Governor's Wellmobile Program

Fiscal Year 2020 Annual Report

University of Maryland School of Nursing

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EXECUTIVE SUMMARY

For the past 26 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 for expanding student learning opportunities in caring for underserved populations

FY20 was a year of transition for the Wellmobile Program, in three distinct phases. Efforts focused on sustaining the modified interprofessional collaborative practice (IPCP) implemented under Health Resources and Services Administration funding, operating with a reduced workforce subsequent to program contraction, and pivoting to telehealth during the COVID-19 pandemic. With all previous funding sources exhausted, the program was scaled down to one day a week in mid-October 2019. The patient panel was reduced over the course of the fiscal year to align optimal patient care with program funding and operational capacity.

The reconfigured Wellmobile Program continued to operate under a "Bridge to Care" model, filling the gap in Prince George's County's primary care infrastructure by managing patients who lacked access to community-based clinics and health care homes. Patients with complex health problems accessed advanced diagnostic services and intermittent specialty consultations through the medical neighborhood. Patients who could not be safely managed in this model and those with insurance and other clinic options were referred to available patient-centered medical homes (PCMHs). Telehealth became the vital asset for patient appointments as the COVID-19 pandemic unfolded and when access to other clinics was limited. In FY20, the Wellmobile service model included nurse practitioner (NP), nurse care management, outreach, and social work.

Service accomplishments include 638 NP, 183 nurse care manager, and 152 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. The State of Maryland's annual allocation of $285,250 supported Wellmobile Program operations in FY20. 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.

Sustaining the nurse-managed IPCP, an enhancement of the Bridge to Care model, demonstrated the feasibility of creating a statewide prototype responsive to health care reform initiatives ensuring access to care in the most underserved areas. The driving principles of the model were:

- facilitating interprofessional care tailored to community partner needs
- strengthening care management

- maintaining access during COVID-19-related restrictions
- exploring funded health system partners

Efforts continued to assure sustainability of the Wellmobile Program by securing 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. Sustained dialogue with potential new partners in Prince George’s County and other regions was interrupted by the COVID-19 pandemic.

The Wellmobile Program requires sufficient state funding to leverage a meaningful partnership with a health care system, to rebuild and 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, state funding 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 underserved populations.

GOVERNOR'S WELLMOBILE PROGRAM ANNUAL REPORT

UNIVERSITY OF MARYLAND SCHOOL OF NURSING

FISCAL YEAR 2020

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. 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 University of Maryland School of Nursing (UMSON) raised corporate and philanthropic donations to purchase the original mobile unit in 1994, outfitting it as a medical clinic. The existing Wellmobile Program is designed around three mobile health units with the capacity to travel throughout the state to provide health care services and education to underserved and uninsured populations. UMSON has been the institutional home of the program since its inception and leads community partners and private citizens in making the concept a reality.

STATE OF MARYLAND SUPPORT FOR PROGRAM EXPANSION

At its inception, the Wellmobile Program targeted improvement of maternal-child health through access to care. In 1998, a second mobile unit, funded by the Health Resources and Services Administration (HRSA), began serving the Eastern Shore. 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. The program deployed the original unit to serve a primarily uninsured adult population and those lacking access to health care in Central Maryland. This shift in priorities addressed 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:

- to provide primary and preventive health care services to geographically underserved communities and uninsured individuals across the state
- to 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 Health Resources and Services Administration (HRSA grant submission for a Western Maryland mobile unit was not funded, a private benefactor gifted the 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 the funds necessary to close the gap in program operating expenses. From 1999 to 2002, the program grew from one unit to four, servicing 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 the 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 underserved populations
- 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, Federally Qualified Health Centers (FQHCs), other health care providers, and local social service agencies, who became community partners.

FISCAL YEAR 2010 PROGRAM CONTRACTION

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. Level state funding could not keep up with rising marketplace personnel and operating expenses. Following the 50% reduction of FY10's allocation from $570,5000 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 or a new public-private partnership.

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 the 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 HEALTH SERVICES AND RESOURCES ADMINISTRATION 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. From FY16 to FY18, an HRSA Bureau of Nursing Cooperative Agreement funded interprofessional collaborative practice (IPCP) and education using an integrated care model on the Wellmobile. "Bridging Interprofessional Practice and Education with Integrated Care Through a Medical Neighborhood" provided salary support for a University of Maryland School of Medicine Department of Family and Community Medicine physician faculty member, a University of Maryland School of Pharmacy clinical pharmacist, an embedded bilingual nurse care manager, and an additional bilingual outreach worker. Funding for student and faculty/staff education in an IPCP 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 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 interprofessional collaboration. 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) enhanced the medical neighborhood for 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. The program completed the final year of HRSA-funded clinical implementation in FY18 and electronic health record (EHR) implementation in FY19. This grant was ineligible for renewal, resulting in service reduction to one day a week in October 2019.

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, a family nurse practitioner (FNP) on UMSON's faculty, a nurse care manager, and a social worker. 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 uninsured patients. 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 to diagnose and treat common acute and chronic illnesses across the lifespan. An increasingly aging population receive care for chronic conditions such as diabetes, hypertension, and hyperlipidemia. FNPs order diagnostic tests, prescribe generic prescriptions, and initiate specialty referrals to stabilize the patient. The social work faculty 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), age-specific screenings, and clinical exams as well as 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. 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.

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 constant for those 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 provides 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.

The social worker, bilingual nurse care manager, and outreach staff identify community resources and agencies, including other local safety-net health providers willing to accept specialty referrals and transfers to a permanent medical home. When patients 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 primary care provider (PCP). Uninsured patients with chronic and unmanageable acute conditions and comorbidities 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.

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 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.

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. The director is responsible for overall program administration, including:

- administrative support for patient management
- community-partnership development
- fundraising and grant writing
- office and medical equipment and supply management
- payment of invoices
- policies and procedures
- planning and evaluation
- program development
- regulatory compliance and quality assurance

- reports
- staffing

The Wellmobile Program provides these services in the 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 uninsured patients, whom providers means test to determine eligibility for sliding-fee and pro bono arrangements.

BRIDGE TO CARE MODEL

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 PCMH and the increasing role of FQHCs in primary care for underserved populations 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 cooperative agreement. While the Wellmobile Program as a stand-alone entity cannot function as a health care home, this model of care 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: increasing access, eligibility determination, and care management. Each are instrumental in the role of the Wellmobile Program as a gap-filling resource. Program contraction in FY20 accelerated the transition of primarily complex uninsured and newly insured patients to medical homes in local FQHCs. Among these health homes are FQHCs, outpatient clinics, and private physicians that accept the patient's newly established health coverage or offer sliding-scale fees for uninsured patients. The unmet demand for primary care in Prince George's County, complicated by the COVID-19 pandemic, resulted in both insured and uninsured patients remaining under Wellmobile care for varying amounts of extended time. Building access to a medical neighborhood has enabled the program to retain a

number of complex, uninsured patients with the addition of an advanced primary care interprofessional model.

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 receiving 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.

ELECTRONIC HEALTH RECORD

An EHR 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 EHR is essential for partnerships and subcontracts with PCPs and FQHCs. Concurrent access to the clinical record enhances continuity of care, saving time and effort in collating and filing paperwork. An EHR:

- 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 EHR, implementation, and system optimization. Effective with EHR implementation on May 1, 2018, all documentation was captured in the system, facilitating more efficient operations. While documentation of schedules and encounters before May 1, 2018, remains paper-based, subsequent information is now more readily accessible from the patient management and clinical documentation components of the EHR, facilitating more accurate and timely clinical decisions and reporting. With the advent of COVID-19, EHR access enabled the NP and outreach worker to access schedules and medical records remotely while the EHR platform facilitated virtual telehealth visits.

WELLMOBILE IMPACT

The mobility of the Wellmobiles 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. 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 FY20, HRSA awarded 16 Maryland FQHCs a total of $1,261,684 in Quality Improvement grants, of which $51,750 targeted enhanced access.[1] 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, 2019, Maryland residents could enroll in both Medicaid and qualified health plans through the Maryland Health Connection, a single-entry point for coverage through Medicaid expansion and private health plans. Its website, marylandhealthconnection.gov, provided enrollment assistance from grant-funded navigators and assistors. This created the fifth cohort of newly insured beneficiaries, effective Jan. 1, 2020. In response to the Coronavirus State of Emergency, Maryland Health Connection added an additional enrollment period between March 16 and June 15 to facilitate insurance sign-up for uninsured.

Wellmobile services continued to be in high demand, based on reports 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 may reflect sustained increased demand by the newly insured for PCPs in clinics and private practices. The onset of COVID-19 further delayed transition of patients to a PCMH as primary offices limited appointments and engaged in virtual visits.

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 26 years. This has become increasingly important since the Maryland All-Payer Model Agreement, 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

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[1] Health Center Quality Improvement FY 2020 Grant Awards (August 2020). HRSA. U.S. Department of Health and Human Services.
https://bphc.hrsa.gov/programopportunities/fundingopportunities/qualityimprovement/states/MD.html.

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, increased access to coverage, facilitated by Maryland Health Connection to increase health care coverage during the COVID-19 pandemic, will further strain health plan provider 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 2020 FUNDING

The FY20 legislative allocation of $285,000 funded the annual operations. 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 these Wellmobile-designated funds to provide services and fund operating costs in FY20. The COVID-19 pandemic affected the ability to hire a replacement commercially licensed driver and spend associated mobile-unit-personnel and operating expenses.

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 participation in partnership-development activities to address utilizing a mobile health approach to respond to COVID-19. Efforts continued to advance the role of the Wellmobile as a nurse-managed safety-net provider in collaboration with health systems to improve access to care and positively impact population health.

FISCAL YEAR 2020 PERFORMANCE, IMPACT, AND PARTNERSHIPS

A limited budget—resulting in program contraction and elimination of NP and nurse care manager positions, the inability to retain a commercially licensed driver, and the shift to remote work during the COVID-19 pandemic—limited the program's impact in FY20. During the first quarter of the fiscal year, the program focused on sustaining care in five communities in Prince George's and Montgomery counties. Meanwhile, staff triaged patients to retain a subset of the panel to maintain a modified interprofessional primary care clinical service model at one Prince George's County community site when the program contracted. Patients with complex health problems were among the half of the patient panel that staff assisted in locating alternative medical homes. These patients required extensive case management and access to the medical neighborhood to provide specialty care that could not be met exclusively by the Wellmobile care team in a service-reduction model.

OVERALL RECIPIENT IMPACT AND COST EFFECTIVENESS

In FY20, the program provided FNP primary care, nurse care management, social work, and outreach work. During that year, 323 new and established patients received 638 primary care FNP visits and 183 nurse care manager visits. The social worker conducted 47 visits to Wellmobile patients and an additional 105 encounters to social work–only patients. The latter category of patients received both health- and non-health-related assistance. The decrease from 2,490 professional visits in FY19 to 973 in FY20 is attributable to program contraction to one day a week after the first quarter of the fiscal year and a shift to telehealth in March 2020.

The social worker or nurse care manager met with patients after the primary care visit to provide additional case management and health care system navigation assistance based on individualized needs. Interventions included referrals for 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.

Social workers completed applications for enrollment in the CCHCN's specialty provider programs and those from area health systems. Social work encounters ranged from assistance with applications for medical benefits (e.g., Medicaid, CHIP, Medical Care for Children Partnership, and county-specific breast and cervical cancer treatment programs [BCCPs]) to referrals to community programs for emergency assistance, social programs (including legal), and food stamps. The scope of social work outreach included campaigns to raise awareness of entitlement programs, screenings for eligibility, assistance in completing applications, and follow-up on pending eligibility determination. 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. 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. The social worker conducted additional community-based encounters at the Comunidad Católica de Langley Park (CCLP) (Catholic Community of Langley Park) Outreach Center one half-day per week, in addition to social work interventions conducted on the Wellmobile.

The following table summarizes the above-described activities.

FISCAL YEAR 2020 CENSUS AND CLINICAL ENCOUNTERS AND REFERRALS

Unduplicated Medical Patients	Primary Care Encounters	Nurse Care Management Encounters	Medical Social Work Encounters	Social Work Only Encounters
323	638	183	47	105

FISCAL YEAR 2020 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
31	12	132

According to Consumer Health Ratings, the average cost of an emergency department visit in the U.S. was $1,150, compared with an average of $222 for a physician visit.[2] 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 $110,055 in emergency department visit expenditures. Thus, the estimated cost avoidance benefited 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.

Consumer Health Ratings also reports the average cost per patient of a medical visit in 2020 was $335. The market value of the average professional encounter on the Wellmobile (primary care, nurse care management, and social work) in FY20 was $298, compared with $260 (FY19), $220 (FY18), $244 (FY17), $226 (FY16), $197 (FY15), and $225 (FY14). This amount reflects the allocation of all fixed costs across only professional visits (FNP, nurse care manager, and social worker), conducted with the support of the driver, bilingual outreach workers, and the Wellmobile Program office. Bilingual outreach workers interpret for the non-English-speaking population throughout the entire primary care visit with the NP, inclusive of intake, and during post-visit health teaching and care management when not conducted by the bilingual nurse care manager. Wellmobile visits were more time and cost intensive due to inclusion of outreach staff performing interpretation.

The increase in the FY20 cost per visit from the previous fiscal year is attributable to increased faculty and staff salaries and 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). 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.

[2] "Doctors' Charges, Physician Prices, Average Cost, Anesthesia," Consumer Health Ratings, https://consumerhealthratings.com/healthcare_category/doctors-charges-physician-prices-average-cost-anesthesia/ accessed January 6, 2023

REPORT OF CENTRAL MARYLAND FISCAL YEAR 2020 ACTIVITIES

WELLMOBILE SERVICE SITES

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.—was sustained in FY20. The Central Maryland Wellmobile provided services three days per week through Oct. 17, 2020, 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 Station Apartments (Greenbelt)

Subsequent services continued weekly at CCLP. In Montgomery County, the Wellmobile provided services one day a week at the Seventh-Day Adventist Church in Takoma Park through Oct. 16, 2020.

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.

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 Station 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:

- University of Maryland Capital Region Health at the Gwendolyn Britt Senior Activity Center, Brentwood, Prince George's County
- CCHCN, Washington, D.C.
- Community Clinic Inc., 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
- 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

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.

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.

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.

In anticipation of decreased funding in FY20, the nurse care manager and social worker referred Montgomery County residents to Montgomery Cares, which facilitated access to a network of clinics for eligible community residents, assuring continuity of care. The Wellmobile Program referred patients to Community Clinic's Franklin Park clinic in Greenbelt (Prince George's County) and Takoma Park (Montgomery County) and Mary's Center Silver Spring

(Montgomery County) and Adelphi (Prince George's County) sites. With a three-month average wait time for an appointment at these FQHCs, securing appointments for Prince George's County residents was difficult. As a result of persistent waiting lists for new clients, the Wellmobile served as the interim care provider, managing patients until they were transferred to a PCMH. The nurse care manager and social worker continued to provide referral information and guidance on primary care access options. These patients remained under the care of the Wellmobile FNP until they were accepted into care. Stable patients and those amenable to Wellmobile intermittent management were retained on the Wellmobile panel.

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 served by the Wellmobile Program are uninsured, face complex medical and social challenges, 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. With the transition to telehealth prompted by COVID-19 restrictions, the outreach worker provided instruction on how to engage in telehealth visits. The outreach worker provided interpretation during telehealth visits for Spanish-speaking patients.

The social worker and bilingual (English and Spanish) nurse care manager and outreach workers 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.

EDUCATION AND SERVICE ACCOMPLISHMENTS

COMMUNITY EDUCATION AND OUTREACH

Health education and outreach services are essential components of the Wellmobile primary care delivery model. In FY20, the Wellmobile Program remained committed to serving as many patients on the established panel as possible, 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 Outreach Center, continuing the commitment to provide these services in a more economically feasible manner. Social work faculty conducted community outreach and provided consultations and assistance with human services applications at CCLP. This space gave the social work faculty access to additional clients whose entry point to Wellmobile services were primarily social service needs. Langley Park and Bladensburg are two of the six Prince George's County neighborhoods in the county's Transforming Neighborhoods Initiative, which focuses on uplifting county neighborhoods 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 for underserved populations. The significance of this educational mission is underscored by federal health care reform legislation, which emphasizes prevention, public health, and enhancement of the primary care infrastructure. HRSA IPCP cooperative agreement funding facilitated accomplishing the Wellmobile Program's 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 fulfill clinical practicum course requirements by engaging in these experiences, designed to provide mutual benefit to the target population and students. In FY20, the FNPs precepted two FNP students. Support for placement of nursing and social work and additional FNP students with clinical hour requirements was insufficient with a reduction in the staffing model to once a week and elimination of the nurse care manager position. Additional students could not be accommodated during the shift to virtual care at the onset of the pandemic.

RESEARCH AND PROGRAM EVALUATION

The Wellmobile Program offers a multitude of opportunities for research across diverse areas. To manage the data required to generate invoices for projected primary care partnerships and ongoing reports, administrative effort focused on encounter-level data collection methodologies, documentation adherence by Wellmobile staff providing clinical and enabling services, and refining data points, including telehealth visits. 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.

Process and impact outcomes from overarching Wellmobile services 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?
- What is the perceived impact of an IPCP model on Wellmobile providers and student learners?
- What is the impact of the shift to telehealth visit on patient retention and clinical outcomes?

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:

- Are mobile health units effective and efficient in increasing access to primary care in uninsured and underserved populations?
- Can national evidenced-based practice guidelines and standards be translated into care provided to an uninsured population?
- Can evidence-based health promotion programs be adapted to provide culturally and linguistically appropriate information for minority populations?
- Can health promotion activities and routine physical assessments and screenings conducted among relatively healthy uninsured populations defer the onset of chronic diseases and/or improve early detection?

NATIONAL PRESENTATIONS AND PUBLICATIONS

As both a clinical and faculty practice site for UMSON, the Governor's Wellmobile Program is a valuable source for learning and applying best practices. UMSON faculty members 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 underserved populations
- innovative delivery mechanisms and task-shifting
- health promotion and disease prevention in underserved communities
- patient activation
- community and interprofessional partnership development
- rural and minority health care
- opportunities and barriers to fiscal sustainability

In FY20, the Wellmobile Program director delivered the following presentations at national conferences:

> **Antol, S.**, Parsons, L. (2020, October 30). *Nursing Specialty Showcase: Ambulatory care nursing*. National Student Nurses' Association 38th 2020 Midyear Conference. Virtual. (Invited)
>
> **Antol, S.**, Stalter, A., & Turner-Bicknell, T. (2021, June 9). *Responding to dual public emergencies—Advocating for tomorrow's community public health nurse leaders.* Association of Community Health Nursing Educators. 43rd Annual Institute. Advocacy in Community/Public Health Nursing Policy, Education, and Research. Virtual Preconference Workshop. (Peer reviewed)

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 underserved populations and establish a role for the program in the rapidly evolving restructuring of health care delivery. The Wellmobile Program director is a member of the American Academy of Ambulatory Care Nursing Academic Practice Partnership Task Force, which is engaged in curating best practices for establishing ambulatory care practice sites to provide nursing clinical education in ambulatory care settings.

PROGRAM ADMINISTRATION AND FUTURE STRATEGIC DIRECTIONS

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 implemented, attention was refocused on sustainability strategies, including identification of supplemental funding streams. These efforts were maintained through FY20. 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 is evident in 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 UM Medical System network hospitals and expanded statewide to enhance fiscal sustainability concurrent with filling the gap in primary care practices. At the conclusion of the project, the program submitted data to health system leadership on the number of insured patients and potential billable visits. 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 HRSA IPCP cooperative agreement award replicated the CareFirst sustainability model in Central Maryland. Implementing an IPCP by adding a family medicine physician and clinical pharmacist to the team facilitated the primary aim: retaining existing, newly insured, and complex patients on the Wellmobile panel.

Both projects demonstrated that a nurse-managed mobile-unit model could successfully manage and improve health outcomes on panels of complex patients. 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 Maryland Higher Education Commission (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 potential partnership exploration activities are:

- FQHCs
- Rural and urban hospital systems, including the UM Medical System
- Local and state health departments for COVID-19 management
- Maryland State Department of Education and county school systems
- Local community agencies and philanthropic organizations

- Medicaid MCOs

The Wellmobile Program is actively pursuing partnerships with health systems to collaborate on innovative approaches aligning patient encounters with community-based primary care practices close to their facilities and in their communities. In this proposed model, the Wellmobile Program can enhance the capacity of existing health delivery systems, specifically primary care, and prevention initiatives aimed at reducing costs and health disparities. 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.

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 FY20 continued to be securing second-level referral sources for specialty care and diagnostic services. More external consults were necessary to fill the gaps in pharmacy and family medicine consolations since the conclusion of HRSA funding. Other safety-net providers, including FQHCs and other providers treating uninsured populations, 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

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 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. 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.

Wellmobile patients benefit from an array of reduced-fee lab services from Quest Diagnostics. Quest Diagnostics routinely reassesses and increases these fees annually, which the Wellmobile Program passes on to its patients.

Targeting Funding to Restore Eliminated Faculty Practice Positions

Providing access to primary care services does not solve all the problems of uninsured and underserved patients. 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, and the importance of following through with diagnostic and specialty referrals and daily management of their overall health. Incorporation of other health professionals, such as a nurse care manager and social worker, are essential steps to reconstitute the interprofessional team.

An embedded bilingual nurse care manager, complemented by social work and outreach work efforts, facilitates care coordination and links patients to specialty care; oversees clinic flow, outreach, and scheduling activities, including medical records; and precepts entry-level community health and master's nursing students. Central Maryland clients include concentrated pockets of Latino and African populations, who are predominantly uninsured. Recognizing the value of care management and the need to educate future ambulatory care nurse care managers, future proposal submissions have included a nurse care manager position in the line-item budget. An embedded bilingual nurse care manager role on the Wellmobile has enhanced linkages of clients to secondary and tertiary care services, supplementing social work and outreach work efforts. Similarly, the Wellmobile will seek funding opportunities for social work clinical faculty to address social determinants of health and provide clinical opportunities for the future social work pipeline.

Fleet Availability and Maintenance

Opportunities to reactivate a Wellmobile to resume visits were deferred due to ongoing discussions with the Maryland Department of Health for their use to address the COVID-19 pandemic. On June 11, 2020, Gov. Larry Hogan informed acting president Dr. Bruce Jarrell that all three Wellmobiles would be commissioned for COVID-19 testing statewide. Maintaining the aging fleet of Wellmobile vans in the required operating condition to perform the program's legislatively designated missions remains an ongoing challenge. FY20 operating expenditures included maintenance of three Wellmobile vehicles, each requiring semiannual vehicle inspections as mandated by the State of Maryland and the U.S. Department of Transportation, ongoing preventive maintenance for safety, and routine and unpredictable electrical and mechanical repairs. In early FY20, three vehicles were rotated in and out of service to maintain

functionality and sustain program operations while others were undergoing repairs and inspections.

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, which helped ameliorate fuel expenditures.

SUMMARY OF FISCAL YEAR 2020 AND FISCAL YEAR 2021 FUNDING STATUS AND INITIATIVES

The University of Maryland Baltimore Foundation Inc. (UMBF) received donations to the Wellmobile in FY20 from communities and individuals to the sole remaining UMBF 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 effort proposed utilizing a Wellmobile for emergency department diversion. Due to the system's financial circumstances, and the onset of the COVID-19 pandemic, this and other initiatives were not further developed.

The Wellmobile Program submitted the following proposal for funding in FY2020:

Proposal to M Power Covid Response Fund. (2020, June 9). University of Maryland SAFE Center for Human Trafficking Survivors & UMB School of Nursing. (not funded)

FISCAL YEAR 2021 PRIORITIES

Reactivating additional Wellmobiles and rebuilding the statewide program remains a UMSON priority because the Wellmobile Program serves as an interprofessional clinical education site for UMSON NP, community health nursing and other health professions students and is a faculty practice that enables nursing, social work, and potentially additional faculty from the other health professions to maintain professional certification while simultaneously providing clinical education for future health professionals. Clinically competent faculty members model evidence-based and IPCP 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.

The challenge to raise external funds to support care of the uninsured will continue in FY21. The program is dependent on supplemental funds to sustain previous personnel and operational fiscal obligations, which in past years have been supported by dedicated corporate fundraising in UMBF accounts. Funding is needed to sustain the EHR in FY21. The program has just 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 need to continue the current one-day-a-week level of Wellmobile operations in FY21. The annual state allocation is insufficient to cover staffing, operations, and repairs at a higher 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 IPCP. 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 and its role in addressing the COVID-19 pandemic, 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 Jan. 1, 2009)	0.5	4*	3
FY10 (July 1–Aug. 15)	2.8	1.5	0.5	3*	3
FY10 (Aug. 15–June 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 4/1/12, 1.6 as of April 16, 2012)***	0	0.5	1.8	1
FY13	1.6	1 (increased to 1.5 as of June 1, 2013)	0.5	1.8	1
FY14	1.6	1.5 (increased to 1.8 as of Jan. 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 July 1, 2016)	1.8 (decreased to 1.3 as of July 1, 2016)	0.5	1.8 (decreased to 1.2 as of May 1, 2016)	1
FY17	0.85	1.3 (decreased to 0.08 as of March 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 Jan. 20, 2019)	1.4	1
FY20	0.8 (decreased to 0.2 as of Oct. 16, 2019)	1.0 (eliminated Oct. 9, 2019)	decreased to 0.20 as of Oct. 9, 2019	decreased to 0.25 as of Oct. 9, 2019	decreased to 0.25 Oct. 9, 2019 (vacant)

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 that fulfilled 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 2020 WELLMOBILE BUDGET

GOVERNOR'S WELLMOBILE PROGRAM—FINANCIAL REPORT FY20 (JULY 1, 2019– JUNE 30, 2020)

Expenses:			
	Personnel		
		Salaries	$ 202,796
		Fringe Benefits	$ 56,078
		Total Personnel	$ 258,874
	Operating		$ 31,304
	Total Expenditures		$ 290,178
Revenues:			
	State of Maryland Allocation		$ 285,000
		Other Sources	$ 5,178
			$ 290,178

APPENDIX C: WELLMOBILE ADVISORY BOARD MEMBERS

WELLMOBILE ADVISORY BOARD MEMBERS: GOVERNOR'S WELLMOBILE PROGRAM FY20

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