



# Performance Measures

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**Department of  
Health and Human Services**

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## Overview

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The Department of Health and Human Services directs, manages, administers, funds and delivers critical services and supports to the most vulnerable residents of Montgomery County. Services provided include somatic and behavioral health care, financial and housing supports, case management and advocacy services, protective services for vulnerable children and adults and prevention services.

The Department currently serves approximately 70,000 unduplicated Montgomery County residents with a FY08 budget of \$263 million and 1,758 staff positions representing 1,604 workyears.

Core services provided by the Department protect the community's health, protect the health and safety of children and vulnerable adults at risk, and address basic human needs including food, shelter, clothing and personal care as indicated below.

### Contribution to Montgomery County Results

#### **GREATER RESPONSIVENESS AND ACCOUNTABILITY**

##### **1. Information and Referral Services**

- ◆ Information and Referral (I&R) often represents the community's first interaction with HHS.
- ◆ Information and Referral services help link people with resources and services in their community.
- ◆ By volume, Information and Referral is the most common service provided to County residents.
- ◆ Most HHS customers have the capacity and resources to deal with problems/issues once they are given good information and referral(s).

##### **2. Direct HHS Services**

- ◆ Determining the impact of receiving HHS services is central to facilitating a successful outcome for the customer.
- ◆ Determining the impact on customers of receiving HHS services is a management tool for ongoing quality service improvement.

### **3. Team-based Case Management**

- ◆ Cross-systems team-based management of individual or family cases that receive multiple services offers a more coordinated systematic and holistic approach to meeting the customer's needs.
- ◆ Cross-systems team-based case management creates efficiencies through communication and coordinated service delivery for customers that receive multiple services.
- ◆ Cross-systems team-based management leads to improved outcomes for customers: risk mitigation, greater independence, improved access to services and successful case closure.

### **4. Contract Processing**

- ◆ HHS customers and service providers benefit from newly approved contracted programs and services that begin operation within in a reasonable time frame.
- ◆ HHS customers and service providers benefit from ongoing programs and services that continue operation without interruption or disruption.
- ◆ Administrative efficiency leads to better value for tax dollars spent.

### **5. Contracted Services Performance Measurement**

- ◆ Performance measures increase accountability and provide a data driven means for assessing the outcomes of a program or service.
- ◆ Performance measures are a mechanism for continuous quality improvement and therefore more likely to result in better outcomes for clients.
- ◆ Performance measures provide data for use in future funding and contracting decisions.

### **6. Limited English Proficiency Language Assistance**

- ◆ Language assistance to HHS customers facilitates access to HHS services by County residents with limited English language proficiency.
- ◆ Outreach efforts to County residents who have limited English proficiency support HHS efforts to meet the health and human service needs of the diverse County population.
- ◆ Language assistance to County residents seeking HHS services ensures that HHS abides by Federal Limited English Proficiency (LEP) mandates.

## **PROVIDING SAFE STREETS AND NEIGHBORHOODS**

### **7. Juvenile Justice System Screening, Assessments and Referrals**

- ◆ National studies indicate that 50-70 % of youth entering juvenile justice systems have substance abuse and/or mental health problems. HHS aims to reduce the number of repeat youth offenders and to minimize the number of youth referred to the Maryland Department of Juvenile Services (DJS) or the Maryland Department of Corrections by providing substance abuse and mental health screening, education and referral to treatment for certain first-time youth offenders and other repeat youth offenders whose offenses are minor.

## HEALTHY AND SUSTAINABLE COMMUNITIES

- 8. Providing the uninsured with health care coverage and a regular source of care**
  - ◆ Providing access to health care to all residents has many benefits: healthier, more productive residents; less absenteeism from school or work; more prevention, earlier detection and better management of diseases, such as asthma, diabetes, cancer and heart disease and, better use of hospital emergency rooms for true emergencies.
  - ◆ County DHHS staff enrolls thousands of residents into State and federally-funded health insurance programs each year, and recertifies eligibility annually.
  - ◆ Enrollment in health insurance programs funded by the State, including Medical Assistance and similar programs, leverages County dollars (for enrollment workers) with State and federal dollars to cover health care costs.
  - ◆ DHHS staff enrolls uninsured residents who are not eligible for State or federally funded programs into the County Care for Kids program or refer adults to the Montgomery Cares program, to assure access to basic, primary health care and prescriptions (hospital coverage is not included).
  
- 9. Controlling communicable diseases**
  - ◆ The public is protected from communicable diseases by limiting further spread of diseases.
  - ◆ HHS programs provide timely and appropriate response to reports of communicable diseases.
  - ◆ HHS programs provide access to prevention, diagnosis/early intervention, and treatment of communicable diseases for at-risk (exposed) individuals.
  - ◆ HHS educates the public on best practices to further limit the spread of disease and protect the health of individuals.

## PREPARING CHILDREN TO LIVE AND LEARN

- 10. HHS Early Childhood Services and Programs**
  - ◆ HHS Early Childhood Services (ECS) partners with many public and private programs. As one example, the HHS Community Action Agency's Head Start Program works with ECS to provide an array of comprehensive services to children, parents and child care providers that promote school readiness by enhancing children's mental health and social, emotional, intellectual, linguistic and physical development and early learning opportunities.
  - ◆ HHS Public Health Services (PHS) provides health, vision, hearing and dental screening and treatment services, as well as immunizations to Head Start and other pre-school children, in addition to providing prenatal care to 1,700 low-income uninsured women annually, and case management of at-risk pregnant women and children.
  - ◆ PHS enrolls low income children in State and federal health benefit programs and provides links to local medical providers.

## ENSURING VITAL LIVING FOR ALL OF OUR RESIDENTS

### 11. Employment Services

- ♦ HHS assists County residents who meet eligibility criteria in obtaining Temporary Cash Assistance (TCA), the federal cash benefit program.
- ♦ HHS provides TCA recipients assistance in accessing child care, transportation, housing, case management, substance abuse treatment and other medical care services, and employment counseling, training and job placements

## AFFORDABLE HOUSING IN AN ALL-INCLUSIVE COMMUNITY

### 12. Housing Services

- ♦ Maintain housing stability for vulnerable households.
- ♦ Prevent homelessness and the loss of permanent housing.
- ♦ Promote expansion of affordable housing units for special needs populations.
- ♦ Link housing with essential supportive services for special needs populations.

## HHS Services Areas and Programs

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Beyond its core services, the Department provides an array of other services to assist families to be healthy, safe and self-sufficient. These are provided through the five services areas, listed below along with their associate FY08 budgets: Aging and Disabilities; Behavioral Health and Crisis Services; Children, Youth and Family Services; Public Health, and Housing Stabilization Services.

### Aging and Disabilities

#### *Program Summary*

	<i>Expenditures</i>	<i>WYs</i>
Community Network for People with Disabilities	14,726,660	36.7
Assessment and Continuing Case Mgmt Services	5,556,090	51.5
Assisted Living Services	2,021,010	6.3
Community/Nursing Home Med. Assist. & Outreach	2,456,710	32.7
In-Home Aide Services	5,055,190	17.5
Information and Assistance	833,650	9.5
Ombudsman Services	678,570	6.5
Respite Care	1,176,670	0.0
Senior Community Services	4,021,280	20.9
Senior Food Program	1,395,510	3.0
Service Area Administration	488,430	3.0
<b>Totals</b>	<b>38,409,770</b>	<b>187.6</b>

## Behavioral Health and Crisis Services

<i>Program Summary</i>	<i>Expenditures</i>	<i>WYs</i>
System Planning and Management	7,936,210	20.2
Behavioral Health Specialty Services	2,753,730	24.2
Behavioral Health Community Support Services	7,375,270	22.2
Criminal Justice/Behavioral Health Services	2,256,780	19.4
Outpatient Addiction Services (OAS)	3,506,770	29.7
Victims Assistance and Sexual Assault Services	2,478,640	19.4
Child and Adolescent Mental Health Services	3,278,220	18.1
24-Hour Crisis Center	5,569,470	51.5
Mental Health Services: Seniors & Persons with Disabilities	1,923,470	11.0
Partner Abuse Services	3,063,510	19.1
Service Area Administration	628,830	4.1
<b>Totals</b>	<b>40,770,900</b>	<b>238.9</b>

## Children, Youth and Families

<i>Program Summary</i>	<i>Expenditures</i>	<i>WYs</i>
Child Welfare Services	19,236,320	205.3
Conservation Corps	797,220	26.4
Linkages to Learning	5,161,790	6.5
Juvenile Justice Services	4,809,800	13.1
Quality enhancement of Early Childhood Services	2,155,970	13.6
Head Start	2,140,500	9.2
Parent Support Services	599,820	0.0
Services to Children with Special Needs	2,060,540	9.8
Child Care Subsidies	11,478,550	30.6
Income Supports	13,031,600	134.5
Child and Adolescent Services	3,654,540	4.3
Service Area Administration	348,860	3.0
<b>Totals</b>	<b>65,475,510</b>	<b>456.3</b>

## Public Health

<i>Program Summary</i>	<i>Expenditures</i>	<i>WYs</i>
Office of Health Partnerships and Health Planning	13,663,350	15.3
Office of Minority & Multicultural Health Services	4,137,880	10.0
Communicable Disease, Epidemiology, & Lab Services	1,491,990	13.8
Community Health Services	10,241,280	103.7
Dental Services	1,828,110	14.3
Environmental Health Regulatory Services	3,124,150	30.1
Health Care and Group Residential Facilities	1,309,820	12.0
Health Promotion and Prevention	1,325,940	7.6
Cigarette Restitution Fund Programs	1,759,860	6.0
STD/HIV Prevention and Treatment	5,513,360	41.0
School Health Services	18,064,790	228.2
Tuberculosis Services	2,050,620	19.7
Women's Health Services	5,634,960	17.9
Public Health Emergency Preparedness & Response	1,982,860	11.6
Service Area Administration	824,820	4.0
<b>Total</b>	<b>72,953,790</b>	<b>535.2</b>

## Housing Stabilization Services

<i>Program Summary</i>	<i>Expenditures</i>	<i>WYs</i>
Rental & Energy Assistance Program	5,760,480	9.3
Shelter Services	5,568,780	2.8
Supportive Housing Services	1,712,720	10.4
Housing Stabilization Services	4,842,930	32.2
<b>Totals</b>	<b>17,884,910</b>	<b>54.7</b>

## Administration and Support

<i>Program Summary</i>	<i>Expenditures</i>	<i>WYs</i>
Office of the Director	5,846,930	8.1
Office of the Chief Operating Officer	18,579,990	91.0
Office of Community Affairs	2,779,800	12.7
<b>Totals</b>	<b>27,206,720</b>	<b>111.8</b>

# Greater Responsibility and Accountability

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## 1. Information and Referral Services

### Basic Facts

- ◆ HHS has 14 Information and Referral units, the largest of which are the Crisis Center (240-777-4000) and HHS Information Line (240-777-1245).
- ◆ Total annual volume of Information and Referral calls and walk-in contacts is more than 100,000.
- ◆ Total FTE and dollars: TBD (many units have mixed staffing and budgets that have not previously been disaggregated in this fashion).

### Performance

Percentage of customers who report satisfaction with the information and referral assistance received. In future years, HHS will expand its outcomes tracking to examine whether customers received the assistance they were seeking.

*HHS plans to collect baseline data department wide in FY08. In FY07 only a limited number of HHS call centers collected data on this outcome. Aging and Disability Services, using the national POMP (Performance Outcome measurement Project) instrument, found that 91% respondents reported “overall satisfaction” with service; and 94% found assistance to be “useful”. The Child Care Resource and Referral Center (FY07) found that 94% of respondents rated service as “good” to “very good”.*

### Story Behind Performance

#### Supporting Factors

- ◆ Highly trained and knowledgeable staff performs Information and Referral functions.
- ◆ Staff is proficient in a number of non-English languages, enabling service to limited English proficient (LEP) customers.
- ◆ Creation and advertisement of central HHS Information Line (240-777-1245) provides a central point of access to information and referral to HHS services.

#### Barriers

- ◆ Individuals in the community often are not aware of County services, or how to access them.
- ◆ Large numbers of Limited English Proficiency (LEP) residents in County.
- ◆ Difficulty for callers in articulating their problems/issues and what types of service(s) might be of benefit to them.

## What We Propose to Improve Performance

- ♦ Evaluate effectiveness of present HHS Information Line outreach efforts and adjust as needed.
- ♦ On-going education of Information and Referral staff about the wide range of services available via the County as well as in the community.
- ♦ Evaluate internet and email outreach options for information and referral, and use results to strengthen these tools.
- ♦ Standardize Information and Referral expectations and data collection.
- ♦ Expand community awareness of Information and Referral phone lines and functions.

### Fiscal Impact

FY08: \$342K for 6 triage workers and \$60K for social worker case managers needed to staff customer service intake and referral section in 3 locations as the Customer Service Information and Referral Pilot is expanded to two additional sites.

### Partnerships:

- ♦ A single intake and screening system for all of HHS requiring strong partnerships across HHS service areas would improve the quality and breadth of the information received by our customers.
- ♦ A county wide CRM (client resource management) initiative would impact our information and referral services and improve customer service, enhancing the quality and breadth of the information received by all our customers.

### Innovations:

- ♦ Creation of a single screening instrument for all of HHS that supports a no wrong door approach to customer access to our services. HHS currently has a service integration workgroup developing a single screening instrument template for all HHS service entry points. This instrument will be field tested beginning in January 2008.

## 2. Direct HHS Services

### Basic Facts

- ◆ Number of customers receiving direct HHS services.
- ◆ Number of Full Time Equivalent (FTE) staff associated with client related activity.
- ◆ Cost of providing services (staff cost plus program cost).

### Performance

Percent of client cases reviewed that demonstrate beneficial impact from services received. (*Beneficial impact is defined as risk mitigation and greater independence*)

Elements of the Composite Measure:

- ◆ Percent of high risk children, adults and families that have reduced risk after HHS services intervention
- ◆ Percent of individuals living more independently as a result of HHS services
  - ◆ Universe is 100% of customers receiving direct services.
  - ◆ Methodology: Quality Service Reviews (QSRs) will be conducted of cases randomly selected from pool that meet determined criteria for case review. Case review includes in-depth review of case record, interviews with customers and staff assigned to case.

### Story Behind Performance

- ◆ Focus on the beneficial impact of services provided directly by HHS. At this time, contracted services will be included in the case review only if received in combination with services provided directly by HHS.
- ◆ Customers receiving multiple services will be over-sampled as part of the Quality Service Review process, then data “weighted” for analytic purposes so that the over-sampling does not skew the overall results.

### Supporting Factors

- ◆ Department staff works across individual service areas systems to provide services and evaluate impact.
- ◆ Standardized expectations of case management exist, including intake and referral, assessment, case planning, service delivery and evaluation.
- ◆ Best practices models are used in many programs.
- ◆ The community is involved in our evaluative activities.

### Barriers

- ◆ The department did not previously have an operational practice model that supports integrated case practice.
- ◆ Data was not collected or analyzed to support continuous improvement in service delivery.
- ◆ Customers often present with complex needs and problems.
- ◆ HHS has limited resources to address all problems (public agency role is that of provider of last resort).

- ◆ The number of “evidence based practices” empirically validated as effective in addressing some social problems is limited.

### **What We Propose to Improve Performance**

- ◆ Develop and implement an integrated case practice model.
- ◆ Fully develop Quality Service Review case (QSR) review protocol as methodology for improving practice that involves community and agency reviewers.

### **Fiscal Impact**

The costs below covers all QSR activities related to departmental performance measures:

- ◆ \$75,000 initial cost in first year to develop Quality Service Review (QSR) model, establish system for implementation, train reviewers, data collection and analysis and reporting results.
- ◆ \$20,000 ongoing for training reviewers, data collection and analysis and reporting results.

### **Partnerships**

- ◆ Strong partnerships exist across HHS services to maximize beneficial impact to customers.
- ◆ Strong partnerships exist with HHS vendors to achieve beneficial impact to our customers.
- ◆ Strong partnerships exist with other public agencies such as DOCR, DHCA in the county to provide better services.

### **Innovation**

- ◆ HHS is implementing QSR as a department wide tool to assess qualitative impact of HHS services. The Department is in the process of engaging in a bridge contract the organization Human Systems and Outcomes and in partnership with the center for the Study of Social Policy to develop the nation’s first integrated Health and Human Services Quality Service Review tool. This tool will be field tested in February or March 2008 with a full fledged review occurring in late May or June of 2008 to help create the baseline for the FY09 budget cycle.
- ◆ With the Department of Technology services, HHS is seeking an ERP solution to meet HHS case practice related information needs. It is anticipated that interfaces will be built in with the 311/CRM system, the county stat system and the County ERP all of which are in various stages of development at this time.

### 3. Team-based Case Management

#### Basic Facts

- ◆ HHS serves approximately 70,000 clients on an unduplicated basis.
- ◆ Over 30,000 of these clients receive more than one service from HHS.
- ◆ Cross-systems team-based case management for customers receiving three or more services will be evaluated to determine performance on this measure.
- ◆ At any time, all 1,758 of HHS employees plus contracted partners could be involved in servicing customers within and across Service Areas.
- ◆ The HHS budget of \$263 million is involved in serving the universe of clients.

#### Breakdown of Active Cases Receiving Multiple Services

Number of Services	Number of Clients
2	19,834
3	7,163
4	2,157
5	670
6	168
7	54
8	8
9	6
	<b>Total 30,060</b>

#### Performance

Percentage of client cases needing assistance within three or more Service Areas for which effective teamwork is documented.

Methodology: Quality Service Reviews will be conducted of cases randomly selected from a pool that meet determined criteria. The case review will include in-depth review of case record and interviews with customers and staff assigned to case.

#### Story Behind Performance

##### Supporting Factors

- ◆ Staff expertise exists in many areas of health and human services.
- ◆ Many examples of teamwork occur now with teams forming informally.
- ◆ Case management and clinical intervention has best practice pathways mapped out.
- ◆ Practice values are aligned. Tremendous support exists within the Department to build a team model.
- ◆ The Quality Service Review methodology is well evolved and tested in other states and counties and is portable.

## Barriers

- ◆ Integrated case management is not the norm.
- ◆ No current methodology exists for case review and quality assurance that tracks both case specific and systemic performance.

## What We Propose to Improve Performance

- ◆ Define protocols for cross-systems team-based case management.
- ◆ Practice to cross-systems team-based management protocols.
- ◆ Manage to cross-systems team-based management protocols.
- ◆ Determine how teams will form, who will lead each team.
- ◆ Determine how information is coordinated and efficiencies are created.
- ◆ Track performance regularly and use data to manage the change process.

## Fiscal Impact

The costs below cover all QSR activities related to departmental performance measures:

- ◆ \$75,000 initial cost in first year to develop Quality Service Review (QSR) model, establish system for implementation, train reviewers, data collection and analysis and reporting results.
- ◆ \$20,000 ongoing for training reviewers, data collection and analysis and reporting results

## Partnerships

- ◆ Strong partnerships exist across HHS to ensure that customers benefit from the full range of HHS services they need and for which they are eligible.

## Innovation

- ◆ Development of a team based case management practice model. Currently, five workgroups are engaged in developing the practice model that will define service integration for the county. These pertain to the following areas of work:

- ◆ Integrated Intake
- ◆ Single assessment protocol/methodology
- ◆ Integrated Case Management
- ◆ Norms for family engagement
- ◆ Single case record

These recommendations will form the basis of the case practice model.

The deliverables from these workgroups will be finalized by December 31, 2007 with field testing in selected program areas to begin by January 1, 2008 and full implementation of the case practice model to begin department wide by July 1, 2008.

- ◆ Use of the QSR to assess effectiveness of team work within HHS and with HHS partners.

## 4. Contract Processing

### Basic Facts

- ◆ Over 520 business, consulting and direct services contracts are administered by Contract Management Team (CMT).
- ◆ 18 Requests for Proposals (RFPs) needed to be processed in FY07
- ◆ 33 new RFPs need to be processed in FY08.
- ◆ 2 RFPs resulted in contracts processed within deadlines in FY07.
- ◆ 11 Contract Management Team positions in which some or all of the job responsibilities are dedicated to processing RFPs.

### Performance

Percentage of new Request for Proposals (RFP) in which high quality contracts are executed by required HHS deadlines. *(High quality is to be measured by no increase in claims, modifications or challenges related to poor quality work.)*

### Story Behind Performance

#### Supporting Factors

- ◆ Multiple staff from the Department of Health and Human Services program areas and the Contract Management Team as well as the Office of Procurement, County Attorney's Office and other agencies is involved in this process.
- ◆ Each department's staff has their expertise and a set of responsibilities that are clearly outlined.

#### Barriers

- ◆ Workload, ratio of work volume to number of workers. In FY07, the Contract Management Team had 11 staff positions responsible for:
  - 18 RFPs
  - 12 memorandums of understanding
  - 12 claims
  - 1,800 Contract Actions.
- ◆ Other involved County support departments are understaffed with little redundancy in positions.
- ◆ Multiple steps managed by multiple programs and departments are required to complete the process.
- ◆ Delays that occur at any point in the process.
- ◆ Distribution of total work across Services Areas, the Contract Management Team and other County departments is skewed and inconsistent.

## What We Propose to Improve Performance

- ◆ Improve tracking system by identifying target deadlines for each step in the contracting process.
- ◆ Monitor progress toward goal on weekly basis using a department-wide computer based tracking system.
- ◆ Notify Chief Operating Officer and Service Area Chiefs of progress toward goals on a weekly basis.
- ◆ Evaluate distribution of workload between Service Areas and Contract Management Team.
- ◆ Work collaboratively with the Offices of Procurement, County Attorney, Risk Management, and the Office of Community Partnerships on contract reform.

## Fiscal Impact

- ◆ \$145,720 annualized including infrastructure to hire two additional staff in FY09.

## Partnerships

- ◆ Strong partnerships with the Office of Procurement and the County Attorney to ensure that HHS is able to meet this performance measure.
- ◆ Streamline business processes within HHS to ensure that the program areas and the contracts management team are working collaboratively to meet this performance measure.

## Innovation

- ◆ HHS partnership in the county wide contracts reform and non-profit partnership effort jointly initiated by Office of Procurement (DOP), Office of Community Partnerships, Department of Health and Human Services (HHS), Department of Housing and Community Affairs (DHCA), County Attorney and Office of Risk Management. Outcomes of this effort are tri-fold:
  - ◆ improve internal county government processes to streamline contracting
  - ◆ strengthen the non-profit sector to deliver improved high quality services at real cost in a supportive but competitive environment
  - ◆ implement a strong foundation for performance based contracting with a well thought out incentivized payment structure in all county contracts.

## 5. Contracted Services Performance Measurement

### Basic Facts

- Over 520 contracts (competitive and non-competitive)
- Over \$75M of services are procured through contracts (competitive and non-competitive)

### Performance

- Percentage of contracts that include performance measures related to risk mitigation and greater independence for customers served. (Performance measures will be specific to the Service Area related to the contract, but will focus on the two areas of beneficial impact.)

### Supporting Factors

Within the existing process,

- Expectations are identified in Requests for Proposals and included in final contract.
- Requirements are identified in federal and state funding streams.
- Outputs and deliverable timelines are well identified.

### Barriers

- The practice of contract monitoring is not standardized and consistently executed throughout the department.
- The operational definition of performance measures is inconsistent throughout the department.
- The volume of contracts monitored is enormous.
- Numerous staff throughout the department perform contract monitoring functions that range from very little to 100% of their job responsibilities.

### What We Propose to Do to Improve Process

- Standardize the definition and understanding of performance measures.
- Train Service Area staff on the development of and monitoring for performance measurement.
- Review Requests for Proposals and contracts for inclusion of performance measures.
- Incorporate performance measurement into the tracking system for contracts.
- In Year 2 begin to set targets and manage to performance.

### Fiscal Impact

Costs will be absorbed within the HHS budget.

## 6. Limited English Proficiency Language Assistance

### Basic Facts

- ◆ HHS staff had 34,000 service encounters with customers identified as having Limited English Proficiency served by HHS in FY06.
- ◆ The Department has 243 certified bilingual staff, including 194 staff certified in Spanish.
- ◆ The most commonly encountered languages among HHS customers are: Spanish, Amharic, French, Chinese, Korean, Vietnamese, Russian, Farsi, and Portuguese.
- ◆ \$240K in the FY08 budget is allocated for language services including the language line use and translation services.
- ◆ Three types of language services are offered: bi-lingual or multi-lingual staff to meet diverse customer needs, interpreter services and language line services.
- ◆ 38% of certified bilingual staff time spent 25 to 40 hours per week using their bilingual skills. (FY06 staff survey).

### Performance

Percentage of customers identified as needing language assistance that receive linguistically appropriate services.

*(Quality of performance will be assessed under the beneficial impact and customer service measures.)*

### Story Behind Performance

2005 Census data show:

- ◆ 29% of the county's total population of 927,583 was foreign born.
- ◆ 29.5% (1,520 out of 5,150 families below the Federal poverty line) have a family member who is Limited English Proficient.
- ◆ 12.5% of the total County population spoke English "not well" or "not at all," (or Limited English Proficient).

### Supporting Factors

- ◆ All HHS staff receives LEP training about the department's policy and procedures for providing language services.
- ◆ Language usage tracking system data is shared with the department's managers to help identify emerging language trends and to plan for staffing patterns, staff recruitment and outreach efforts.
- ◆ Trained medical interpreters are provided for patients referred to County funded clinics operated by the Primary Care Coalition and Mobile Med. The County provides \$600,000 for these contracted interpretation services through the Latino Health Initiative and the Asian American Health Initiative.

### Barriers

- ◆ The rapid growth of the diverse immigrant and undocumented population spread across the County creates challenges for tracking and outreach efforts.
- ◆ The Federal LEP requirement also affects HHS contractors, adding to the cost of providing language services for LEP clients and therefore impacting the overall cost of delivering the same level of services.
- ◆ HHS needs increased staff capabilities in more languages.

- ◆ Consistency and accuracy of LEP data entry into department's data information system is questionable.

### **What We Propose to Improve Performance**

- ◆ Conduct quality review of existing data; improve data entry compliance and accuracy.
- ◆ Identify best ratio/mix of language resources and services to serve customers.
- ◆ Provide training and technical assistance to contracted service providers on the department's LEP policies and procedures.
- ◆ Conduct ongoing analyses of in-house language capability to plan for language coverage across programs and in various geographical areas.
- ◆ Increase recruitment of bilingual staff.
- ◆ Continue to provide LEP training to new employees and existing staff.
- ◆ Develop and promote outreach programs to the LEP community that are multilingual and educate County residents about HHS programs and eligibility guidelines.

### **Fiscal Impact**

Costs will be absorbed within the HHS budget.

## Providing Safe Streets and Neighborhoods

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### 7. Juvenile Justice Assessments, Screenings and Referrals

#### Basic Facts (FY06)

- ◆ 1,500 County youth under 18 years of age received an alcohol citation and another 2,500 were subjected to physical arrest by the Montgomery County Police Department (MCPD).
- ◆ 3,200 of the youthful offenders were referred directly to the DJS, while about 800 youth who had either received an alcohol citation or who had committed certain nonviolent misdemeanors (usually for the first time) were “diverted” to HHS where they received substance abuse and mental health screening and referrals, if needed, to education or treatment.
- ◆ 94% of youth who were diverted to HHS by MCPD were assessed “compliant” with the terms of their diversion agreement. Those who were non compliant were referred to the DJS intake office.
- ◆ The HHS Juvenile Justice Services’ unit and the HHS Behavioral Health Access team partner to provide mental health treatment referrals for Medicaid eligible youth who are diverted.
- ◆ 30% of diverted youth entered intensive substance abuse or mental health treatment; an additional 27% received intensive substance abuse education including urinalysis, and 33% received less intensive substance abuse education. The remaining 10% were referred back to MCPD to complete community service or other requirements.
- ◆ 23.5 work years and \$1.86 million were expended for operation of the juvenile assessment center and the Screening and Assessment Services for Children and Adolescents (SASCA), the alcohol and substance abuse screening program.

#### Performance

Percentage of offenders under 18 years who are diverted into HHS substance abuse education and treatment or mental health treatment programs that do not re-enter the juvenile justice or adult correction system within twelve months of being assessed compliant with requirements.

#### Story Behind Performance

##### Supporting Factors

- ◆ An array of community-based substance abuse and mental health education and treatment services are available to youthful offenders.
- ◆ Good cooperation exists among HHS, MCPD, DJS agencies and community substance abuse education and substance abuse and mental health treatment providers.
- ◆ MCPD diversion eligibility criteria are pre-established and based upon the severity of the offense and whether or not the youth is a first time offender.
- ◆ HHS has a 10-year track record in providing “diversion” services and a veteran substance abuse and mental health screening and assessment staff.

## Barriers

- ◆ Underlying individual and family factors that result in criminal behavior are not always easily impacted; as a result, HHS interventions are not always effective in preventing recidivism.
- ◆ Some criminal cases against youth who are cited again or re-arrested may eventually be dropped by DJS.
- ◆ “Recidivism” rates or repeat offenses for youthful offenders diverted into HHS programs are not currently available.

## What We Propose to Improve Performance

- ◆ Information on youth who have successfully complied with terms of a HHS diversion program during FY05-FY06 is expected in the second quarter of FY08 from the Montgomery County Juvenile Justice Information System (JJIS). FY07 data is expected by the end of FY08. MCPD also will provide Criminal Justice Information System (CJIS) data on 17-year olds who completed a HHS diversion program as a juvenile, but who were re-arrested within twelve months as 18 or 19 year olds and charged as adults.
- ◆ Analyze JJIS data for diversity trends to determine if diversion and outcomes are disproportionate based on race or ethnicity.

## Fiscal Impact

Costs will be absorbed within the HHS budget.

## Partnerships

- ◆ The Gang Prevention Initiative involving the Police Department, Recreation, MCPS, the Maryland Department of Juvenile Justice, HHS, Regional Services Center, State’s Attorney, private sector partners and the community, is a critical tool in HHS efforts in this area.

## Innovation

- ◆ Pursue viability of making juvenile justice a county function. The county is beginning the initial exploratory conversations with the Secretary of the State Department of Juvenile Services to discuss the possibility of community based parole and probation services coming to the county. This would have a fiscal impact. At this time however, the scope of the project and potential cost is unknown. HHS is currently only in the fact finding stage.

## Healthy and Sustainable Communities

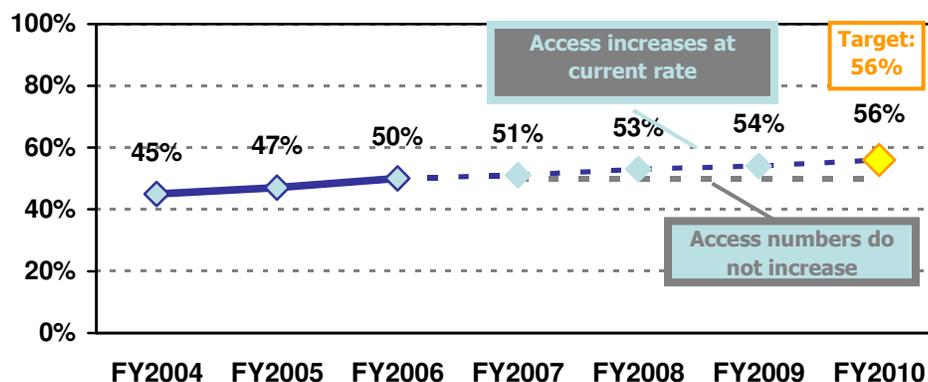
### 8. Providing the uninsured with health care coverage and a regular source of care

#### Basic Facts

- ◆ Montgomery County has 104,529 uninsured residents, including 29,492 children.
- ◆ County DHHS staff enrolled 68,583 County residents in various federal or State funded health insurance programs in State FY 2005.
- ◆ DHHS staff enrolled 4,277 uninsured children, who are not eligible for State or federally funded programs into County Care for Kids program in FY 07; referred 13,273 uninsured adults to the Montgomery Cares program to assure access to basic primary health care and prescriptions; and enrolled an additional 2,308 pregnant females into Maternity Partnerships to assure access to prenatal care and delivery services in FY 07.

#### Performance

Percentage of uninsured individuals who are either enrolled in a medical entitlement program or have an HHS primary care or prenatal care visit. *(Quality of performance will be assessed under the beneficial impact and customer services measures).*



#### Story Behind Performance

##### Supporting Factors

- ◆ Multiple entry points provide enrollment including Public Health Service Eligibility Units; Aging and Disabilities sites; Children, Youth and Families Income Support units; Montgomery Cares clinics; Correctional facilities; Emergency Departments, and Recreation Centers.
- ◆ County leadership supports continued expansion of capacity for Montgomery Cares clinics for uninsured adults.
- ◆ HHS provides language interpretation for large number applicants with limited English ability, online application available for Maryland Children's Health Insurance Program in English and Spanish, and Health Promoters from the community and other outreach staff.
- ◆ Volunteer doctors and nurses contribute valuable time; clinics and hospitals contribute services.

- ◆ Hospitals cover half the cost for County eligibility staff working in Emergency Rooms.
- ◆ State grants and federal reimbursement cover full or partial costs of many County eligibility staff.

### **Barriers**

- ◆ State and federal eligibility criteria for entitlement programs.
- ◆ The number of eligibility staff is insufficient to meet the demand resulting in a long wait for processing enrollment.
- ◆ New proof of citizenship required by federal/State Medical Assistance presents challenges for residents and staff.
- ◆ The capacity at Montgomery Cares clinics does not meet needs of the uninsured adult population.
- ◆ Many residents are not aware they are eligible for a federal/State program which results in higher unmet demand for County safety net programs.

### **What We Propose to Improve Performance**

- ◆ Advocate for hiring and training additional eligibility workers as supported by data.
- ◆ Continue to streamline procedures for residents applying for programs.
- ◆ Continue to expand capacity of Montgomery Cares program to meet demand.
- ◆ Standardize eligibility requirements in all participating clinics in Montgomery Cares Program.
- ◆ Launch the multilingual Montgomery Cares website ([www.MontgomeryCares.org](http://www.MontgomeryCares.org)) and its brochures in multiple languages in FY 08 and FY09.
- ◆ Continue to work with the Collaboration Council to highlight programs on the new resources website now available to County residents ([www.InfoMontgomery.org](http://www.InfoMontgomery.org))
- ◆ Advocate for additional volunteer Health Promoters and train them to explain how to apply for available publicly funded health insurance/primary care programs.

### **Fiscal Impact**

Additional fiscal resources will be identified through the budget process.

### **Partnerships**

- ◆ Access to healthcare for the uninsured and underinsured requires very strong partnerships with community based health clinics and local hospitals. Montgomery County has a unique network of provider partnerships to support this very important outcome.

### **Innovation**

◆ Montgomery County is the only county in the State and probably one of the few jurisdictions nationally to attempt this issue and develop infrastructure to address this important policy consideration. HHS is examining new and different governance structures to better support the outcomes of providing healthcare to the uninsured through a public-private partnership.

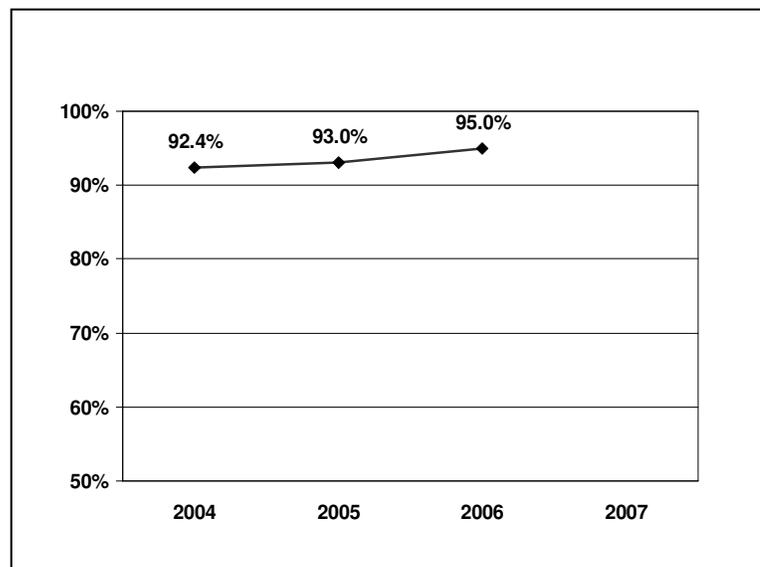
## 9. Communicable Diseases Control

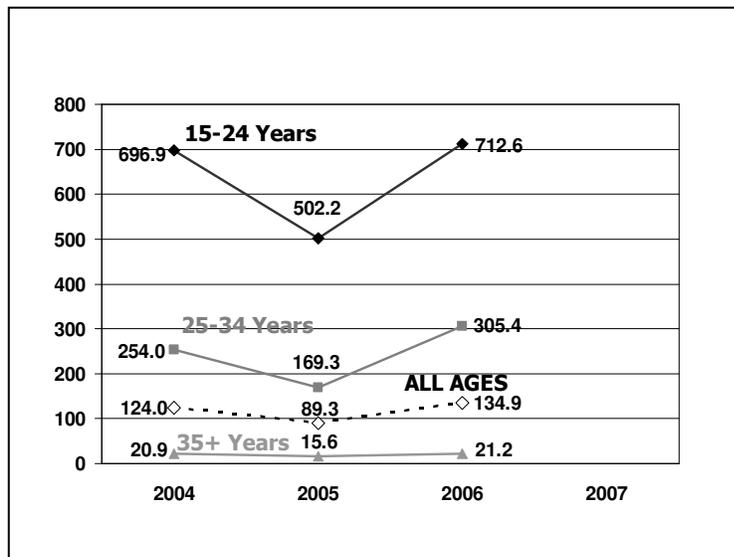
### Basic Facts

- ◆ Annually, within Public Health Services, there are over 110 foodborne complaints/investigations (including Campylobacter, E.coli, Hepatitis A, Salmonella or Shigella), 2,500 communicable disease cases (including vaccine-preventable diseases, rabies exposure, Lyme disease, and bacterial meningitis), 75 active TB investigations involving approximately 1,000 individuals, and 575 STD (Chlamydia, Gonorrhea, HIV and Syphilis) investigations. Approximately 200 suspected cases of TB are evaluated annually, with an average of 75-80 cases requiring and undergoing treatment.
- ◆ The HHS TB program annually manages approximately one out of every 200 of the national TB cases (approximately 25-30% of Maryland cases).
- ◆ The HHS Immunization Program administered 23,629 vaccines to 15,634 children and 5,980 vaccines to 4,250 adults.
- ◆ Time frames and workload for outbreaks vary based on severity- a single outbreak may be resolved in a few days or three months. Smaller outbreaks are managed by one investigator but larger outbreaks take 8-10 investigators to control. Timeframes from onset of symptoms to case investigation range are outlined in protocols according to contagion and vary based on severity and mode of transmission of the contagion.
- ◆ Communicable Diseases and Epidemiology is supported with 74.5 work-years and \$9.056 million in FY08 with Foodborne Diseases and Illnesses being addressed in an integrative approach with Licensure and Regulatory Services, contributing an additional 13.6 work-years and \$1.345M in FY08.

### Performance:

Percent of clients with active infectious tuberculosis who receive directly observed therapy and successfully complete the 6-to 24-month treatment regimen.





**Chlamydia Incidence Case Rates per 100,000 Population among Montgomery County Residents by Age**

*(Rapid response to prevent further spread of disease and prompt and appropriate treatment once a patient is diagnosed with TB or STD)*

### Story Behind Performance

- Public Health Services engages in multiple activities that are designed to: prevent disease from occurring through immunization, outreach and education programs; identify/diagnose disease through education, screening, and diagnostic evaluations; treat diagnosed diseases using most effective prescribed protocols; and limit the further spread of disease with education, outreach, and partner/contact notification for persons exposed to contagion.

### Supporting Factors

- ◆ Quick response time to outbreaks and emerging diseases is the norm.
- ◆ Education, trust and the Maryland Code of Regulations are used to ensure persons with illness are consistently practicing healthy behavior, with emphasis on completion of treatment and adherence to treatment regimens.
- ◆ Sustaining strong relationships with key partners including: State DHMH laboratory for diagnostic lab testing, consultations with the local detention centers, private medical community, major clinical trial groups in the metropolitan area, Federal Quarantine Facility located at Dulles, and academic institutions.
- ◆ Immunizations are offered to County residents of all ages in a variety of settings and after hours.
- ◆ Intensive medical and nurse case management of diagnosed diseases is provided.
- ◆ Aggressive strategies in place for contact tracing and partner notification.
- ◆ Public health investigations follow federal and state guidelines for controlling communicable diseases, using sound epidemiological principles.
- ◆ TB control program provides screening to contacts of infectious cases of TB, to newly arrived refugees, immigrant students prior to admission, county residents per job classification, inmates at the Detention center, clients entering substance abuse centers and to symptomatic residents who walk in to the clinic to rule out TB. The clinic also provides treatment for latent TB infection to high risk individual with the appropriate intervention/follow up.

- ◆ The TB Program successfully manages a number of drug resistance cases as well some cases of multi-drug resistant tuberculosis (MDR-TB) where treatment can extend to two years.

### Barriers

- ◆ Public perception of risk is often inconsistent with actual risk, with the potential of untreated communicable disease presenting high risks to the general public.
- ◆ Public health is challenged to find a balance to motivate people to have safe and prudent behavior verses overreaction, restriction and seeking unnecessary treatment.
- ◆ County residents without legal status fear seeking medical care and consequently present with advanced disease.
- ◆ A lack of trust and denial delays screening and treatment.
- ◆ While STD clinics see 150 customers weekly to be tested for an STD, the lack of capacity causes an additional 100+ callers to be turned away weekly- 65% of callers get an appointment, with 35% of callers postponed and asked to call back at a later date.
- ◆ TB program waiting times for clients to commence treatment for latent TB infection could be up to 4 weeks.
- ◆ HHS will not be able to respond in a timely manner to all presenting cases, or be able to provide the full spectrum of services and delivery of care currently available to meet the needs of the community due to 20 percent annual shortfall in grant revenue. Consequently, customers could be identified in advanced stages of disease, and may result in increased cost, illness and death.
- ◆ There is an increase in co-morbidity among communicable diseases.

### What We Propose to Improve Performance

- ◆ Improve internal process for completing reports on closed cases to DHMH.
- ◆ Provide education/outreach on preventing and limiting the spread of communicable diseases by providing consistent cultural and language appropriate messages on all aspects of health topics to improve public awareness and trust in HHS services.
- ◆ Continue to invest in relationships with key partners.
- ◆ Continue to assess changing needs of the community and develop innovative ways to address those needs, such as increasing access via evening clinic hours.
- ◆ Advocate for additional revenue to compensate for shortfall from grant awards Two grants were decreased in FY08 amounting to a loss of \$41,000. All other grants were level-funded which requires General Fund revenue to meet salary increments and COLA expenses. With less operating revenue for grants, most or all grant funds go toward personnel costs. A current staff vacancy in one of the grants is being lapsed to compensate for a grant shortfall.
- ◆ Advocate for additional clinic staff and space for appropriate screening, treatment, education and counseling/case management, specifically for an STD clinic up-county.
- ◆ Improve internal process for managing patient flow.

- ◆ Advocate for resources to train staff on best screening, counseling and treatment practices.

### **Fiscal Impact**

\$41K in FY08 to compensate for shortfall from grant awards.

### **Partnerships**

- ◆ Strong partnerships necessary with public and private community partners including those at local, State and federal levels to ensure effective disease detection/surveillance, treatment and containment.
- ◆ Strong partnership with Office of Homeland Security.

### **Innovation:**

- ◆ A syndromic disease surveillance information system developed in partnership with the Federal and Maryland State Governments. The Electronic Surveillance System for the Early Notification of Community-based Epidemics (ESSENCE), provides ongoing and systematic collection, analysis and interpretation of health data that are used to determine the need for public health action and to assess the effectiveness of programs. The ESSENCE syndromic surveillance system that is supported by the Johns Hopkins University Applied Physics Laboratory is designed to capture both naturally occurring infectious diseases and bioterrorism. On a daily basis, data streams from multiple health settings in the community (including emergency room visits from area hospitals, military outpatient visits, over-the-counter pharmacy sales, and school absenteeism) are analyzed using standardized algorithms derived by CDC and the US Department of Defense according to key syndrome groups (respiratory, neurological, dermatologic (hemorrhagic and infectious) fever/malaise/sepsis, gastrointestinal, and coma/sudden death), with alerts posting any anomalies that need investigation by the epidemiologist to rule out or verify the finding.

# Preparing Children to Live and Learn

## 10. Early Childhood Services and Programs

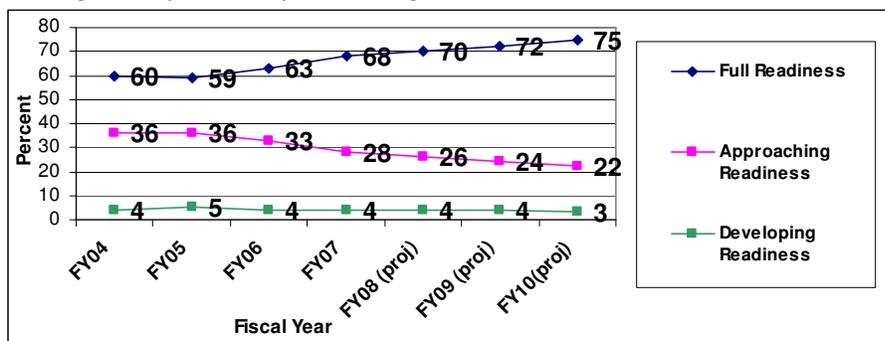
### Basic Facts: (FY07)

- Over 60,000 children ages 0-4 resided in the County (U.S. Census); 12,000 County 5-year olds were enrolled in public and private kindergarten programs.
- Child care information and referral was provided to almost 50,000 parents.
- The Infants and Toddlers Program active caseload was 1,800 families. (6/07)
- 648 children were enrolled in Head Start.
- 5,459 health screens for newborns were conducted in hospitals by the Baby Steps program contract staff.
- 12,439 program referrals were made to early childhood and family support services by CHILDLINK staff.
- 3,973 child care providers received workshop training and 96 received scholarships to pursue early childhood coursework at Montgomery College.
- 17,257 pieces of early childhood public engagement materials were distributed.
- 100% of children receiving HHS early childhood mental health services avoided expulsion from child care
- ECS: \$4.9 million includes \$2.8 million in contracts. 18.4 work years.
- PHS: \$7.5 million for Maternity Partnership, Case Management of Pregnant Women and Infants, Head Start Health, and Preschool Immunizations. 70 work-years.

### Performance:

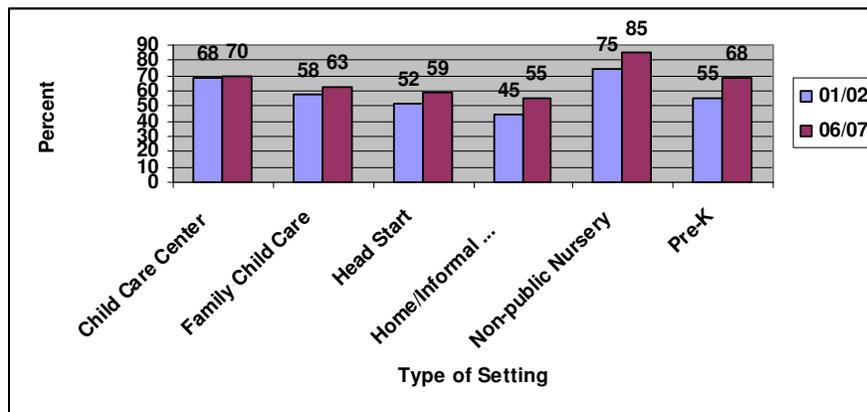
Percentage of Head Start, licensed child care center, and family-based child care students that demonstrate “full readiness” upon entering kindergarten. (Measurement takes place after entry into kindergarten. Hence, prior care is assessed in the context of a child’s readiness to learn upon entry to kindergarten.)

### Montgomery County Kindergarten Student Readiness



Source: Maryland State Department of Education (MSDE)

## Percentage of Kindergarten Students Fully Ready by FY by Prior Child Care Setting



Source: Maryland State Department of Education (MSDE)

### Description of performance

- The percentage of MCPS children achieving full kindergarten readiness has increased steadily in recent years. The Maryland State Department of Education (MSDE) defines “full readiness” as: Students consistently demonstrate skills, behaviors and abilities needed to meet kindergarten expectations successfully.
- The percentage of County kindergartners assessed as fully ready has exceeded the State’s average for the last four years.
- The percentage of children achieving full kindergarten readiness varies by type of prior child care setting; those in child care centers (nonpublic nursery school, pre-K) demonstrate the highest readiness scores. Children in home/informal care demonstrate the lowest readiness scores. Kindergarten readiness has improved in all settings between 01/02 and 06/07.

### Story Behind Performance

#### Supporting Factors

- Collaborative partners at the State (the Governor’s Office, MSDE and Maryland Department of Health and Mental Hygiene) and County levels (Montgomery County Public Schools (MCPS), the Department of Libraries, the Department of Recreation and private non-profit partners) provide a continuum of comprehensive services to support children’s successful transition to kindergarten, and continue to show annual improvement in coordination and service delivery. Increased focus on collaboration among partners led to improvements in academic performance over the past four years, FY04-FY07
- Effective MCPS Head Start curriculum, teacher and instructional assistant training, and program guidance and training of the family service workers and social workers that work with each Head Start family, contribute to better kindergarten readiness for children enrolled in the Head Start program.

#### Barriers

- ♦ Children enrolled in Head Start, who come from families with incomes below the federal poverty level, face several disadvantages compared to their counterparts in privately operated child care programs:
  - ♦ 60% come from single parent families

- ♦ 54% come from homes where the primary language is not English
- ♦ in 31% of Head Start families, the parents' highest level of education is less than high school; another 36% have only high school diplomas or GEDs.
- ♦ A significant percentage of all immigrants coming into the State of Maryland settle in Montgomery County, creating challenges to providing culturally appropriate early childhood services.
- ♦ Lack of funding for public engagement educational outreach limits access to appropriate services and constrains progress in kindergarten readiness.

### **What We Propose to Improve Performance**

- ♦ Seek funding for a public engagement campaign for outreach to the diverse population with a goal of increasing awareness among parents and caregivers about school readiness, in particular skills that will assist children entering kindergarten to be assessed as “fully ready.”
- ♦ Increase the availability of community based pre-kindergarten programs and professional development for child care providers aligned with MCPS Pre-Kindergarten curriculum.
- ♦ Advocate for a reduction in the State’s Purchase of Care program parent co-pay so that more income eligible families can afford quality child care.
- ♦ Analyze ethnic and racial variations in County MSDE kindergarten readiness data and assess special needs of limited English-speaking populations.

### **Fiscal Impact**

Costs will be absorbed within the HHS budget.

### **Partnerships**

- ♦ This performance measure is strongly dependent on our partnerships with the State Department of Education, child care licensing, the Montgomery County Public School System and the Montgomery County Child Care Provider community.

### **Innovation**

- ♦ Early childhood services and programs are experimenting with the most successful evidence based wrap-around model to improve outcome of children entering kindergarten ready to learn. The new universal pre-kindergarten RFP out on the street will support the identification and sustainability of the most effective evidence based practice in early learning.

# Ensuring Vital Living for all of our Residents

## 11. Employment Related Services

### Basic Facts

- Federal law requires TCA recipients who are not exempted to participate in employment activities leading to economic self sufficiency in order to qualify for and retain TCA. If eligible, they can receive Medicaid and food stamps and qualify for child care subsidies and transportation reimbursement while participating in employment activities.
- The State of Maryland tracks outcomes relevant to increased economic independence for TCA recipients who receive job placements including: job retention rate, earnings gain rate, hourly wage rate at job placement, and percentage with full time employment that are offered health insurance benefits within one year of case closure.
- Budget/Staffing: FY04, \$2.7 million, 7.6 workyears; FY05, \$2.5 million, 7.6 workyears; FY06, \$2.6 million, 7.8 workyears

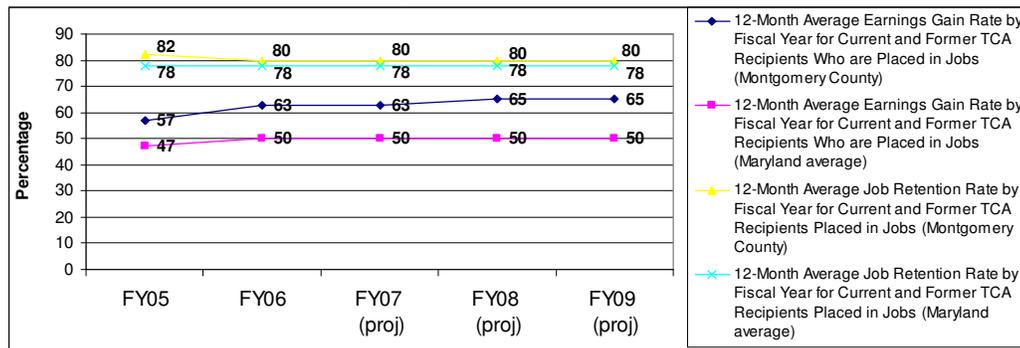
### Performance

Percent of Temporary Cash Assistance (TCA) recipients who are placed in jobs that demonstrate evidence of greater economic independence during the first year following job placement.

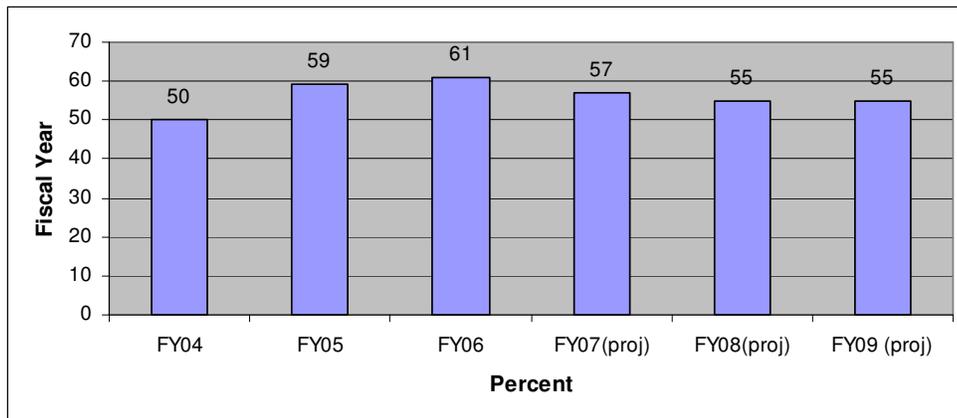
Components of the measure:

- 12 Month Average Earnings Gain Rate for current and former Temporary Cash Assistance (TCA) recipients who receive job placement
- 12 Month Average Job Retention Rate for current and former TCA recipients who receive job placement
- 12 Month Average Hourly Wage for TCA recipients at job placement
- Percentage of TCA recipients offered health insurance benefits within one year of job placement

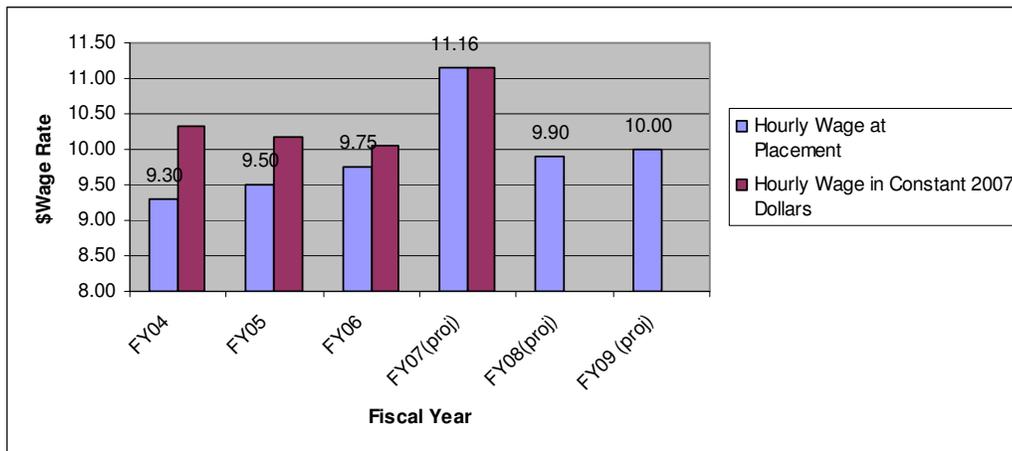
TCA Earnings Gain Rate and Job Retention



**Percentage of TCA Recipients Offered Health Insurance Benefits Within One Year Of Job Placement**



**Hourly Wage Rate For TCA Recipients At Job Placement in Real/Constant Dollars**



### Story behind the performance

- Between FY04 and FY07 over one-half of all TCA recipients who were placed in fulltime jobs were offered health insurance benefits within one year of employment.
- Montgomery County has consistently surpassed the State in job retention and earning gain rate in recent years.

While the hourly wage rate at job placement for Montgomery County TCA recipients rose between FY04-FY06, the wage rate in constant dollars actually decreased, indicating that the wage rate increase did not keep pace with inflation.

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### Supporting Factors

- ♦ HHS intensive case management and follow-up services to TCA applicants and recipients increases the likelihood that those eligible will be able to obtain and retain jobs that will enable them to become more economically independent
- ♦ Strong partnerships with other public agencies such as Economic Development and with our private sector partners as job placement resources for internships and permanent employment.

### Barriers

- ◆ Funding for intensive long-term tracking of client outcomes was cut in the past so that only minimal follow-up of TCA clients' employment status and job earnings now occurs.
- ◆ Earned Income data are not available for some time periods for current or former TCA recipients who are federal workers, affecting both the earnings gain and the job retention statistics.
- ◆ There is a significant lag in data availability from the State MABS database for data on earnings, job retention, hourly wages and health insurance offered.

## What We Propose to Improve Performance

- ◆ Strengthen the comprehensive employment services program with a new vendor beginning in FY08 to maintain 10 year better than average performance on all of the State's performance measures.
- ◆ Work with the State Office of Economic Development to bring jobs to the County that employ TCA recipients at a wage level that will promote family self-sufficiency and that will provide health insurance benefits within one year.

### Fiscal Impact

Costs will be absorbed within the HHS budget.

### Partnerships

- ◆ This performance measure requires strong partnerships between the Department of Economic Development, the County's Welfare Innovation Board, the private business community, and HHS private sector employment training partners, the State Department of Human Resources, the State Departments of Economic Development and Labor, Licensing and Regulations and our customers.

# Affordable Housing in an All-Inclusive Community

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## 12. Housing Services

### Basic Facts

- ◆ Supportive Housing Rental Assistance Program (SHRAP) began housing special needs renter households in late FY07. In FY08, it is anticipated to provide permanent supportive housing to 75 households with incomes below 30% of Area Median Income (AMI) and at least one special need which is defined as homeless, developmental disability, chronic mental or substance abuse, co-occurring disability, sensory, cognitive or mobility impairment, elderly in need of assisted or independent living, or youth transitioning from a system of public custodial care. Supportive services are provided to each household in addition to a “deep” rental subsidy. Budget: Over \$1M with 0.5 WY.
- ◆ Partnership for Permanent Housing 2 (PPH2) began housing homeless households in mid FY07. In FY08, it will provide a “deep” rental subsidy and supportive services for 55 homeless households with incomes at or below 30% of AMI. Budget: Over \$1M.
- ◆ In FY07, 5,700 emergency services grants were issued with County and State funds to assist households with preventing evictions and utility cutoffs. 80 grants also assisted with burial expenses and 205 grants assisted with other emergency issues. Budget: County Funds \$1.4M; State Funds over \$1M.
- ◆ Home Energy Assistance Program provided approximately 6,000 Maryland Energy Assistance Program (MEAP) grants and 6,000 Universal Service Program (EUSP) grants in FY07 to households at or below 150% of the Federal Poverty Level to help with electricity and heating costs.

### Performance

- ◆ Percentage of households remaining housed 12 months after participating in the SHRAP or PPH2 permanent supportive housing program. (Baseline will be established in FY08 - programs have not been in operation for a full 12 months.)
- ◆ Percentage of households that received an emergency financial grant for eviction prevention or for help with electricity and heating costs that sought additional assistance within 12 months. (Baseline will be established in FY08)

### Story Behind Performance

#### Supporting Factors

- ◆ HHS provides specialized case management, mental health and substance abuse counseling and referrals to a range of services such as mediation, training and employment to help maintain housing stability for vulnerable households. HHS also supports over 20 programs in Housing Stabilization Services, Transitional Housing and Shelter Services, including 35 contracts that offer shelter, transitional housing and other programs benefiting poor and homeless persons.

- ♦ County Rental Assistance Program (RAP) in FY07 assisted an average of 1,715 low-income families and disabled and elderly households whose incomes were below 50% of area median income (AMI) to pay rent. Budget: \$4.3M, 4.5 WY.
- ♦ Handicapped Rental Assistance Program (HRAP) in FY07 assisted an average of 215 individuals monthly who reside in a group home and have a mental illness. Budget: \$480K.

### Barriers

- ♦ Fair Market Rent (FMR) for a two bedroom apartment in Montgomery County is \$1,286. A household must earn \$51,440 annually to afford this level of rent and utilities without paying more than 30% of income on housing. This translates to a Housing Wage of \$24.73 per hour.
- ♦ Shortage of Affordable Rental Units.
- ♦ Increase in number of people needing assistance.
- ♦ Additional support services and intensive case management required beyond rental subsidies to ensure special needs populations maintain their housing.
- ♦ Waiting lists for SHRAP and RAP because funds budgeted are insufficient to serve all applicants determined to be eligible.

### What We Propose to Improve Performance

- ♦ Collaborate with HHS partners to pilot “Housing First” to expedite the movement of homeless families and single adults into permanent housing
- ♦ Seek case management services to support vulnerable households that seek financial assistance more than twice in a calendar year.
- ♦ Explore creating a project-based component to SHRAP to leverage new housing options for the special needs population.
- ♦ Collaborate with HOC and DHCA to explore opportunities to increase the supply of affordable housing units.

### Fiscal Impact

Resources will be determined through the budget process.

### Partnerships

- ♦ This performance measure requires strong partnerships between HHS, DHCA, our homeless services coalition members and the non-profit community, Housing Opportunities Commission, landlords and tenant associations, municipalities within the County, and the development of sound County policy with our key policy makers and stakeholders.

### Innovation

- ♦ Implementation of Housing First Initiative Pilot. There are three primary goals of the Housing First Philosophy:
  - ♦ Move families through the intake/assessment phase of the system as quickly as possible
  - ♦ Place families into suitable housing as quickly as possible
  - ♦ Deliver the necessary services required to keep families in housing to stabilize their situation and prevent a reoccurrence of homelessness.