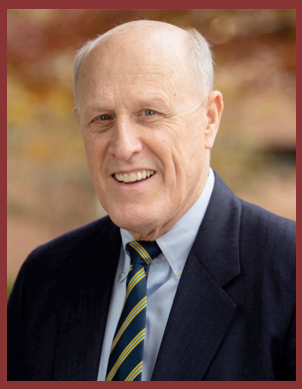
UNIVERSITY of MARYLAND
BALTIMORE

Mobile Health *in* Baltimore

Consensus Conference Overview Report

MARCH 19, 2024



“I have hope that our City Council and our Mayor’s office, and our city and our state will help us to accomplish the things that we’re in this room for. They all have to put their shoulder to that wheel to push. This has to be part of their mission, not just part of being in Baltimore. And, I would like to add, with full participation by the people that we serve, because without that I know this won’t work. It won’t move forward.”

Bruce E. Jarrell, MD, FACS
President, *University of Maryland, Baltimore*

CONSENSUS REPORT AUTHORS

Esa M. Davis, MD, MPH
Associate Vice President for Community Health
University of Maryland, Baltimore

Chuck Callahan, DO
Clinical Professor of Pediatrics
University of Maryland School of Medicine

Peter H. Henderson, PhD, MPP
Senior Policy Advisor to the President
University of Maryland, Baltimore

Table of Contents

One Vision

The flexibility and reach of mobile health care emerged from the COVID-19 pandemic as a key strategy to address population health and health equity. In 2023, Councilwoman Phylicia Porter was engaging with Ascension St. Agnes Hospital about mobile health, and pediatrician Chuck Callahan from the University of Maryland School of Medicine was similarly talking with Baltimore City Health Department leaders. While Dr. Esa Davis was charged by President Jarrell at the University of Maryland, Baltimore to develop a community health strategy.

These three thought leaders recognized a unique moment in time and understood that any vision to expand and coordinate mobile health services needed the voices of all stakeholders. The Mobile Health Consensus Conference was born from their instinct for success when everyone was in the room together.

The Mobile Health Consensus Conference was convened at the University of Maryland, Baltimore on March 19, 2024, under the guidance and direction of Dr. Davis.

CONFERENCE THEMES

Provide an overview of the **health needs of Baltimore City,** and identify those who are not reached by current medical services

Gain a **historical perspective** and current examples of the breadth of mobile health services in Baltimore

Examine how mobile health units' **use of technology and data systems** to address health systems' gaps and improve access

Examine the **financial profiles** of mobile health units to determine sustainability, cost effectiveness and impact on the total cost of care

Identify strategies to improve coordination, communication and integration of mobile health services into the healthcare system to **improve patient access and continuity of care**

Building Consensus

The Baltimore City Mobile Health Consensus Conference brought together 112 experts, thought leaders, stakeholders and community leaders from academia, healthcare, business, nonprofit and community organizations, and city government from the greater Baltimore region. Their purpose was to take the first step on a consensus journey to reach a long-term strategic approach for city-wide integrated and sustainable mobile health delivery.

These passionate and committed people shared their mobile health best practices, ideas, solutions, and experiences. They examined how and to whom this type of alternative care can be delivered, funded, and evaluated for impact on health outcomes. They also questioned every aspect of the current mobile health care approach; all aimed at the long-term goal of collaborative mobile health services across the city.

In a post-pandemic world, mobile health providers were eager to expand services and opportunities for access and health equity. Their conversations and collaborations soon raised challenging questions. The Mobile Health Consensus conference was framed to find answers to these questions:

WHAT do our mobile health services look like in Baltimore?

WHO are we serving and not serving?

HOW are the mobile health units being funded?

HOW is mobile health impacting the various health systems?

HOW is communication about patients occurring between mobile teams and the larger healthcare systems?

In Partnership

Dear Baltimore,

Our city has long been at the forefront of innovative public health initiatives, including leading the nation in deploying mobile health services to connect residents in underserved communities with access to quality, affordable health services. Through programs like our Community Paramedicine Program — a partnership with the Baltimore City Fire Department, University of Maryland Medical Center and the University of Maryland, Baltimore — we demonstrated success leveraging mobile integrated health to reduce health disparities, decrease emergency room visits, and prevent hospital readmissions. In communities with disproportionately poor health outcomes, we know that access to mobile integrated health can help bridge the access gap and get our residents access to the treatment they need in a convenient and cost-effective manner.

The Baltimore Mobile Health Consensus Conference led by the University of Maryland, Baltimore brought together stakeholders to create a strategic roadmap to guide the coordination and sustainability of mobile health services in Baltimore. This roadmap will be instrumental in addressing the challenges and opportunities we face, ensuring that our mobile health initiatives are not only effective but also resilient and adaptable to the evolving needs of our population.

To this end, the City of Baltimore reaffirms our commitment to mobile integrated health as a strategy to reduce health care fragmentation and deliver services to residents out of hospital environments.

By taking on these efforts, we can work to ensure that every resident has access to the care they need.

In Service,

Brandon M. Scott
Mayor
City of Baltimore

Phylicia Porter
Councilmember
District 10

WE SUPPORT:

Establishing a Mobile Healthcare Board that will oversee joint mobile health care efforts and coordinate efforts for data sharing and sustainable funding.

Integrating mobile health care into the city's health-care systems to improve coverage, targeting, coordination, and referral for patients who need longer, more complex care.

Developing plans for long-term sustainability that includes payers, City and State governments.

Establishing a means to link data systems to allow transfer of patient information and secure communication between the units providing care and within the healthcare systems.

Integrating community health workers/community advocates into all mobile health care efforts.

The Situation

Need for a Coordinated Approach

Mobile health has a decades long history in Baltimore, and it filled an immediate gap that was thrust upon patients and health care providers during the restrictions of the COVID pandemic. From COVID-19 virus testing and community vaccination efforts to delivering routine medical care via telehealth, mobile health kept patients and medical teams safe.

The term mobile health care or 'mobile health' broadly includes vehicle-based health services, facilities with telehealth capability, and care delivered over mobile devices such as tablets or PDAs. The array of care services includes prevention screenings, primary care, substance use disorder treatment, and sexually transmitted infection screening and treatment as well as mammography for breast cancer screening and low-dose CT scans for lung cancer.

For thousands of Baltimore residents, mobile health allows them to overcome one of the major barriers to health care: access. A lack of access comes in many forms: from little or no insurance coverage and long wait times for a provider visit, to a lack of transportation to the provider, the lack of health care facilities near home, and the fear and mistrust of the healthcare systems.

Post pandemic, as the US reimagines health care, mobile health has emerged as a strategy to address access as well as population health, health equity, and social determinants of health.

KEYNOTE SPEAKER

> "80% of health outcomes are unrelated to what happens in health care settings. In other words, there is no way to 'health care' out of these discrepant health outcomes."

Philip Levy, MD, MPH
Edward S. Thomas Endowed Professor
Department of Emergency Medicine
Wayne State University

The Challenges

Issues for Long-term Sustainability

The Mobile Health Consensus Conference highlighted the benefit that mobile health services provide to those most in need. Yet the challenges — while not insurmountable — are many in order to achieve successful, sustainable and integrated mobile health services in Baltimore. The challenges fall under these broad categories:

SERVICE OVERLAPS

Mobile health providers are unaware of others providing similar services in the same area. There is no mechanism for providers to communicate with each other.

OPERATING IN ISOLATION

The mobile health provider is the only one providing care to a particular population e.g., undocumented or unhoused, and lacks a seamless linkage to a health system for comprehensive medical and social services.

FINANCIAL BANDWIDTH

There is no long-term financial model to ensure continuity of care and the ability to provide logistical and technology support to mobile health providers.

We can learn from cities such as Detroit, where data-driven mobile health care engages patients in preventive services. Innovative health leaders such as Dr. Phillip Levy in Detroit, have established capitated rates with payors for mobile preventive services and developed a strategic vision for a state-funded mobile health system.

An integrated and well-coordinated mobile health care delivery system — similar to the EMS system — is an essential approach to increasing access to primary care and preventive services that improves population health and health equity in Baltimore.

> “We realized that there are many, many challenges throughout the city that we as practitioners, we as scientists, we as community members, take on our shoulders when we do these things for our community; when we bring back resources, when we bring back the best and brightest to serve our community, when we just simply execute our everyday missions within our own capacities within Baltimore City.”

Phylicia Porter
Councilmember, District 10

Consensus Recommendations

Conference participants were united in their desire for greater coordination, collaboration and integration of mobile health care delivery for underserved populations in Baltimore city. The synthesis of input and ideas from conference participants, panel experts and speakers as well as from post-conference survey respondents resulted in five specific recommendations. These recommendations provide a road map for enhancing and sustaining mobile health care in Baltimore.

RECOMMENDATION 1:

Board of Representatives

Establish a board of representatives from each healthcare system along with community partners to provide oversight for a city-wide mobile health effort that will include a central operational unit to coordinate services.

The City of Baltimore will establish a Mobile Health Care Board for Baltimore that will guide joint mobile health care efforts and coordinate data sharing and sustainable funding. The board will:

- Include representatives from all participating healthcare systems and collaborating community, government, nonprofit, business and academic partners.

• Include voices from the community for the planning and strategic operation of mobile health care.

• Collaborate to establish central strategic health priorities for the mobile health care effort (e.g. hypertension screening, diabetes screening etc.) based on community health assessments undertaken by the city's healthcare systems and Health Department.

• Work with medical systems, city agencies, state legislature, Medicaid Care Organizations and other payors to support this effort with sustained funding.

The Mobile Health Care Board will establish, identify and collaborate on a central, coordinating operations center for mobile health care. The operations center will:

• Identify best place or agency for alignment and ideal infrastructure for sustainability.

• Serve as the central coordination and collaboration body for city-wide mobile health care.

• Consider all potential sites for care delivery (e.g., schools, faith-based communities, community centers, street-medicine etc.)

The Mobile Health Care Board will determine working vocabulary and definitions for mobile health or mobile health care based on national standards. (The term 'mobile health care' is likely preferable for mobile and placed-based care delivery platforms and strategies.)

RECOMMENDATION 2:

Healthcare Systems

Integrate mobile health care into the city's healthcare systems and community to improve coverage, targeting, coordination, and referral for patients who need longer, more complex care.

The city's healthcare systems will develop improved community health assessments. These assessments will:

• Better incorporate individual and population data on social determinants of health into data systems and use to improve community health assessments.

• Better understand the 'missing people' who never or rarely interact with the healthcare system.

The Mobile Health Care Board and operations center should use these improved community health assessments to better coordinate and target mobile health units in order to:

• Determine target populations for mobile units based on demographics, geography, community needs, health conditions, etc.

• Specifically target mobile health care to geographic regions where residents do not regularly engage with the healthcare system (e.g. unhoused encampments, undocumented residents etc.).

• Focus mobile health care on underserved populations and provide a range of services for acute and chronic medical conditions (including primary care and preventive services), behavioral health and addiction medicine. Specialty care, dental, pharmacy and other services will be carefully coordinated by the operations center.

Mobile health care units should:

• Improve training for staff who screen for health-related social needs and refer clients for support.

• Assess and address social drivers of health and establish a closed loop system for assistance with referrals for health-related social needs.

• Provide basic dental care and closed loop dental referrals.

Future mobile health care iterations will include options for cancer screening such as mobile mammography and lung cancer screening (e.g. currently developing partnerships with radiographic industry).

Health systems, nonprofit organizations and mobile health programs will establish pharmacist and community health worker (CHW) partnerships for ideal medication management within the community along the lines of the Detroit/Wayne State model. These partnerships will:

• Deliver preventive care in the most efficient and cost-effective means. (Preventive services do not require a provider encounter.)

• Offer a 'warm handoff' between mobile health care and fixed-facility staff and systems; this is an essential part of the model.

The Mobile Health Care Board in collaboration with healthcare systems, nonprofit organizations and payors will identify resources to help patients pay for medications (e.g. uninsured co-pays, deductibles).

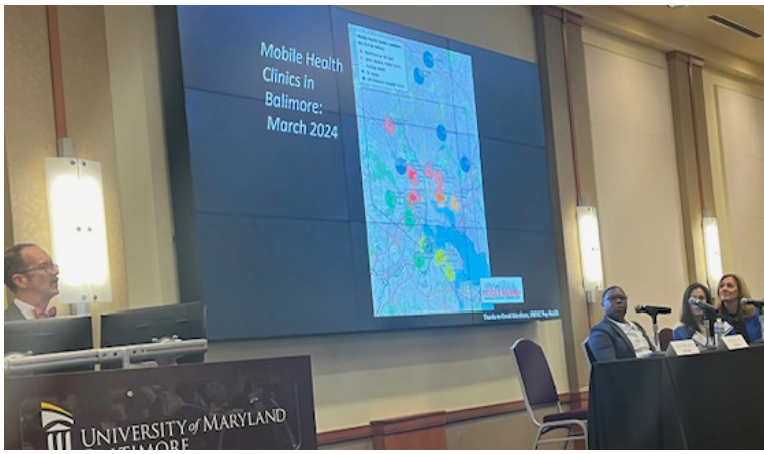
RECOMMENDATION 3:

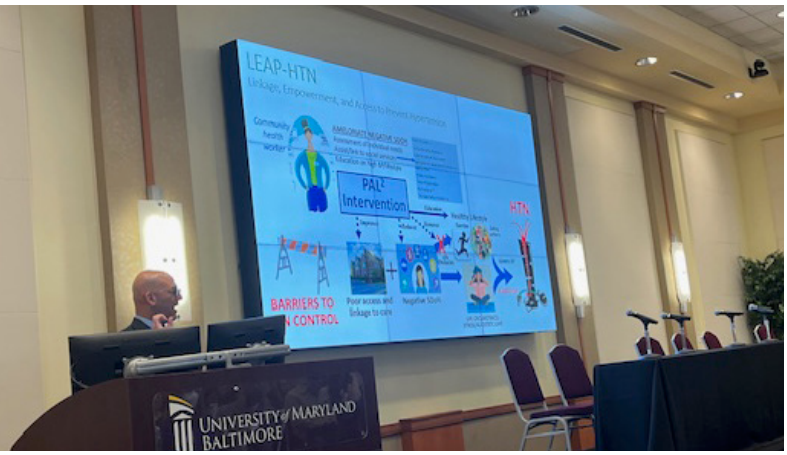
Long-term Sustainability

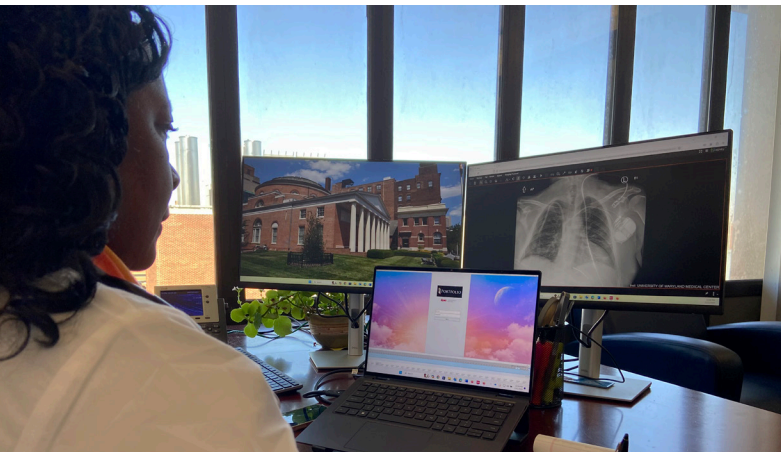
Develop plans for long-term sustainability that includes payors, City and State governments.

The Mobile Health Care Board will facilitate further stakeholder discussion about long-term financial sustainability of mobile health care programs. Consider billing, institutional funding, philanthropy, government grants, government appropriations, and other revenue sources.

The Mobile Health Care Board will work with State agencies, e.g. Maryland Health Services Cost Review Commission (HSCRC) and others as well as payors to determine new compensation models for mobile health including Current Procedural Technology (CPT) codes for preventive services, similar to those developed in Michigan by Detroit/Wayne State.







RECOMMENDATION 4:

Data Systems

Establish a means to link data systems to allow transfer of patient information and secure communication between the units providing care and within healthcare systems.

In collaboration with healthcare systems and the State Health Information Exchange (CRISP), the Mobile Health Care Board will:

- Facilitate means to promote electronic medical records interoperability and explore the feasibility of additional technology to secure support communication and referrals across different mobile health care platforms as well as the continuum of the healthcare system.
- Develop a central database that includes best and last contact information for frequently identified patients (e.g., CRISP and/or payors with databases may provide possible options) for secure patient communication and messaging.
- Ensure technology solutions allow operability between all potential sites for care delivery, e.g. schools, faith-based communities, community centers, street-medicine, etc.
- Capitalize on opportunities to establish telemedicine connectivity and referral capability based on community needs, service delivery model, and unit capabilities.

RECOMMENDATION 5:

Community Inclusion

Integrate community health workers and community advocates into all mobile health care efforts.

The Mobile Health Care Board will include voices from the community for the planning and strategic operation of mobile health care in the City.

The Mobile Health Care Board and health systems deploying mobile health care units will consider best practices for incorporating trusted community-based messengers to work with the community.

Operators of mobile health units should support the incorporation and career advancement of community health professionals (e.g., CHWs, doulas, health educators) into mobile health care delivery, including establishing certifications and career pathways for these professionals in the conventional healthcare system. These trusted resources in the community are essential in connecting people to the medical system for care.

As care for the caregivers is an essential component in caring for these underserved populations, mobile health care providers will draw on social, spiritual, and psychological professionals as partners in the work.

Accelerating Consensus

The conference concluded with small group discussions that generated a plethora of ideas falling into five categories: mobile health landscape; coordination, communications and integration; funding and sustainability; data and technology; and community engagement. We suggest the list of ideas (or prompts) below be used as a resource by mobile health providers and healthcare organizations in identifying solutions and planning the next step in the mobile health consensus journey.

Mobile Health Landscape

- Need to be able to identify the population that is being served or needs services, no good data currently
- Everyone should have access to the same standard of medical care
- Mobile health is a stop gap — shows the need for more permanent services
- Find people who do not access care in other settings — maybe this is the long-term solution for certain populations
- Mobile health services people in locations where they are living or working
- Translate lessons learned via mobile health care to the broader health system
- Need to create flexibility — not one size fits all
- Make a better mobile health care network by reinvesting
- Address access issues by being flexible to patient need and location
- Consider wider breadth of locations for services churches, schools, street, shelters, encampments and places of employment
- Advertise in media appropriate to the specific mobile health audience
- Just-in-time capability, off-hours availability
- Linkage to eligible benefits and ability to fill in gaps financially
- Incorporate social system navigators and health coaching services
- Expand in-home capability to facilitate telemedicine for specialty/PCP services
- Increase access and incorporate pharmacy services into mobile health care
- Offer dental, eye care, behavioral health services
- Opportunities to address fall-prevention older adults, chronic disease, asthma, hypertension, diabetes, heart failure, opioid use disorder
- Opportunity for urgent care and follow-up services
- Better identify and service the health care deserts and encampments

Coordination, Communications and Integration

- Need a coordinated effort, rather than each entity operating similar overlapping services
- Baltimore City Health Department or other entity should be charged with consolidating information about availability of services
- Mobile health units should have the ability to make referrals, especially to specialty care
- Utilize CRISP for referrals, communication, input and output of information

- Closed loop referrals for social determinants of health
- Need to have more participation from the community, building of community capacity and organized
- Maximize resources: Pool resources, data sharing, common data elements, align strategies across organization, outreach and education about ongoing efforts
- Staff members need to be flexible. Flexible institutions and relationship with the institutions
- Building a bus barn hub for maintenance/ centralized hub
- Establish coordinating centers, consider partnering with 211, United Way, and GIS data
- Need greater transparency
- Abandon the ROI model and focus on public good as the concept to defend
- Share vans and share staffing
- Healthcare systems and teams to stop working in silos and come together around a shared priority for delivering mobile health care
- Mobilize around specific services such as opioid use disorder, primary care, asthma, social determinants of health
- Widen the net of service to not only focus on underserved but to provide access to anyone
- Greater collaboration among the health care systems

Funding and Sustainability

- Health systems need to fund the community to do the work
- Could move to bundled payments
- Need payor/health system agnostic funding/ collaborative community health
- Should be separated from the idea of business and venture capital
- Need upfront investors, such as philanthropy for start up
- Multilayer-ROI, public good cost savings
- Engage HSCRC
- Change the city narrative to city health strategy
- One approach — take inventory of all mobile units, all target areas, and then disperse to areas most in need of service with one funding mechanism
- Fee-for-service billing for 'preventative visit'
- Fund telemedicine
- In-rates funding from hospitals (pool resources)
- City government funding shared with pooled hospital resources
- Include in the state government budget
- Primary patient care and prevention — having the infrastructure to do it
- Coordination of mobile health care services at the city level to reduce cost
- Understanding who is in the mobile health care space and linking programs together is critical
- Mobile health clinic vs programs
- Health street medicine should be included in the mobile health care model
- Operations cell — city needs coordination capability, legislative funding
- Decrease administrative burden; Maryland all-payor model to create new codes for mobile health care services

Data and Technology

- EHR/CRISP linkage with hospitals/outpatient clinics for care coordination and outcome measurement
- Explore every potential for artificial intelligence and data sharing

Community Engagement

- In-person and outreach is very important in-home
- Link with community health workers
- Sensitivity training for health professionals
- Focus on addressing trust and past trauma
- Engage younger age group
- Keep some roles consistent (e.g. drivers)
- Engage college campuses

Questions

To Facilitate Research, Policy & Practice Decisions

Target Populations

It appears that mobile health outreach from the different health systems may be caring for the same, small population of patients, and thus a concern for over utilization of services by the same population, how do we identify and track patients across the multiple mobile platforms to ensure that all the populations that needs services can get them?

Should mobile health care be positioned by population demographics, geography, diagnoses/conditions or other?

Care Provided/Integration with Healthcare System

What is the typical duration of care relationship for patients served by mobile clinics? And what should it be?

Should primary care by mobile health care replace placed-based primary care? How should we redirect patients when appropriate back to existing primary care practices?

How do you navigate those that utilize the mobile units to actual primary care services at the institutions?

For those uninsured patients, such as immigrants, who are only receiving medical care via a mobile health unit and need to see a specialist, how do they get referred or connected into specialty care?

What are the opportunities for community-based cancer screening using mobile units? Screening on mobile units vs connecting patients to an office or clinic?

For patients with heart failure, is there capacity to diuresis a patient on the mobile unit or do they have to go to the emergency department or to another site?

Has dental/oral health come up in any community health needs assessments? And if so, are there any partnership/linkages with dentists or dental services using mobile units?

Medications

How should pharmacy be integrated into mobile health care?

Cost and affordability of medications was the #1 need identified in community needs assessment in West Baltimore MIH-CP program. What resources are there to assist uninsured or underinsured patient with covering medication costs?

What role can pharmacist plan on the mobile health care team? To what extent is the role of nurse practitioners in patient medication management on the mobile health units?

Data Access, Storage and Management

How are patient/client data stored on the mobile units? What platforms do mobile health care (e.g., mobile units, telehealth) use to access and store patient data? How are they integrated into other data systems within the hospital electronic health records? And if they are not, should they be and how would this work? Do mobile clinics leverage their partner hospital EMRs to store or access patient data?

What opportunities are there to integrate mobile health patient data with CRISP?

Logistics

Are there opportunities to share mobile health care units across city as opposed to everyone buying their own, especially if they are not always delivering services during the week? Does each mobile unit need a fixed-site partner? How are mobile health care staff hired? Are they hired through a hospital system? Do they have access to all the data systems (e.g., EMR, CRISP etc.) offered to in-hospital staff?

Parking and logistics for mobile units can be complex. What should be considered for maintenance, parking and other logistical aspects (e.g., disposal of hazardous waste and sharps) to owning and deploying mobile units?

Community

What strengths do community members bring to make mobile healthcare better?

What are the best practices for incorporating trusted community messengers into mobile health care work with the community?

Financial Models

How do we engage the payors and the MCOs in this effort to fund and sustain mobile health care in the city?

What are the various ways of billing for mobile services? What are the barriers to billing? What are the considerations for caring for patients without insurance coverage, (e.g., Sliding scale? Charity care?).

What proportion of mobile health care services collected from billing Medicare/Medicaid patients comes back into the program? What percentage of mobile health expenses are covered by billing?

Conference Participants

Larry Alston
Baltimore City Health Department

Joy Bell
Baltimore City Health Department

Danny Bellamy
Total Health Care Inc

Michelle Berkley-Brown
Grace Medical Center

Tony Bibbo
University of Maryland Schoolof Medicine

Ingrid Blackwell
Baltimore City Health Department

Paula Blackwell
Central Maryland AHEC

Mary Beth Bollinger
University of Maryland Children's Hospital Breathmobile

Sarah E Bradley
University of Maryland School of Medicine

Brandon Brown
Total Healthcare

Chuck Callahan *(Moderator)*
University of Maryland School of Medicine

Rebecca Carter
Univeristy of Maryland School of Medicine Pediatrics

Kellie Cash
Mission Mobile Medical

Todd Crocco
Emergency Medicine

Kate D'Adamo
SPARC Women's Center

Terrie Dashiell
LifeBridge Health

Karen Dates Dunmore
University of Maryland Medical Center

Elizabeth David
UPMC Western Maryland

Esa Davis *(Speaker)*
University of Maryland School of Medicine

Kelly Doran
University of Maryland, Baltimore Community Engagement Center and School of Nursing

Wonder Drake
University of Maryland School of Medicine

Warren D'Souza *(Panelist)*
University of Maryland Medical System

Ihuoma Emenuga *(Speaker)*
Baltimore City Health Commissioner

Olivia Farrow
Ascension St. Agnes Hospital

Maria Ferraris
Mission Mobile Medical

Laura Fisher
University of Pittsburgh Medical Center

Alejandra Flores-Miller
Johns Hopkins University

Mary Carole Fortunato
Johns Hopkins Medicine

Becky Frank
Chase Brexton Health Care

Cicely Franklin
Baltimore City Health Department-Community Risk Reduction Services

Laurel Freedman
Lifebridge Health

Danielle Friedman Nestadt
Johns Hopkins Bloomberg School of Public Health

Andrea Gaspar *(Speaker)*
MedStar Health

Dan Gingold
University of Maryland School of Medicine Department of Emergency Medicine

Mark Gladwin *(Speaker)*
University of Maryland School of Medicine

Tyler Gray
Healthcare for the Homeless

Tamara Green *(Speaker)*
Baltimore City Health Department

Bobby Harris *(Speaker)*
Baltimore City Health Department and Johns Hopkins University

Darryl Hayes
Baltimore City Health Department

Peter Henderson
University of Maryland, Baltimore

Lindsay Herbert
Johns Hopkins University

Jasmine Herndon
University of Maryland School of Medicine Department of Neurology

Tom Hopkins
University of Maryland Medical Center

Linda Horn
University of Maryland, Baltimore

Bruce Jarrell *(Speaker)*
University of Maryland, Baltimore

Anne King
Baltimore City Health Department

Roderick King
University of Maryland Medical System

Patrice Kingsley
CareFirst Blue Cross Blue Shield

Joel Klein *(Moderator)*
University of Maryland Medical System

Christina Koch
University of Maryland School of Medicine

Deborah Kotz
University of Maryland School of Medicine

Lisa LaCarrubba *(Panelist)*
CloseKnit Health

Colleen Landi
University of Maryland Medical Center

Anne Langley
Charm City Care Connection

Jessica LaRicci
Johns Hopkins University CIDNI

Phillip Levy *(Keynote Speaker)*
Wayne State University

Vernell Lewis
Epic

Nicole Logan
University of Maryland School of Medicine

Jarvis Thanex Louis
Mobile Health Map-Harvard Medical School

Tre'Jenae Mack
Central Maryland Area Health Education Center

David Marcozzi *(Moderator)*
University of Maryland
Medical Center

Jennifer Martin
Baltimore City Health
Department

Nicki McCann *(Panelist)*
Johns Hopkins Medicine

Keyona McClure
CareFirst/CloseKnit

Tiombe Mitchell
Lifebridge Health

Marik Moen
University of Maryland
School of Nursing

Holly Moody-Porter
University of Maryland
School of Medicine

Alexandra Moran
University of Maryland
Medical Center

Irene Mortera
University of Maryland, Baltimore
Community Engagement Center
and Health Suite

Brittany Moyer
City of Baltimore

Aislynn Moyer
University of Maryland
Medical Center

Mallory Mpare *(Panelist)*
March of Dimes

Patrick Mutch
Chase Brexton Health Care

Medhat Nagib
University of Maryland
Medical Center

Darien Nolin *(Speaker)*
Total Health Care

Wendy O'Donnell *(Moderator)*
University of Maryland
School of Medicine

Dawn O'Neill *(Speaker)*
Ascension Saint Agnes

Yolanda Ogbolu *(Panelist)*
University of Maryland
School of Nursing

Emily Ogunbo
CRISP

Katy Olive
Baltimore City Health
Department

Ana Ortega
Johns Hopkins University

Kathleen Page
Johns Hopkins Medicine

Jasmine Pope *(Speaker)*
University of Maryland
Children's Hospital

Phylicia Porter *(Speaker)*
Baltimore City Council

Michael Preston
Johns Hopkins University

Megan Priolo *(Panelist)*
CRISP

Gabriel Ramirez
Johns Hopkins School of Medicine

Destiny-Simone Ramjohn *(Panelist)*
CareFirst BlueCross BlueShield

Molly Rice
Baltimore City Health
Department

Allison Robinson
Maryland AHEC Program

Magaly Rodriguez de Bittner
University of Maryland
School of Pharmacy

Amanda Rosecrans *(Panelist)*
Johns Hopkins Medicine and
Baltimore City Health Department

Jeremiah Savage
University of Maryland, Baltimore
EMRACE

Olufunke Sokan
University of Maryland
School of Pharmacy

Natalie Spicyn
University of Maryland
Institute of Human Virology
JACQUES Initiative

Rhea Steen
University of Maryland
School of Medicine

Stacey Stephens
University of Maryland
School of Social Work
and B'more for Healthy Babies

Mariellen Synan
University of Maryland
Medical Center
Community Health Improvement

Anna Tatro
West Baltimore Renaissance
Foundation

DeNotta Teagle
Total Health Care

Vicki Tepper
University of Maryland
School of Medicine

Jessica Thomas
Baltimore City Fire Department

Laurie Timberlake
University of Maryland
School of Medicine
Family and Community Medicine

Anthony Tingler
Baltimore City Fire Department

Ozhan Turan
University of Maryland
School of Medicine
OB/GYN

Marselle Urquiza Gutierrez
Johns Hopkins School of Medicine

Darien Weatherspoon
University of Maryland
School of Dentistry

Marcee' White
Total Health Care

Tiffany Wiggins
University of Maryland
Medical System

Rhonda Williams
Grace Medical Center

Seantrese Wimbuish
University of Maryland
Medical Center

Kenneth Wong
University of Maryland, Baltimore
Graduate School

Wendy Zhang
Medstar Health

Stanley Zheng
MedStar Health

CONFERENCE PLANNING COMMITTEE

Chuck Callahan
Lucas Calson
Esa Davis
Phyllis Gray
Robert Harris
Peter Henderson
Tom Hopkins
Caulina Merrick
Elissa Miller
Wendy O'Donnell
Amanda Rosecrans
Laurie Timberlake

Conference Organizations

“I want you to be creative when you think about how we’re going to solve this issue of coordinating and connecting health care and public health and mobile health across the city.

We will be a leader in this space, with regards to how we coordinate mobile health across the city and the state. We will be an example to all in Maryland’s 24 jurisdictions. We have the best brains. We are bringing competent, brilliant and dedicated public servants and professionals and practitioners together to solve this issue.”

Mark T. Gladwin, MD
Dean, University of Maryland School of Medicine
Vice President for Medical Affairs, University of Maryland, Baltimore
John Z. and Akiko K. Bowers Distinguished Professor and Dean

Scan the QR code to go to the Mobile Health Baltimore website to download the full Consensus Conference Report or the shorter Consensus Overview. The Consensus Conference Report details the consensus recommendations, remarks by conference speakers, Baltimore's mobile health landscape, case studies, and links to research and information.

UNIVERSITY of MARYLAND
BALTIMORE

School of Dentistry | Graduate School | School of Medicine | School of Nursing
School of Pharmacy | School of Social Work | Carey School of Law