the navigators and assistors for enrollment through Maryland Health Connection. Outreach staff and social work students assist patients in assembling documentation required for completing applications, facilitating MCO enrollment, and selecting PCPs.

Once the Wellmobile staff have assessed and treated immediate patient 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 wraparound 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. Providing clinical pharmacist consultation on the Wellmobile and building access to a medical neighborhood have enabled the program to retain a number of complex, uninsured patients with the addition of an advanced primary care interprofessional model.

Care management is the third model component. The Wellmobile continues to provide care to patients awaiting eligibility determination until they can be safely transitioned to the appropriate clinical practice. The average wait time for a new-patient appointment at clinics and practices accepting uninsured patients is typically two to three months. During this phase, the Wellmobile Program continues managing these patients, providing individualized physical and social assessments, lab 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 Prince George's and Montgomery counties, 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, including limited availability of those accepting Medicaid, also resulted in both insured and uninsured patients remaining under Wellmobile care for varying amounts of extended time. Factors influencing the duration that a patient may continue under Wellmobile Program management include:

- level of clinical stability or 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
- availability of an appointment slot in a PCMH

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 workups, prescriptions, and treatments for patients pending transfer. These patients are then transitioned, along with their medical history, in a relatively more stable condition than if they had self-referred to the practice or were referred by an emergency department. This attention to stabilizing the patient, including diagnosing and treating immediate conditions, and to the accompanying clinical documentation facilitates patient transfer and creates a climate of more willing acceptance by the receiving provider.

The sustained number of unduplicated patients demonstrates the trend towards a more long-term patient empanelment, 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 contribute to program fiscal sustainability.

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. These efforts were maintained through FY19. Although not a new model, the strategy required renewed and targeted efforts toward engaging a generation of new funders through grants, foundations, and business and community partnerships. When Wellmobile funding was robust, the expectation was that community partners would provide referrals, service sites, and in-kind services and 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 Bridge to Care model

provides the framework for the community partnership subcontractual model, one potential sustainability strategy.

Experience with this level of nurse-managed patient care in the Bridge to Care model provides evidence that the Wellmobile Program can 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 contribute to program fiscal sustainability.

The strategy of forging partnerships between the Wellmobile and health system–affiliated primary care practices, piloted on the Upper Eastern Shore with Chester River Health System/UM Shore Regional Health and funded by CareFirst, could be replicated with other University of Maryland Medical System network hospitals and expanded statewide to enhance fiscal sustainability concurrent with filling the gap in primary care practices. The goal was to achieve a fiscally sustainable model by the conclusion of the third project year by integrating the Wellmobile into the UM Shore Regional Health primary care system through subcontractual arrangements and potential incorporation into the health system–affiliated practices.

The February 2014 HRSA IPCP grant proposal submission, funded for FY16-18, was designed to replicate the CareFirst 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 the University of Maryland Medical System
- University System of Maryland academic institutions
- local and state health departments
- the Maryland State Department of Education and county school systems
- local community agencies and philanthropic organizations
- Medicaid Managed Care 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 2019 AND FISCAL YEAR 2020 FUNDING STATUS AND INITIATIVES

Combined federal, public, and private funds of $669,909.15 supported Wellmobile Program operations in FY19. UMBF received donations to the Wellmobile in FY19 from communities and individuals to the sole remaining UMB Foundation account available to supplement unanticipated time-limited Wellmobile operations.

UMSON continued to explore partnership opportunities with UMCRH executives to collaborate on projects of mutual priority. One such example was utilizing a Wellmobile for emergency department diversion. Due to the system's financial circumstances, this and other initiatives were not further developed.

The UMSON and UMSOP submitted program revision models to the Maryland Community Health Resources Commission (Patient-Centric Innovation to Care: Meeting Patients Where They Live) for consideration. These program modifications aimed to refocus community-based patients as the target population. The proposal included reduced funding for the Wellmobile through September 2018.

FISCAL YEAR 2020 PRIORITIES

The challenge to raise external funds to support care of the uninsured will continue in FY20. 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 corporate fundraising in UMBF accounts. However, these funds were depleted by the end of FY17. A funding source is needed to sustain the electronic health record in FY20, which was previously supported by HRSA. The program has not yet begun to benefit from access to patient information regarding utilization and outcomes. Furthermore, if the program is unable to garner sufficient funding from the state and other sources, UMSON will not be able to sustain the current level of Wellmobile operations in FY20. The annual state allocation is insufficient to cover staffing and repairs at the current level of service.

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. Wellmobile leadership is actively pursuing a partnership with a health delivery system to create sustainability. 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.

Other options include enlisting assistance from UMSON's Office of Development and Alumni Relations to locate, prepare, and submit education grants to foundations, 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. The Wellmobile Program will continue to pursue collaborative extramural funding opportunities with UMSON specialty program directors and other UMB professional education programs that provide faculty practice and service opportunities aligned with the mission of the Wellmobile Program. 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.

During this time of statewide and national transition in the delivery of primary 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 (decreased to 1.5 as of 1/1/2009)	0.5	4*	3
FY10 (7/1-8/15)	2.8	1.5	0.5	3*	3
FY10 (8/15-6/30)	0.6	0	0.5	2*	0.8
FY11	0.6	0	0.5	1.8*	0.75**-1.0
FY12	0.6 (increased to 0.8 as of 4/1/2012, 1.6 as of 4/16/2012)***	0	0.5	1.8	1
FY13	1.6	1 (increased to 1.5 as of 6/1/2013)	0.5	1.8	1
FY14	1.6	1.5 (increased to 1.8 as of 1/16/2014)	0.5	1.8	1
FY15	1.6	1.8	0.5	1.8	1
FY16	1.65 (decreased to 0.85 as of 7/1/2016)	1.8 (decreased to 1.3 as of 7/1/2016)	0.5	1.8 (decreased to 1.2 as of 5/1/2016)	1
FY17	0.85	1.3 (decreased to 0.08 as of 3/1/2017)	0.5	1.4	1
FY18	0.8	0.8	0.5	1.4	1
FY19	0.8	1.0	0.5 (decreased to 0.40 as of 1/20/2019)	1.4	1

The table above illustrates the Wellmobile staffing model, representing number of positions by full-time equivalents allocated across the operation of four Wellmobiles for FY09 and the first six weeks of FY10.

From Aug. 15 to June 30, 2010, and for FY11 and FY12, these positions were allocated across operations of one core Wellmobile and a second Wellmobile fulfilling additional educational and programmatic functions.

In FY13, FY14, and FY15, these positions were allocated across the operation of two Wellmobiles.

In FY16, due to program contraction from the Upper Eastern Shore with the decrease in operations to only one Wellmobile (Central Maryland), full-time equivalents were reduced.

Notes:

One full-time equivalent outreach worker is also a driver.

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

*** 0.8 full-time equivalent Upper Eastern Shore NP began orientation on April 16, 2012.

APPENDIX B: FISCAL YEAR 2019 WELLMOBILE BUDGET

Governor's Wellmobile Program—Financial Report FY19 (7/1/18-6/30/19)

Expenses:		
Personnel		
	Salaries	$ 454,067.64
	Fringe Benefits	$ 137,585.86
	Total Personnel	$ 591,653.50*
Operating		$ 54,928.90
Total Expenditures		$ 646,582.40
Revenues:		
	MHEC Funds	$ 285,000.00
	Other Sources	$ 361,582.40
		$ 646,582.40

*Note: $15,264.00 in salary and $3,972.04 in fringe related to program evaluation for mandatory HRSA Nurse Education, Practice, Quality, and Retention IPCP cooperative agreement reports and $5,234.21 for electronic health record consultation are included in the total budget. These personnel and operating expenses are excluded from the cost per visit calculation. Direct services salaries and fringe total equal $572,417.46. Direct operating expenses are reduced to $49,694.69. Total cost per visit is based on $622,112.15.

APPENDIX C: WELLMOBILE ADVISORY BOARD MEMBERS

WELLMOBILE ADVISORY BOARD MEMBERS
GOVERNOR'S WELLMOBILE PROGRAM FY19

MEMBER	AFFILIATION
Jane M. Kirschling, PhD, RN, FAAN	Chair Dean and professor, UMSON
Linda Roszak Burton	Business member
Joseline A. Pena-Melnyk	Maryland House of Delegates
Dottie Tiejen Li	Media member
Toni Thompson-Chittams	Health member
Craig A. Zucker	Maryland Senate
Vacant	Business member
Vacant	Health member
Vacant	Media member