Governor's Wellmobile Program

Fiscal Year 2021 Annual Report

University of Maryland School of Nursing

EXECUTIVE SUMMARY 1
BACKGROUND AND HISTORY 3
PARTNERSHIP MODEL 3
STATE OF MARYLAND SUPPORT FOR PROGRAM EXPANSION 3
FISCAL YEAR 2010 PROGRAM CONTRACTION 4
FISCAL YEAR 2012 CAREFIRST FUNDING 4
FISCAL YEAR 2016 HRSA COOPERATIVE AGREEMENT 5
WELLMOBILE PROGRAM SERVICE MODEL 5
BRIDGE TO CARE MODEL 7
ELECTRONIC HEALTH RECORD 8
WELLMOBILE IMPACT 9
FISCAL YEAR 2021 FUNDING 10
FISCAL YEAR 2021 PERFORMANCE, IMPACT, AND PARTNERSHIPS 10
OVERALL RECIPIENT IMPACT AND COST EFFECTIVENESS 11
REPORT OF CENTRAL MARYLAND FISCAL YEAR 2021 ACTIVITIES 11
Community Partners 11
Health Disparities Impact 13
EDUCATION AND SERVICE ACCOMPLISHMENTS 13
COMMUNITY EDUCATION AND OUTREACH 13
CLINICAL EDUCATION ACTIVITIES 13
RESEARCH AND PROGRAM EVALUATION 14
NATIONAL PRESENTATIONS AND PUBLICATIONS 14
OPERATIONAL CHALLENGES 15
Fiscal Partners 15
Procuring Funding to Restore Eliminated Faculty Practice Positions 16
Fleet Availability and Maintenance 17
FUNDING AND STRATEGIC SUSTAINABILITY INITIATIVES 17
SUMMARY OF FISCAL YEAR 2021 AND FISCAL YEAR 2022 FUNDING STATUS AND INITIATIVES 19
FISCAL YEAR 2022 PRIORITIES 19
APPENDIX A: WELLMOBILE STAFFING 22
WELLMOBILE STAFFING COMPARISONS BY FISCAL YEAR 22
APPENDIX B: FISCAL YEAR 2021 WELLMOBILE BUDGET 24
GOVERNOR'S WELLMOBILE PROGRAM—FINANCIAL REPORT FY21 (JULY 1, 2020–JUNE 30, 2021) 24

APPENDIX C: WELLMOBILE ADVISORY BOARD MEMBERS 25
WELLMOBILE ADVISORY BOARD MEMBERS: GOVERNOR'S WELLMOBILE PROGRAM FY21 25

EXECUTIVE SUMMARY

For the past 27 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

The Governors Wellmobiles were not deployed for program activities in FY21 due to their deployment by the Maryland Department of Health for COVID-19 testing and vaccination efforts. Alternatively, the Wellmobile Program continued to sustain the nurse-managed primary care practice by engaging patients through telehealth visits while developing a plan for reentry into the Langley Park community. Efforts focused on sustaining the family nurse practitioner's (FNP) patient panel, supported by the outreach worker and the electronic health record. The program continued to operate with this reduced workforce effected in FY20 after program contraction. The patient panel was reduced to 127 from 323 over the course of the fiscal year, driven by patient acceptance of telehealth visits and the absence or availability of other primary care options.

The reconfigured Wellmobile Program continued as 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 continued to access advanced diagnostic services, although access to specialty consultations through the medical neighborhood was limited. Patients who could not be safely managed in this model or those with other clinic options sought care at available sites. The goal was to maintain access to primary care during COVID-19 restrictions and prevent emergency room admission for COVID-19 by directing patients to available testing and access to treatment and vaccines. In FY21, Wellmobile service model was limited to 325 FNP telehealth visits, supported by the outreach worker and program director.

$164,032 of the State of Maryland annual allocation supported program personnel and other personnel and operating costs. The Wellmobile Program's Bridge to Care and care management 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 practice, a modified 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. Efforts to secure funding and activate a reentry plan included:

- engaging community partners and health care systems and public health in collaborations that entail a mobile health solution for pent-up primary care
- engaging state health departments, local health systems, and community partners interested in collaborations that include a mobile health solution to address COVID-19
- exploring funded health system partners to resume in-person health services in the Langley Park (Prince George's County) community
- drafting a reentry plan

Sustained dialogue with potential new partners in Prince George's County and other regions continued despite the persistence of the COVID-19 pandemic. 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 patient-centered medical homes and to secure an arrangement with a medical center to collaborate on technology infrastructure for sustainability and billing.

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 2021

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:

- 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 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 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 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.

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 shift in funding profiles 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 and is accessible to UMSON's Baltimore and Universities at Shady Grove (Rockville) students.

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 (FY12–15) 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 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. 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 (UMSOM) Department of Family and Community Medicine physician faculty member, a University of Maryland School of Pharmacy (UMSOP) 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 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 Wellmobiles were not utilized for primary care services in FY21 due to deployment in support of state COVID-19 mitigation efforts. The core staffing model includes a

faculty family nurse practitioner (FNP) and a driver/outreach 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 populations. 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 current program, staffed by an FNP and outreach worker, provides the following services via telehealth:

1. **Clinical care:** The FNP conducts physical exams and diagnose and initiates treatment for common acute and chronic illnesses across the lifespan. An increasingly aging population receive care for chronic conditions such as diabetes, hypertension, and hyperlipidemia. The FNP orders diagnostic tests, prescribes generic prescriptions and over-the-counter medications to stabilize the patient, and initiates referrals for diagnostic and specialty consultations to providers available through the medical neighborhood.

2. **Life-cycle-specific screenings:** While the FNP traditionally performs physicals, including age-specific screenings to identify and diagnose chronic and acute health problems within the context of a primary care encounter, the physical exam portion could not be completed during telehealth visits. Instead, cervical cancer screenings were 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, in addition to the colonoscopies and mammograms that they were already performing.

3. **Care management and service linkages, referrals, and system navigation**: The FNP assumed management 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.). 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. In a fully funded staffing model, a social worker and/or a nurse care manager would assist patients who need such services or specialty health care to locate and obtain local, state, and federal resources. The FNP refers complex patients with chronic and unmanageable acute conditions and comorbidities who cannot be effectively managed by a one-day-a-week telehealth model to FQHCs or other willing providers.

4. **Health promotion:** Educating patients in health promotion, disease prevention, developmentally specific immunization and screening thresholds, and COVID-19 infection-control measures is the cornerstone of nurse-managed health care. The FNP, supported by the bilingual outreach worker, instructed patients on self-management and disease management.

The Wellmobile FNP and outreach worker function collaboratively, maximizing efficiency and cost effectiveness. 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 worker 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
- planning and evaluation
- policies and procedures
- program development
- regulatory compliance and quality assurance
- reports
- staffing

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. The FNP initiates 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 for whom having a provider means getting tested 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 patient-centered health home model 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 a 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. The unmet demand for primary care in Prince George's County, complicated by COVID-19, resulted in both insured and uninsured patients remaining under Wellmobile care for varying amounts of extended time.

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 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 primary care providers (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

Since May 1, 2018, all documentation was captured in the system, facilitating more efficient operations. While previous schedules and encounters remain 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. During the COVID-19 pandemic, EHR access has enabled the NP and outreach worker to access schedules and medical records remotely while its platform facilitated virtual telehealth visits.

WELLMOBILE IMPACT

The mobility 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 that are less likely to attract health professionals. Prince George's County patients served by the Wellmobile Program reside in federally designated medically underserved areas, health professional shortage areas, or medically underserved populations.

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 FY21, HRSA awarded Maryland FQHCs a total of $7.2 billion and an additional $82,964,846 in COVID-19 funding (HRSA Fact Sheet, FY 2021 – Maryland, data as of 9/30/2021). These awards did not sufficiently expand primary care services and were insufficient for ameliorating the demand for primary care in Prince George's County. Wellmobile services continued to be in high demand, based on reports of long wait times when Wellmobile patients attempted to schedule an initial appointment at an FQHC. This may reflect primary offices' limited appointments and virtual visits and sustained demand due to the COVID-19 pandemic.

Between Nov. 1 and Dec. 15, 2020, 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. It's website, *marylandhealthconnection.gov*, provided enrollment assistance from grant-funded navigators and assistors. This created the sixth cohort of newly insured beneficiaries, effective Jan. 1, 2021.

Without telehealth visits by the Wellmobile FNP, 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 27 years. This remains 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, increased access to coverage—facilitated by Maryland Health Connection to increase health care coverage during the COVID-19 pandemic and patient readiness to seek care to address pent-up health needs—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 2021 FUNDING

The Wellmobile Program expended $164,032 to provide services and fund operating costs in FY21. 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 unavailability of the Wellmobiles and the COVID-19 pandemic negatively impacted the ability to reactivate the Wellmobile Program hire a replacement CDL driver, and spend additional 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 the COVID-19 pandemic. 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 2021 PERFORMANCE, IMPACT, AND PARTNERSHIPS

Program contraction and elimination of FNP and nurse care manager positions in FY20, retirement of the social worker in FY21, and the shift to remote work during the COVID-19 pandemic, limited the program's FY21 impact. Resumption of in-person care and direct participation in COVID-19 efforts were not feasible due to the loan of one Wellmobile to the University of Maryland College Park (UMCP) for COVID-19 mitigation research and pending deployment of the remaining two units to the Maryland Department of Health. The FNP focused on sustaining care using a telehealth model.

OVERALL RECIPIENT IMPACT AND COST EFFECTIVENESS

In FY21, 127 established patients received 325 primary care FNP visits. This decrease from 973 professional visits in FY20 was attributable to program contraction to one day a week after the first quarter of the fiscal year, elimination of the nurse care manager, retirement of the social worker, and continued reliance on telehealth visits since March 2020. In addition to continuity of care, a goal during the telehealth visit was to evaluate patient status with respect to COVID-19 exposure, assess symptoms, advise on preventive infection-control measures, and provide guidance on when and how to access testing sites and vaccination clinics. Patients kept the FNP advised of their symptoms, positive diagnoses, and hospitalizations during telehealth visits and in phone calls triaged by the outreach worker.

Consumer Health Ratings reports the average cost per patient of a medical visit in 2020 was $335. The market value of FNP telehealth encounter in FY21 was $407. Costs related to the purchase of telemedicine equipment and Wellmobile maintenance were excluded from the calculation, as telehealth visits were completed without these services. This amount reflects the allocation of personnel and office supplies, including the EHR across FNP telehealth visits and care management activities, conducted with the support of the bilingual outreach worker and the Wellmobile Program office. The bilingual outreach worker provides interpretation for the non-English-speaking population throughout the entire primary care visit with the NP and during post-visit health teaching and care management. Wellmobile visits are more time and cost intensive due to inclusion of outreach staff performing interpretation.

The increase in the FY21 cost per visit, from $298 in FY20, is attributable to increased faculty and staff salary and fringe rates and an approximate two-thirds reduction in visits. 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.

REPORT OF CENTRAL MARYLAND FISCAL YEAR 2021 ACTIVITIES

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. 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 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
- 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
- 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
- Montgomery Cares, Montgomery County
- Montgomery County Department of Health and Human Services
- 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 FNP 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 and in Langley Park with FY10 and FY20 respective program contractions.

The PCMH is an integral concept in the PPACA. Throughout the COVID-19 pandemic, the Wellmobile Program sustained its commitment as the "front door" for numerous uninsured and underserved residents of Prince George's and Montgomery counties. 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 Prince George's and Montgomery counties.

With a three-month average wait time for an appointment at these FQHCs, securing appointments for Prince George's County residents remained 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 FNP 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 for all appointments and interpretation during telehealth visits for Spanish-speaking patients.

The bilingual (English and Spanish) outreach worker works 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. During FY21, these services were unavailable at the Comunidad Católica de Langley Park (CCLP) (Catholic Community of Langley Park) Outreach Center (a Wellmobile community partner) due to COVID-19-related closure. 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 is consistent with the Wellmobile's legislative charge.

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 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 accomplishment of 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 the students. In FY21, FNP students could not be accommodated in the virtual care model and an on-site nurse care manager was required to precept nursing students. This one-day-a-week staffing and virtual care model remains insufficient to support placement of students with specific clinical hour requirement.

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 related to the current telehealth-visit model present opportunities to address the following research questions:

- What is the impact of the shift to telehealth visits on patient retention and clinical outcomes?
- What would be the impact on health costs and client outcomes of continuing a telehealth-visit option for certain subpopulations and visit types?
- Can Wellmobile visits be optimized using a virtual visit to gather intake and preliminary assessment data?
- What are the opportunities to conduct telehealth visits from the Wellmobile?
- What is the extent of intra COVID-19 and post-pandemic patient acceptance of resumption of in-person appointments?

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. Additional research questions generated by the program's experience with underserved populations have potential for future investigation.

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.

In FY21, the Wellmobile Program director delivered the following presentations at national conferences:

> Stalter, A., Agubokwu, J., **Antol, S.**, Farra, S., Hobba-Glose, J., & Oetjen, C. (2021, June 11.) *Research in action: Mentoring our galaxy of affinity groups to advocate for evidence in community/public health nursing and education.* Association of Community Health Nursing Educators. 43rd Annual Institute. Advocacy in Community/Public Health Nursing Policy, Education, and Research. Virtual Research Plenary Session. (Peer reviewed)
>
> **Antol S.**, Emerson, C., Farra, S., Hekel, B., Keeps, S., & Stalter, A. (2021, June 11.). *What the "H" are we doing?* Association of Community Health Nursing Educators. 43rd Annual Institute. Advocacy in Community/Public Health Nursing Policy, Education, and Research. Virtual Research Plenary Session.

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 practice sites to provide nursing clinical education in ambulatory care settings.

PROGRAM ADMINISTRATION AND FUTURE STRATEGIC DIRECTIONS

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 because of coverage expansion.

Fiscal Partners

One of the biggest challenges facing the Wellmobile Program in FY21 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 patients, 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 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.

In FY11, the Wellmobile Program negotiated an array of reduced-fee lab services with Quest Diagnostics and passed on the reduced rates to clients. Wellmobile staff members collected the fees during the Wellmobile visit and provided the patient with a pre-paid lab slip. Clients accessed 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.

Procuring Funding to Restore Eliminated Faculty Practice Positions

Providing access to primary care services does not solve all uninsured and underserved patients' problems. 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. Adding additional health professionals, including a nurse care manager and a social worker, are essential steps to reconstitute the interprofessional team. The nurse care manager position was eliminated in FY20. The program has been unsuccessful in recruiting a social worker from the University of Maryland School of Social Work to replace the faculty who retired at the end of FY20.

An embedded bilingual nurse care manager role on the Wellmobile has enhanced linkages of clients to secondary and tertiary care services, complemented by social work and outreach work efforts. As an interprofessional clinical team member, the bilingual nurse care manager 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 will include a nurse care manager position in the line-item budget. 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

Maintaining the aging fleet of Wellmobile vans in the required operating condition to perform the program's legislatively designated missions remains an ongoing challenge. Opportunities to reactivate a Wellmobile to resume visits were deferred due to ongoing discussions with the Maryland Department of Health for their use during various phases of 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. A Wellmobile on loan to UMCP for infection-control research earlier this year was recalled to UMB. Efforts focused on readying the Wellmobiles for release and subsequent deployment. FY21 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.

The statewide COVID-19 response shifted to vaccine administration in early 2021. Following the Wellmobiles' return to UMB, the Maryland Department of Health subsequently recommissioned them in March 2021 for vaccine administration efforts by the Vaccine Equity Task Force in conjunction with the Maryland National Guard.

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 FY21. 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 the Chester River Health System and 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 State 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 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 2021 AND FISCAL YEAR 2022 FUNDING STATUS AND INITIATIVES

The University of Maryland Baltimore Foundation Inc. (UMBF) received donations to the Wellmobile in FY21 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 example was 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 proposals for funding in FY21:

S Antol PI. (2021, January 25). *Expanding Governor's Wellmobile Program faculty practice, 7/1/2022-6/30/2025*. Proposal to Maryland Higher Education Commission Nurse Support Program II. ($984,056 requested, not funded).

N Khanna PI. (2021,May 18). *The family COVID-19 vaccine outreach project: A national intervention to support special needs youth and their families vaccine hesitancy*. Proposal to HRSA, subcontractor to UMSOM Department of Family Medicine. (funded)

S Antol PI. (2021, January 14). *Field testing of AHRQ TeamSTEPPS for improving diagnostic capacity, 3/2021-2022*. Proposal to Medstar Health Research Institute Inc. ($1,500 requested, funded)

In July 2020, A concept paper was submitted to the Maryland Department of Health detailing a collaboration between the Wellmobile for a childhood immunization campaign.

FISCAL YEAR 2022 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 faculty to maintain professional certification as they provide 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.

Resumption of Wellmobile in-person care in the Langley Park community remains a priority, given the extensive time patients have been managed through virtual telehealth visits. This requires at least one operational Wellmobile, hiring a CDL driver, and a contract with a community partner site. In anticipation of resuming in-person care, the Wellmobile Program purchased telemedicine equipment to capture, record, and transmit physical assessment information that will interface with the EHR. This technology's store and forward capacity will facilitate sending clinical information to health system clinical partners and their primary care and specialty providers.

The challenge to raise external funds to support care of uninsured patients will continue in FY22. 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 and the newly acquired telemedicine equipment in FY22. 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 FY22. 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 educational 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 recently completed HRSA IPCP cooperative agreement, 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 further capitalize 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 health care systems, local area health education centers, and other UMB professional schools, 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 April 1, 2012, 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 Oct. 16, 2019	1.0 (eliminated Oct. 9, 2019)	0.5 decreased to 0.20 Sept. 1, 2019	1.4 decreased to 0.25 Oct. 9, 2019	decreased to 0.25 Oct. 9, 2019
FY21	0.2	0	0	0.25	0 (position posted)

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 2021 WELLMOBILE BUDGET

GOVERNOR'S WELLMOBILE PROGRAM—FINANCIAL REPORT FY21 (JULY 1, 2020–JUNE 30, 2021)

Expenses:			
	Personnel		
		Salaries	$ 93,717
		Fringe Benefits	$ 21,618
		Total Personnel	$ 115,335
	Operating		$ 48,697
		Total Expenditures	$ 164,042
Revenues:			
		State of Maryland Allocation	$ 285,000

APPENDIX C: WELLMOBILE ADVISORY BOARD MEMBERS

WELLMOBILE ADVISORY BOARD MEMBERS: GOVERNOR'S WELLMOBILE PROGRAM FY21

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