Performance Measures

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Department of Health and Human Services

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Table of Contents

Overview

DHHS Service Areas and Programs

DHHS Headline Measures

Overview

Mission

The mission of the Department of Health and Human Services (DHHS) is to promote and ensure the health and safety of the residents of Montgomery County and to build individual and family strength and self-sufficiency.

The Department ensures delivery of a full array of services to address the somatic and behavioral health, economic and housing security, and other health and human services needs of County residents. DHHS directs, manages, administers, funds and delivers critical supports for the most vulnerable residents. Services provided also include 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 FY09 budget of $273.5 million and 1,741 staff positions representing 1,609 work years.

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 discussed in general terms below.

Contribution to Montgomery County Results

The Department's 14 Headline Measures are ordered according to their primary contribution to Montgomery County Results.

A Responsive and Accountable County Government

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

2. **Direct DHHS Services**
   - Determining the impact of receiving DHHS services is central to facilitating a successful outcome for the customer.
   - Determining the impact on customers of receiving DHHS services is a management tool for ongoing quality service improvement.

3. **Team-based Case Management**
   - Cross-systems team-based case 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 case management leads to improved outcomes for customers: risk mitigation, greater independence, improved health, better access to services and successful case closure.

4. **Contract Processing**
   - DHHS customers and service providers benefit from having contracts to provide programs and services approved to begin operation within in a reasonable time frame.
   - DHHS 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 future funding and contracting decisions.

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

SAFE STREETS AND SECURE NEIGHBORHOODS

7. **Juvenile Justice System Screening, Assessments and Referrals**
   - National studies indicate that 50-70 percent of youth entering juvenile justice systems have substance abuse and/or mental health problems. 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 will reduce the number of repeat youth offenders and minimize the number of youth referred to the Maryland Department of Juvenile Services (DJS) or the Maryland Department of Corrections.

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 in the County Care for Kids program, enrolls low-income uninsured pregnant women in the Maternity Partnership Program and refers adults to the Montgomery Cares program to ensure 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 their further spread.
- DHHS programs provide timely and appropriate response to reports of communicable diseases.
- DHHS programs provide access to prevention, diagnosis/early intervention and treatment of communicable diseases for at-risk (exposed) individuals.
- DHHS educates the public on best practices to further limit the spread of disease and protect the health of individuals.

10. Social Connectedness and Emotional Wellness

- DHHS provides a comprehensive system of mental health and substance abuse treatment services to children, youth, adults and families. Services incorporate evidence-based or best practices along a continuum of care.
- Crisis and victim services are available around the clock. Victimization occurs in schools, homes and in the community.
- Access to behavioral health specialty services provides screening and referrals along with treatment on an outpatient basis.
- Services to families with public health insurance are monitored including outpatient mental health clinics, psychiatric rehabilitation and residential rehabilitation programs.

CHILDREN PREPARED TO LIVE AND LEARN

11. DHHS Early Childhood Services and Programs

- DHHS Early Childhood Services (ECS) partners with many public and private programs. As one example, the DHHS 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.
- DHHS 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.

VITAL LIVING FOR ALL OF OUR RESIDENTS

12. Employment Services

- DHHS assists County residents who meet eligibility criteria in obtaining Temporary Cash Assistance (TCA), the federal cash benefit program.
- DHHS 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.

13. Maintaining Independence in the Community

- DHHS provides assessment and continuing case management, and an array of services to elderly and disabled County residents including: nursing assessment, personal care, housing subsidies, structured and supervised daytime activities, respite care, home modifications and assistive devices, and support groups for caregivers.
- The DHHS Older Adult Waiver program allows for more in-depth array of services to prevent premature institutionalization.

AFFORDABLE HOUSING IN AN INCLUSIVE COMMUNITY

14. Housing Services

- DHHS works to:
    - 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.

DHHS Service Areas and Programs

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 associated FY09 budgets: Aging and Disability Services; Behavioral Health and Crisis Services; Children, Youth and Family Services; Public Health Services, and Special Needs Housing.

Aging and Disability Services (A&D)

The mission of A&D is to affirm the dignity and value of seniors, persons with disabilities, and their families by offering a wide range of information, home and community-based support services, protections and opportunities which promote choice, independence, and inclusion.

Program Summary	*Expenditures*	*WYs*
Community Network for People with Disabilities	16,126,820	44.3
Assessment and Continuing Case Mgmt Services	6,084,770	54.4
Assisted Living Services	2,078,420	6.8
Community/Nursing Home Med. Assist. & Outreach	2,657,740	32.9
In-Home Aide Services	4,722,360	16.9
Information and Assistance	945,060	9.8
Ombudsman Services	650,880	6.3
Respite Care	1,196,040	0.0
Senior Community Services	3,757,460	21.1
Senior Food Program	1,685,690	2.9
Service Area Administration	473,440	2.8
Totals	**40,378,680**	**198.2**

Behavioral Health and Crisis Services (BHCS)

The mission of BHCS is to foster the development of a comprehensive system of services to assist children, youth, adults and families in crisis or behavioral health needs.

Program Summary	*Expenditures*	*WYs*
System Planning and Management	8,225,890	18.8
Behavioral Health Specialty Services	2,786,700	22.5
Behavioral Health Community Support Services	5,623,890	22.5
Criminal Justice/Behavioral Health Services	2,354,830	19.2
Outpatient Addiction Services (OAS)	5,854,770	30.3
Victims Assistance and Sexual Assault Services	2,586,450	19.2
Child and Adolescent Mental Health Services	3,272,960	17.3
24-Hour Crisis Center	5,149,170	43.1
Mental Health Services: Seniors & Persons with Disabilities	1,934,160	11.0
Partner Abuse Services	3,346,210	18.8
Service Area Administration	601,380	3.9
Totals	**41,736,410**	**226.6**

Children, Youth and Family Services (CYF)

The mission of CYF is to promote opportunities for children to grow up healthy and ready for school, and for families to be self-sufficient.

Program Summary	*Expenditures*	*WYs*
Child Welfare Services	22,126,320	211.0
Conservation Corps	843,450	27.3
Linkages to Learning	5,175,820	5.6
Juvenile Justice Services	4,881,060	18.7
Quality enhancement of Early Childhood Services	2,845,410	14.8
Parent Support Services	621,450	0.0
Services to Children with Special Needs	2,282,050	9.9
Child Care Subsidies	10,861,960	26.0
Income Supports	15,025,440	140.7
Child and Adolescent Services	3,632,800	4.2
Service Area Administration	361,310	2.5
Totals	**68,657,070**	**460.7**

Public Health Services (PHS)

The mission of PHS is to protect and promote the health and safety of County residents.

Program Summary	*Expenditures*	*WYs*
Office of Health Partnerships and Health Planning	12,675,980	16.6
Communicable Disease, Epidemiology, & Lab Services	1,749,620	14.2
Community Health Services	10,437,760	100.4
Dental Services	2,254,850	15.1
Environmental Health Regulatory Services	3,140,490	30.8
Health Care and Group Residential Facilities	1,331,640	10.7
Health Promotion and Prevention	1,368,460	7.7
Cigarette Restitution Fund Programs	2,240,820	7.0
STD/HIV Prevention and Treatment	6,295,600	41.7
School Health Services	20,820,690	237.4
Tuberculosis Services	2,198,680	19.9
Women's Health Services	5,106,620	17.6
Public Health Emergency Preparedness & Response	1,977,230	11.2
Service Area Administration	1,371,780	6.6
Totals	**72,970,220**	**536.9**

Special Needs Housing (SNH)

The mission of SNH is to provide oversight and leadership to the County's efforts to develop new and innovative housing models to serve special needs and homeless populations and maintain housing stability for vulnerable households.

Program Summary	*Expenditures*	*WYs*
Rental & Energy Assistance Program	7,994,390	12.5
Shelter Services	5,929,980	2.8
Supportive Housing Services	1,811,290	10.2
Housing Stabilization Services	4,893,310	30.2
Service Area Administration	294,820	1.8
Totals	**20,923,790**	**57.5**

Administration and Support

The mission of Administration and Support is to provide overall leadership, administration and direction to the Department, while providing an efficient system of support services to ensure effective management and delivery of services.

Program Summary	*Expenditures*	*WYs*
Office of the Director	2,734,280	22.2
Office of the Chief Operating Officer	18,661,780	85.1
Office of Disparities Reduction	3,856,870	6.5
Office of Community Affairs	3,584,030	14.9
Totals	**28,836,960**	**128.7**

DHHS Headline Measures

1. Information and Referral Services

Basic Facts

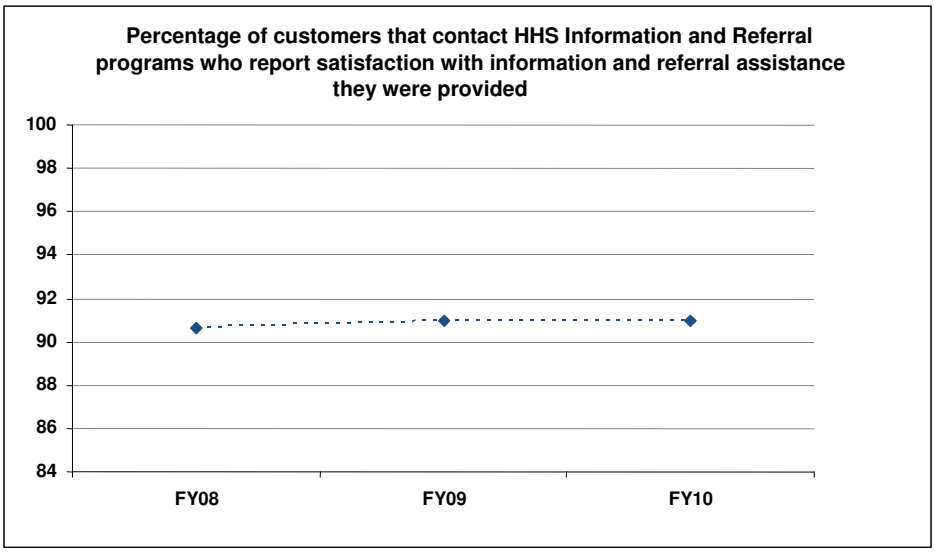
- DHHS has eight principal Information and Referral (I&R) units, the largest of which are the DHHS Information Line (240-777-1245), Aging and Disability Resource Unit (ADRU) and the Crisis Center.
- The total annual volume of I&R calls and walk-in contacts is more than 41,000*.

*Client contacts lasting more than one minute but less than five minutes. Contacts of less than one minute are often re-routing of people to more appropriate locations, and encounters of more than five minutes typically involve more in-depth counseling and assessment.

Performance

Percentage of customers that contact DHHS Information and Referral programs who report satisfaction with the information and referral assistance they were provided.

Methodology: DHHS performance measurement reflects FY08 baseline data only. In prior years only a limited number of DHHS call centers collected data on this outcome. To standardize data collection the DHHS-wide I&R instrument was modified from the nationally validated POMP (Performance Outcome Measurement Project) I&R instrument developed by Westat for the U.S. Administration on Aging. Items relevant to DHHS were retained or modified where necessary. The instrument was translated into Spanish using forward and back translation to ensure its accuracy.



- **Overall Satisfaction**
  Ninety-one percent of all respondents stated they were satisfied with I&R services, with 67 percent being "very satisfied". The units with the lowest levels of satisfaction were: ADRU, Childcare Subsidy, Takoma East Silver Spring Center (TESS) and Crisis Center. A review of written and anecdotal responses indicated that many of those expressing "dissatisfaction" were responding to the inability to get services to which they were referred (which is often something that service units have no control over due to eligibility restrictions by downstream programs).
- **Information Useful**
  Ninety-two percent of all respondents stated that the information provided was useful to them in resolving their presenting problem or issue. The units with the highest scores on this item were: ChildLink and DHHS Information and Referral Line. The units with the lowest scores on this item were ADRU and Child Care Subsidy.

Story Behind Performance

Supporting Factors

- Highly trained and knowledgeable staff performs I&R functions.
- Staff is proficient in a number of non-English languages to facilitate service to customers with Limited English Proficiency (LEP).
- Creation and advertisement of central DHHS Information Line (240-777-1245) provides a central point of access to information and referral to DHHS services.

Barriers

- Awareness of County services, or how to access them, by individuals in the community is somewhat lacking.
- There are large numbers of Limited English Proficiency (LEP) residents in the County.
- It can be difficulty for callers to articulate their problems/issues and the types of services that might be beneficial to them.

What We Propose to Improve Performance

- Evaluate effectiveness of present DHHS Information Line outreach efforts and adjust as needed.
- Provide ongoing education of I&R staff about the wide range of services available via the County as well as in the community.
- Evaluate Internet and e-mail outreach options for I&R, and use results to strengthen these tools.
- Standardize I&R expectations and data collection.
- Expand community awareness of I&R phone lines and functions.

Fiscal Impact

Costs of providing Information and Referral Services

	FY09 Budget	Work Years
Information and Referral		
DHHS Information Line	352,543	5.31
Information, Assessment and Service Delivery		
ADRU	781,240	9.00
Crisis Center	5,157,175	43.11
ChildLink	84,221	1.23
Child Care Resources	384,000	4.85
Housing Stabilization	2,552	.02
TESS	347,836	4.50
Child Care Subsidy	74,382	1.00
Totals	**$7,183,949**	**69.02**

Partnerships

- A single intake and screening system for all of DHHS requiring strong partnerships across DHHS service areas would improve the quality and breadth of the information received by our customers. Our partnership with the Collaboration Council has resulted in the customization of its InfoMontgomery resource database for I&R use and has facilitated easier access to information for the central DHHS I&R telephone line.
- A county wide Client Resource Management initiative would impact DHHS I&R services and improve customer service, enhancing the quality and breadth of the information received by all our customers.

Innovations

- In FY08, the Department developed a new intake and screening process and tool to better assess the range of needs of customers. First, customers complete a Needs Questionnaire to identify the services they need. The customer then meets with a triage worker who reviews the Needs Questionnaire using probes to confirm the list of services requested and make referrals to appropriate services. Use of the Needs Questionnaire will be expanded to all regional service offices and additional selected programs in FY09.

2. Direct DHHS Services

Basic Facts

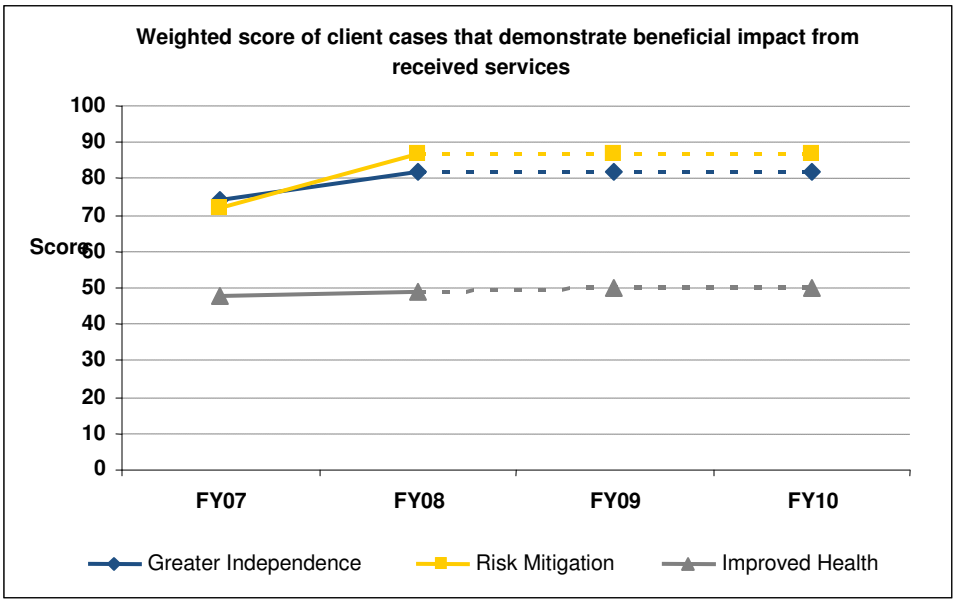
- DHHS serves approximately 70,000 clients on an unduplicated basis.
- Over 36,300 of these clients receive more than one service from DHHS, an increase of nearly 6,300 since FY08.
- DHHS has 1,761 full or part-time staff plus contracted partners who, at any time, may be involved in serving customers within and across Service Areas.
- The approved FY09 DHHS budget of $273.5 million is involved in serving the universe of clients.

Performance

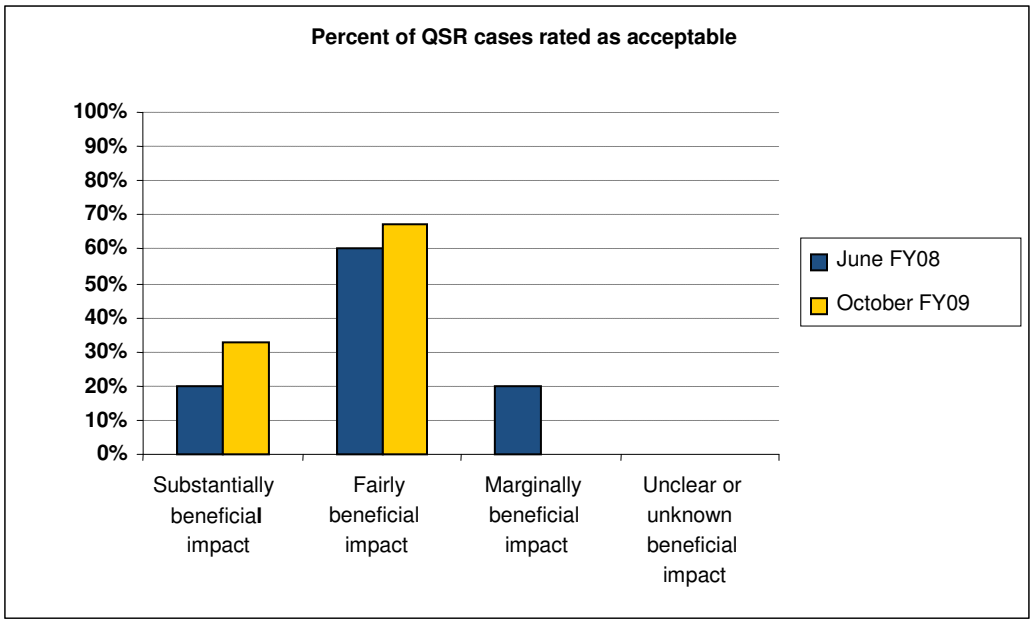
Percentage of DHHS client cases that demonstrate beneficial impact from received services. (B*eneficial impact is defined as risk mitigation (RM), greater independence (GI*) or *improved health and wellness (IH)*.

Elements of the Measure:

- Quantitative: weighted composite score for each type of beneficial impact
  - Universe: 100 percent of clients served in those 18 highly-visible DHHS programs for which reliable outcomes data exist.
  - Methodology: Establish multiple (currently 24) measures of beneficial impact annually for each DHHS function, and "roll up" results into composite measures of RM, GI, IH by weighting each measure in accordance with its relative proportion of service recipients and budget.
  - FY08 data are baseline; FY07 estimates are provided on assumptions of stable funding/client ratios.



- Qualitative: assessment of overall beneficial impact that DHHS services have made on the lives of particular individuals
  - Universe: 100 percent of the small sample of DHHS clients whose cases are selected for a Quality Service Review (QSR) and who consent to participate. All reviewed cases are open for at least six months and involve multiple DHHS services.
  - Methodology: Compile and report reviewer ratings provided through the QSR process as often as it occurs. Case review includes in-depth review of case records and interviews with the client, assigned staff, other service providers and other external parties suggested by the client. Ratings are based on the consensus judgment of two reviewers after evaluating client status and system performance across 16 defined indicators.
  - FY08 is baseline; FY09 preliminary data are also presented.



Story Behind Performance

- Determining the beneficial impact of direct DHHS services is central to facilitating a successful outcome for the client and is a management tool for ongoing improvement of service quality.
- Quantification provides the impetus for increasing beneficial impact over time and for analyzing factors that affect the weighted scores.
- Development, testing and implementation of the QSR protocol for qualitative assessment has led to active planning for the improvement of system performance around team-based case practice.

Supporting Factors

- Development and implementation of an integrated DHHS case practice model is ongoing.

- There is interest on the part of Departmental staff to work across DHHS functions to both provide services and evaluate impact.
- Expectations of case management, including intake and referral, assessment, case planning, service delivery and evaluation are standardized.
- Best practices models are used in many programs.

Barriers

- Knowledge about service integration and the team-based case management model is inconsistent throughout the Department.
- There is a need to further enhance data collection and analysis to support continuous improvement in service delivery.
- The needs of a population adversely affected by economic downturn are increasing in intensity and there are limited public resources.
- Evidence-based Practices empirically validated as effective in addressing some social problems are limited in number.

What We Propose to Improve Performance

- Build staff skill in using an integrated case practice model.
- Refine indicators that are "rolled up" annually into composite measures of beneficial impact: greater independence, risk mitigation and improved health and wellness.
- Continue and expand QSR and establish a process to review and use results for continuous improvement.

Fiscal Impact

The costs below cover FY09 QSR activities related to departmental performance measures:

- Staffing costs of conducting QSR will be absorbed within the existing budget.
- The Department received $46,879 in grant funding for one round of QSR involving external trainers who mentor less experienced staff reviewers. Additional grant funding expected to cover the cost of a Team Coordinator is pending.

Partnerships

- Strong partnerships exist across DHHS services to maximize beneficial impact to customers.
- Strong partnerships exist with DHHS vendors to achieve beneficial impact to our customers.
- Strong partnerships exist with other public agencies in the county and beyond to provide better services.

Innovation

- Implementation of QSR department-wide to qualitatively assess the impact of DHHS services across all programs is the first such protocol for an integrated health and human services agency in the country.
- With the Department of Technology services, DHHS is seeking an enterprise solution to meet its case practice-related information needs.

- Efficiencies are continuously being sought to deal with pressure on the system to serve more people with ever-decreasing resources.

3. Team-based Case Management

Basic Facts

- DHHS serves approximately 70,000 clients on an unduplicated basis.
- Over 36,300 of these clients receive more than one service from DHHS, an increase of nearly 6,300 since FY08.
- DHHS has 1,761 full or part-time staff plus contracted partners who, at any time, may be involved in serving customers within and across Service Areas.*
- The approved FY09 DHHS budget of $273.5 million is involved in serving the universe of clients.*

Breakdown of Active Cases Receiving Multiple Services

Number of Services	Number of Clients	
	FY08	FY09
2	19,834	23,329
3	7,163	8,853
4	2,157	2,943
5	670	1,016
6	168	328
7	54	90
8	8	3
9	6	1
Total	**30,060**	**36,316**

Performance

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

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

On an operational level, teams that have formed are functioning at different levels of success. The QSR process and internal barometers both point to the need to strengthen team formation, dynamics and functioning. Among the 10 cases reviewed in FY08 and 12 reviewed in FY09 (both small samples that cannot be used to generalize about case practice), the percent of cases found to have acceptable levels on two different aspects of teaming are:

Percentage of Cases with Acceptable Levels of Team Formation and Functioning

Team Aspect	FY08	FY09 (to date)
Formation	50%	67%
Functioning	30%	58%

Story Behind Performance

Supporting Factors

- Team-based case management that brings the customer together with staff and service providers serving his/her multiple needs is present. The team determines shared goals, activities to reach the goals, and decision-making authority and accountability. The objective is to achieve goals more quickly and in a better coordinated manner.
- Five service integration workgroups researched and proposed recommendations for system improvement in Intake and Screening, Assessment, Integrated Case Management, Client Engagement and Single Case Record. This resulted in initial development of service integration case practice model.
- Revisions of the intake process incorporated more comprehensive screening to identify client needs, make appropriate referrals for service, and determine clients potentially eligible for service integration (depending on the level and number of service referrals).
- A process has been initially developed to coordinate the final determination of service integration eligibility and to convene a cross-systems team that includes the client and case workers from all involved programs.
- A protocol for a case practice model has been initially developed, centering on cross-systems team-based case management including: identification of the team leader, team norms, values and functioning; assignment of responsibilities; and accountability and tracking of team meeting activities.
- A qualitative evaluation protocol, QSR, has been developed. The pilot test of the QSR evaluation methodology was conducted in June 2008, and involved 10 cases, including some that were team-based case-managed. A second review was conducted in October 2008, and a third will be conducted in January 2009.

Barriers

- Integrated case management is not the norm.
- More targeted training and time is needed for teams to function well on a broad scale and for teaming to become institutionalized as standard case practice. Skills to be honed include functioning in an integrated service delivery model with the customer as an integral member of the team, shared decision-making and goal setting, and accountability.
- Information technology infrastructure support is under development and needs enhancement to easily identify and support case movement into team-based management and team functioning across the Department.
- Current confidentiality requirements make sharing customer information on a need-to-know basis difficult.

What We Propose to Improve Performance

- Finalize development of a strong policy on sharing of information and confidentiality to support the goal of integrated case practices.
- Expand the no wrong door approach to integrated intake and screening to all three of the Department's largest intake points and additional selected program areas.
- Design and implement staff training on team-based case management.
- Improve communication up and down the line about the team-based case practice model for service integration.
- Improve team-based case practice protocols.
- Practice and manage to cross-systems team-based management protocols.
- Use grant funds for a team coordinator to support team formation and functioning.
- Track performance regularly and use data to manage the change process.
- Continue development and implementation of computerized system for making referrals and scheduling appointments for DHHS Services.

Fiscal Impact

The costs below cover FY09 QSR activities related to departmental performance measures:

- Staffing costs of conducting QSR will be absorbed within the existing budget.
- The Department received $46,879 in grant funding for one round of QSR involving external trainers who mentor less experienced staff reviewers. Additional grant funding expected to cover the cost of a Team Coordinator is pending.

Partnerships

- Strong partnerships exist across DHHS to ensure that customers benefit from the full range of DHHS services they need and for which they are eligible,
- With consent of the customer, external service providers will be asked to participate in the relevant team.

Innovation

- The QSR methodology developed by the Department is the first of its kind in the nation to reflect the broad and complex range of needs and related services in an integrated health and human services department.

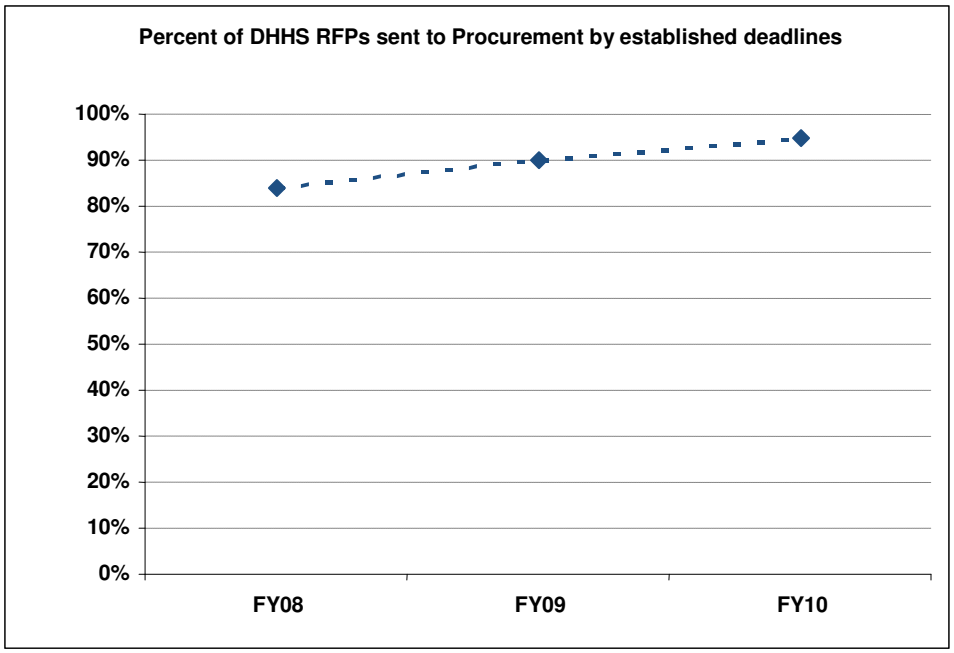
4. Contract Processing

Basic Facts

- Over 520 business, consulting and direct services contracts are administered by a Contract Management Team (CMT).
- 21 Requests for Proposals (RFPs) resulted in 55 contracts in FY08.
- During FY08, an additional 16 RFPs were worked on but not completed.
- An estimated 35 RFPs (including 16 RFPs begun but not finished in FY08) need to be completed in FY09, with contracts in place by July 1, 2009.

Performance

Percentage of DHHS Requests for Proposals (RFPs) that are sent to Procurement by established deadlines.



Story Behind Performance

Supporting Factors

- Multiple staff from DHHS program areas and the CMT, as well as the Department of General Services' (DGS), Office of Procurement, County Attorney's Office and other agencies are involved in this process.
- Each County department's staff has its expertise and a set of responsibilities that are clearly outlined.

Barriers

- Workload and ratio of work volume to number of workers continue to be significant challenges. Two senior CMT staff with primary responsibilities for RFP development retired as part of the FY08 Retirement Incentive Program. CMT had a new position (Grade 21, Administrative Specialist II) approved in the FY09 budget. Filling these positions has been problematic due to the need to obtain exemptions to the hiring freeze, the FY09 cost savings plan, and the lengthy hiring process. It is anticipated that these positions will not be filled before January/February of 2009.
- Other involved County support departments are understaffed with little redundancy in positions or have filled positions with staff with limited procurement experience.
- Multiple steps managed by multiple programs and departments are required to complete the process.
- Delays can occur at any point in the process.
- Distribution of total work across Services Areas, CMT and other County departments is skewed and inconsistent.

What We Propose to Improve Performance

- Establish internal DHHS deadlines for submission of various types of contract actions and solicitations to CMT.
- Monitor progress toward goal on weekly basis using an Access data base to track work assignments in CMT.
- Report regularly on contract related issues in weekly Senior Leadership Team meetings.
- Prioritize RFPs by senior Departmental management.
- Evaluate distribution of workload between Service Areas and CMT.
- Work collaboratively with the DGS' Office of Procurement, County Attorney, Risk Management, and the Office of Community Partnerships on contract reform.

Fiscal Impact

- Salaries to replace two senior CMT staff who retired as well as new Administrative Specialist II position are included in the FY09 budget.

Partnerships

- Maintain strong partnerships with DGS Office of Procurement and the County Attorney to ensure that DHHS is able to meet this performance measure.
- Streamline business processes within DHHS to ensure that the program areas and CMT are working collaboratively to meet this performance measure.

Innovation

- DHHS partnership in the county-wide contracts reform and non-profit partnership effort jointly initiated by DGS' Office of Procurement, Office of Community Partnerships, DHHS, Department of Housing and Community Affairs, 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 incentive payment structure in all county contracts.

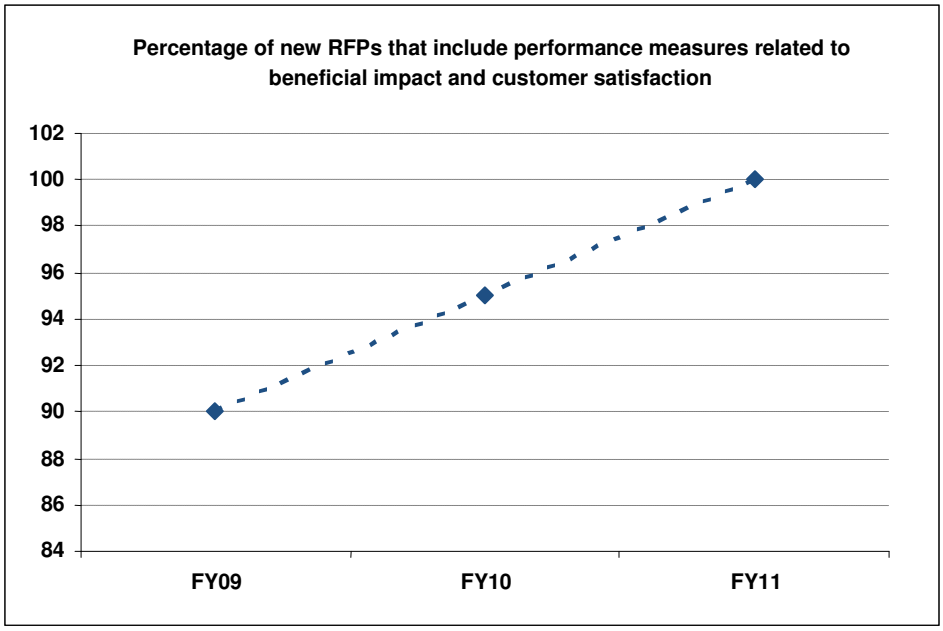
5. Contracted Services Performance Measurement

Basic Facts

- DHHS has over 520 contracts (competitive and non-competitive)
- Over $90M of services are procured through contracts (competitive and non-competitive)

Performance

Percentage of new Requests for Proposals (RFPs) that include performance measures related to beneficial impact and customer satisfaction.



Story Behind Performance

- Performance measures related to customer satisfaction and beneficial impact were developed in collaboration with vendors and are specific to the Service/Program area. Measures focus on two aspects of beneficial Impact: risk mitigation and greater independence for customers; some measures also address improved health, a third aspect of beneficial impact.
- Beginning in FY09, performance measures will be incorporated into new FY09 program-related RFPs and resultant contracts.

Supporting Factors

- Within the existing process, expectations are identified in RFPs 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 percent of their job responsibilities.

What We Propose to Improve Performance

- Continue efforts to develop and refine program-specific performance measures for beneficial impact in partnership with DHHS vendors.
- Work with the Department of General Services (DGS) to provide information on performance-based contracts to our vendors.
- Train Service Area staff on the development of and monitoring for performance measurement.
- Review RFPs and contracts for inclusion of performance measures.

Fiscal Impact

- Costs will be absorbed within the DHHS budget.

Partnerships

- DHHS collaborated with vendors on development of performance measures for program-related contracted services.
- DHHS continues to collaborate with DGS to develop training and on other issues related to performance-based contracts.

6. Limited English Proficiency Language Assistance

Basic Facts

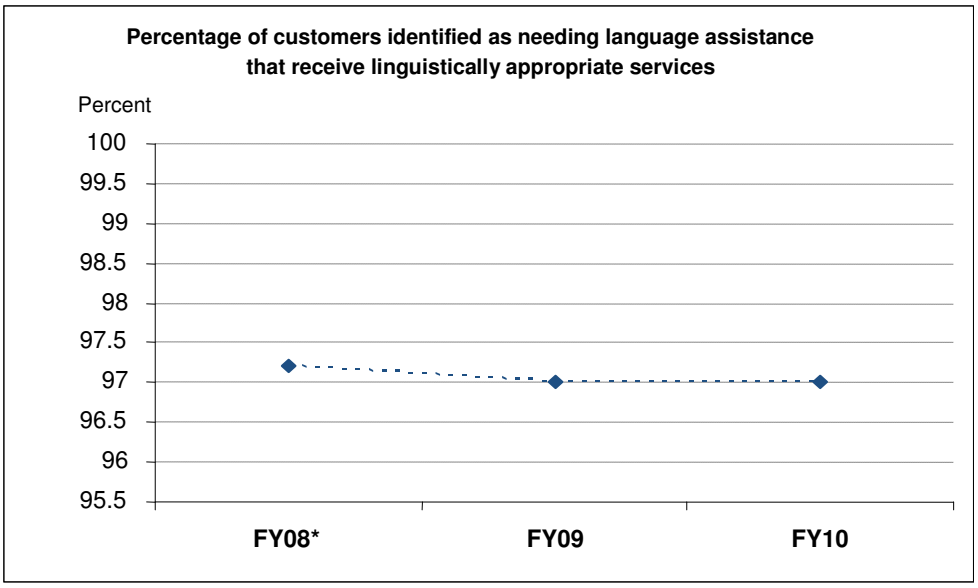
- DHHS staff had 50,785* service encounters with customers identified as having Limited English Proficiency in FY08. A total of 42,088 of those encounters with Limited English Proficient clients involved DHHS bilingual staff.
- In FY08, 7,175 calls totaling 92,564 minutes were made using the Language Line at a cost of $120K. Eighty-two percent of the calls were for Spanish interpreters. The most commonly encountered languages among DHHS customers are: Spanish, Chinese, French, Amharic, Korean, Vietnamese, Russian, Farsi, and Portuguese.
- $220K in the FY09 budget is allocated for department-wide use of the Language Line and translation services to serve LEP clients.
- Over 100 documents were translated into a multitude of languages to help communicate vital program information.
- The number of Department-certified bilingual staff has increased by six percent to 257 in FY08 from 243 in FY07. A total of 201 are certified in Spanish, an increase from 194 in FY07. The remaining 56 staff are certified in a variety of Asian, African and European languages.
- Four types of language services are offered to departmental staff: OHR certified bi-lingual or multi-lingual staff, per diem interpreter services, phone interpretation services, and volunteers from the Volunteer Language Bank.
- The current fields for the collection of LEP data were designed based on requirements from the Maryland Department of Health and Mental Hygiene (DHMH) to all local jurisdictions. The primary goals of the federal LEP data collection mandate are to identify a language need, record that need in the client record, and prepare in advance for future appointments with the client.

* The data represented service encounters and not discreet clients. That is, every time a LEP client comes in to DHHS for service, language assistance is captured by staff. However, since some programs are still capturing data manually and not all encounters are diligently entered by staff, the total service encounters may be undercounted.

Performance

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

Methodology: Two LEP questions were asked in the customer satisfaction survey conducted for I&R functions in the Department.



- Of 330 individuals surveyed, 72 (21.7 percent) indicated a need for language assistance. Of those who needed assistance, 69 of 71 (97.2 percent) reported that they received language assistance. In addition, 86.6 percent of callers who called the County-funded Bilingual Medical Hotline at CASA in FY08 accessed health services as a result of information and assistance provided by the Line.

Story Behind Performance

A 2006 Census snapshot of the Washington region shows:

- 29 percent of the county's total population was foreign born.
- 29 percent of the foreign born entered the U.S. after 2000.
- 29.5 percent (1,520 out of 5,150 families below the federal poverty line) have a family member who is Limited English Proficient.
- 13 percent of the total County population spoke English less than "very well."
- Linguistic problems are more pronounced among immigrants born in Latin America than in other countries of origin. In 2005, 67 percent of speakers of Spanish residing in the county reported speaking English less than well.
- Infants and Toddlers, a DHHS program which serves children from birth to three with developmental delays, has seen a 40 percent increase in families served since FY03. In FY08, 2,255 families were referred for services; 40 percent speak another language and received language assistance for their mandated services.

Supporting Factors

- All DHHS 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.

- Thirty-five DHHS contractors were trained in FY08 on DHHS and federal LEP policy and requirements.
- The DHHS Latino Health Initiative operates a bilingual health service patient navigation hotline and provides medical interpreters during clinic visits for LEP patients referred through Public Health Services for clinical appointments. The cost in FY08 was $350K. The Asian American Health Initiative (AAHI) began the set up of a similar patient navigation assistance system that targets multiple Asian languages, with a FY09 budget of $350 K.

Barriers

- The rapid growth of the diverse immigrant and undocumented population spread across the County creates challenges for tracking and outreach efforts.
- Although DHHS has begun to train contractors on Federal LEP mandates, the additional cost of providing language appropriate services can be a burden on contractors who may not have budgeted for that cost. The diversity of the languages in the County can be a challenge for local government entities and non-profits.
- The current data fields in the DHHS electronic Client Record System are not designed to collect information about the gaps in providing language assistance throughout the Department. Modification of the LEP fields is on hold until further assessment of the entire Information Technology platform for the Department is completed.
- DHHS has consistently increased its hiring of Spanish-speaking direct service staff. However, more direct staff from other language groups that have picked up in numbers needs to be hired.
- Consistency and accuracy of LEP data entry into department's database remains a challenge.

What We Propose to Improve Performance

- Consider modifying the LEP fields to better capture data, as part of the Department's information technology assessment.
- Coordinate data collection with new requirements that may come from DHMH in FY09.
- Continue the Train the Provider series so that more DHHS contractors are aware of LEP requirements and will begin to look at addressing that need.
- Work on better reporting system for the vendors who provide language services.
- 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 DHHS programs and eligibility guidelines.

Fiscal Impact

- Costs will be absorbed within the DHHS budget.

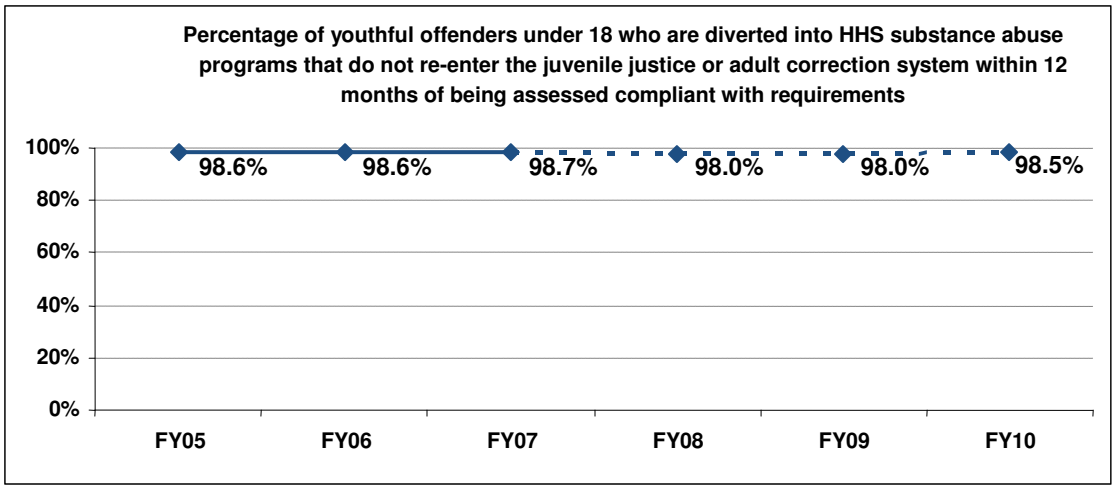
7. Juvenile Justice Assessments, Screenings and Referrals

Basic Facts (FY08)

- 387 County youth under 18 received an alcohol citation, and 5,042 juvenile arrests were made by the Montgomery County Police Department (MCPD).
- 3,820 of the youthful offenders were referred directly to the Department of Juvenile Services (DJS), while 922 youth who had either received an alcohol citation or who had committed certain nonviolent misdemeanors (usually for the first time) were "diverted" from DJS to DHHS where they received substance abuse and mental health screening and referrals, if needed, to education or treatment.
- 94 percent of youth diverted to DHHS 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 DHHS Juvenile Justice Services' unit and the DHHS Behavioral Health Access team partner to provide mental health treatment referrals for Medicaid-eligible youth who are diverted.
- 25 percent of diverted youth entered intensive substance abuse or mental health treatment; an additional 20 percent received intensive substance abuse education including urinalysis, and 45 percent received less intensive substance abuse education. The remaining 10 percent were not referred to community services based on their assessment. These youth may have had to complete community service or other requirements through MCPD.
- 8.2 work years and $947K were expended for operation of the Screening and Assessment Services for Children and Adolescents (SASCA), the alcohol and substance abuse screening program. This program assessed and referred a total of 1,756 juveniles in FY08.

Performance

Percentage of offenders under age 18 who are diverted to substance abuse education and treatment or mental health treatment programs that do not re-enter the juvenile justice or adult correction system within 12 months of being assessed compliant with requirements.



- Only 10 youth (1.3 percent) of the 741 FY07 diversions re-offended and re-entered the juvenile justice system within 12 months of successfully completing their diversion program.
- As of now, DHHS only has data for the juvenile justice system component. Results graphed reflect only youth who did not re-enter the juvenile justice system. Starting in FY09, the addition of Criminal Justice Information System (CJIS) data, combined with the Juvenile Justice Information System (JJIS) data, will give a more complete result.
- On average, between FY05 and FY07, less than 2 percent of youthful first-time offenders screened for mental health and substance abuse disorders and diverted from the Juvenile Justice System into community education and treatment services became re-involved in the juvenile justice system within a 12-month follow-up period.
- CJIS numbers are expected to be minimal. Of those youth who offended initially and were diverted during FY07, preliminary CJIS data show that only two re-offended during FY08. While between FY05 and FY07 an average of 742 youth diverted into educational and treatment programs, in FY08 there were 922 diversions, an increase of 24.4 percent over the prior year. Further conclusions will be drawn after the CJIS data for diverted youth who commit more serious crimes during the follow-up period are incorporated into the recidivism rate measure.

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 DHHS, MCPD, DJS agencies, and community substance abuse education and substance abuse and mental health treatment providers.
- Pre-established MCPD diversion eligibility criteria are based upon the severity of the offense and whether or not the youth is a first time offender.
- DHHS 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, DHHS 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.

What We Propose to Improve Performance

- Further analyze CJIS data during FY09 to determine if any additional diverted youths in FY05-FY07 cohorts committed more serious crimes, resulting in additional referrals to the adult correctional system. Determine if the re-offense trend observed in CJIS for FY07 also occurred in FY05 and FY06. Refine preliminary recidivism rates based on these analyses.
- Partner with the Montgomery County Collaboration Council on an FY09 grant from the state. This grant will enable the Department to hire a case manager to increase the number of SASCA diversions that become engaged in the diversion process, and increase the retention rate among diversion program participants.
- 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 DHHS budget.

Partnerships

- The Gang Prevention Initiative involving the Police Department, Department of Recreation, Montgomery County Public Schools, the Maryland Department of Juvenile Justice, Regional Services Center, State's Attorney, private sector partners and the community, is a critical tool in DHHS efforts in this area.

Innovation

- DHHS is pursuing the viability of making juvenile justice a County function. The County is beginning the initial exploratory conversations with the Secretary of the State DJS and within County government to look at the possibility of community-based DJS services coming to the County. At this time the scope and fiscal impact of the project is unknown. DHHS is currently in the fact-finding stage.

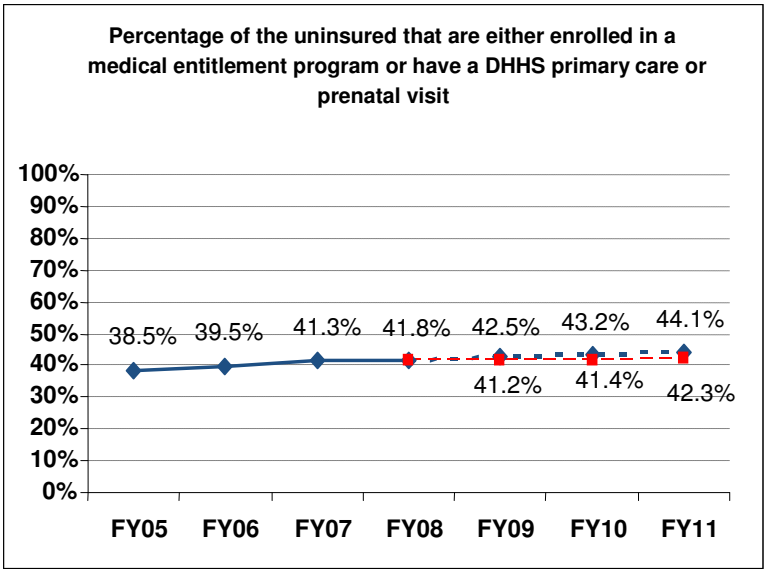
8. Providing the Uninsured with Health Care Coverage and a Regular Source of Care

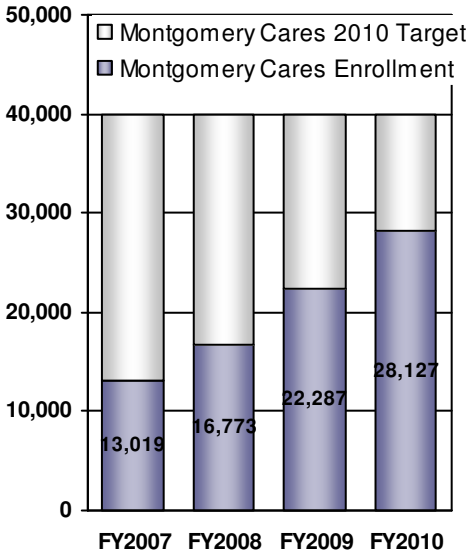
Basic Facts

- Montgomery County had 139,787 uninsured residents in 2005, including 27,318 children.
- County DHHS staff enrolled more than 73,000 county residents in various federal or State funded health insurance programs in FY08.
- DHHS staff enrolled 3,800 uninsured children, who are not eligible for State or federally funded programs, into the County's Care for Kids program in FY08 and enrolled an additional 2,300 pregnant women into the Maternity Partnership to ensure access to prenatal care and delivery services. The Montgomery Cares Program provided access to basic primary health care and prescriptions to 16,800 uninsured adults in FY08.

Performance

Percentage of the uninsured that are either enrolled in a medical entitlement program or have a DHHS primary care or prenatal care visit.





- Both projections assume the uninsured population continues to grow. Top dotted line assumes DHHS services remain level; bottom dotted line assumes DHHS services decline by 10 percent.

Story Behind Performance

Supporting Factors

- County residents may enroll in health care access programs at multiple sites including: Public Health Service Eligibility Units; Aging and Disabilities sites; Children, Youth and Families Income Support units; Montgomery Cares clinics;

correctional facilities; hospital emergency departments and recreation centers.
- County leadership supports continued expansion of capacity for Montgomery Cares clinics for uninsured adults.
- DHHS provides language interpretation for large number applicants with limited English proficiency. In addition, the Department supports residents in using an online application to enroll children in the Maryland Children's Health Insurance Program. Health Promoters from the community and other outreach staff also help to link residents to health access programs.
- To support Montgomery Cares, Care for Kids and the Maternity Partnership, health care providers contribute their time and local clinics and hospitals contribute services and facilities.
- Hospitals cover half the cost of County eligibility staff working in the hospitals.
- State grants and federal reimbursement cover full or partial costs of many County eligibility staff.

Barriers

- State and federal agencies establish eligibility criteria for entitlement programs.
- DHHS does not have sufficient eligibility staff to quickly process enrollment applications, resulting in delays and additional expense to individuals, hospitals and the County.
- Proof of citizenship or five-year permanent resident alien status that is required to obtain federal/state Medical Assistance presents challenges for applicants and staff.
- The Montgomery Cares clinics currently do not have sufficient capacity to meet the demand for services should every eligible low-income uninsured person enroll.
- 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 the capacity of Montgomery Cares Program to meet demand.
- Standardize eligibility requirements in all participating clinics in Montgomery Cares Program.
- Support the multilingual Montgomery Cares web site. (www.MontgomeryCares.org) and its brochures in multiple languages.
- Continue to work with the Collaboration Council to highlight programs on the new resources web site now available to County residents. (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 has led the way in the state and is probably one of the few jurisdictions nationally to attempt to address this issue at the local level. DHHS is examining new and different governance structures to better support the outcomes of providing healthcare to the uninsured through a public-private partnership.

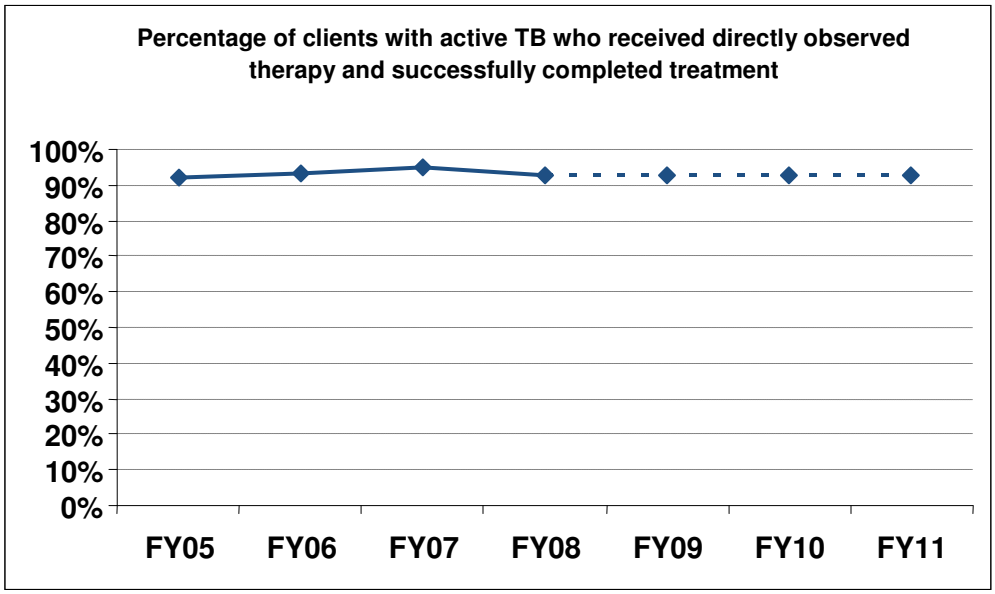
9. Communicable Diseases Control

Basic Facts

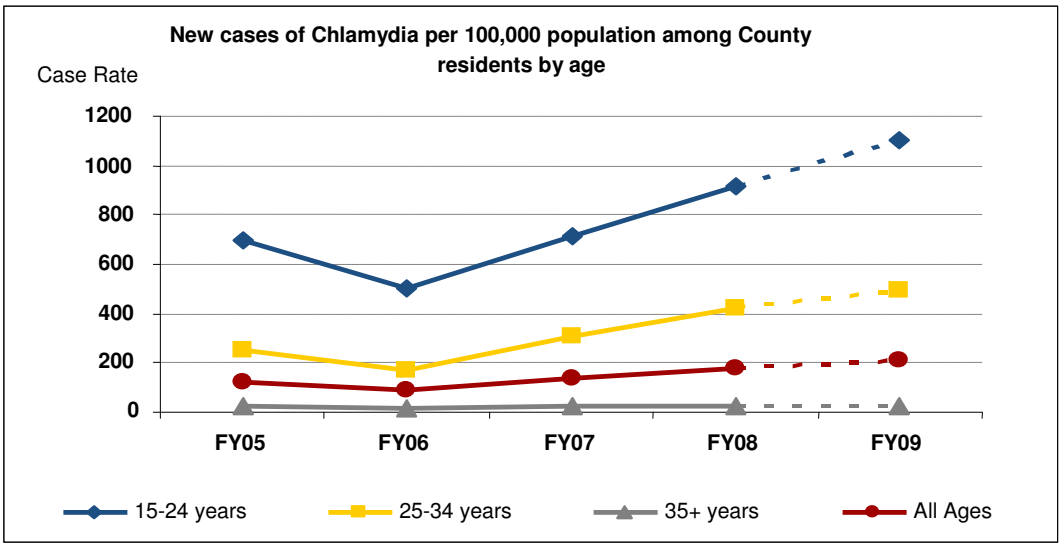
- Annually, within Public Health Services (PHS), there are over 300 foodborne complaints/investigations (including Campylobacter, E.coli, Hepatitis A, Salmonella or Shigella); 2,600 communicable disease cases (including vaccine-preventable diseases, rabies exposure, Lyme disease, and bacterial meningitis); 75 active tuberculosis (TB) investigations involving approximately 1,000 individuals; and 535 sexually-transmitted diseases (STD) investigations, including Chlamydia, Gonorrhea, HIV and Syphilis.
- Approximately 200 suspected cases of TB are evaluated annually, with an average of 75-80 cases requiring and undergoing treatment.
- The DHHS TB program annually manages approximately one out of every 200 of the national TB cases (approximately 25-30 percent of Maryland cases). There were 82 cases diagnosed and treated in 2007.
- In FY08, the DHHS Immunization Program administered 26,401 vaccines to 16,519 children and 2,201 vaccines to 1,980 adults.
- Timeframes and workload for outbreaks vary based on severity and mode of transmission of the contagion. 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.
- Communicable Diseases and Epidemiology is supported with 74.5 work-years and $9.1 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 $1.3M in FY08.

Performance:

Percent of clients with active infectious tuberculosis who received Directly Observed Therapy and successfully completed the treatment regimen



New Cases of Chlamydia per 100,000 Population in Montgomery County



Story Behind Performance

- PHS 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 the 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 regulatory authority are used to ensure persons with illness are consistently practicing healthy behavior, with emphasis on completion of treatment and adherence to treatment regimens.
- DHHS sustains strong relationships with key partners including State DHMH laboratory (for diagnostic lab testing), and consultations with the local detention centers, private medical community, major clinical trial groups in the metropolitan area, the 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.
- The County operates a strong emergency preparedness program, including exercises and training, recruitment of community volunteers (e.g. Medical Reserve Corps) and development of plans for public health emergencies
- Intensive medical and nurse case management of diagnosed diseases is provided.
- Aggressive strategies are in place for contact tracing and partner notification.
- Public health investigations follow federal and State guidelines for controlling communicable diseases, using sound epidemiological principles.

- To rule out TB, the TB control program provides screening to contacts of infectious cases of TB, newly arrived refugees, immigrant students prior to admission, County residents per job classification, inmates at the Detention Center, clients entering substance abuse centers, and symptomatic residents who walk into the clinic. The clinic also provides treatment for latent TB infection to high risk individuals 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.
- Funding issues have led to staff shortages in Communicable Disease and Licensure and Regulatory areas, which investigate foodborne disease outbreaks.
- Public health is challenged to find a balance to motivate people to have safe and prudent behavior versus overreaction, restriction and seeking unnecessary treatment.
- County residents without legal status fear seeking medical care and consequently present with advanced disease.
- While STD clinics see 150 customers weekly to be tested for an STD, the lack of capacity causes an additional 300 callers to be turned away monthly – 65 percent of callers get an appointment, with 35 percent 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 four weeks.
- DHHS 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 (e.g. co-infection with HIV and syphilis).

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 DHHS services.
- Continue to invest in relationships with key partners, including efforts to implement a community health assessment involving local public health system partners and use information from this assessment to develop a Community Health Improvement Plan.

- 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 $41K. 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.
- 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 are necessary and exist with public and private community partners, including those at local, state and federal levels, to ensure effective disease detection/surveillance, treatment and containment.
- A strong partnership is maintained with the Office of Emergency Management and Homeland Security.

10. Social Connectedness and Emotional Wellness

Basic Facts

- Of the 60,390 Crisis Center contacts, approximately 9,000 were children and adolescents. A total of 466 were referred by their schools to be assessed for level of risk to themselves or their community; 96 percent of these students did not require emergency department services, were stabilized in the community, and could return to school.
- According to the Uniform Crime Report, 1,431 individuals in Montgomery County reported an incident of partner abuse to legal authorities in Calendar Year 2007. Additionally, there were 151 reported rapes in FY07. All of those rape victims were offered advocacy and counseling by trained and supervised volunteers who respond directly to police stations or the hospital.
- The Clinical Assessment and Triage Staff (CATS) of the Criminal Justice/Behavioral Health Services programs orient and screen over 9,000 offenders entering the Montgomery County Detention Center (MCDC) annually.
- There has been a 100 percent success rate in screening, assessing and preventing suicides at the MCDC since January 2000. Criminal Justice Behavioral Health Services programs, in collaboration with the Department of Correction and Rehabilitation (DCR), screen and assess all admissions to Montgomery County correctional facilities to prevent suicides; there have been no suicides since the inception of this program.
- The Child and Adolescent Mental Health Home-Based Team served a total of 149 children in FY08. Of those served, 99 percent were able to be maintained in the current placement. Only one percent (n=2) of the children had to be referred to out-of-home care.
- From FY07 to FY08, the number of Montgomery County consumers accessing the Public Mental Health System grew by 9 percent from 7,022 to 7,652. This upward trend is expected to continue given the uncertain economic times and an increasing number of returning veterans needing services.

Performance

Percentage of individuals served by the continuum of behavioral health services that demonstrate a higher degree of Social Connectedness and Emotional Wellness as demonstrated by:

- **Increased/retained employment**
- **Increased success in school**
- **Increased stability in housing**
- **Improved outcomes for those receiving Evidence Based Practices**
- **Decreased arrest rates.**

Story Behind Performance

Supporting Factors

- A continuum of comprehensive community-based substance abuse and mental health treatment services is available to individuals across the life span.
- Strong collaborative partnerships exist between DHHS, Montgomery County Public Schools, DCR and community providers to support a comprehensive system of care.
- DHHS provides well established County-operated crisis services.
- DHHS has a strong commitment to delivering services that are either recognized as evidence-based or promising practices.

Barriers

- An adequate data system to provide timely and accurate information to effect sound, data-driven decision making is lacking.
- There can be extensive time delays from the time a service need is identified to actually having a contract in place to provide needed services to our community.
- Society sometimes criminalizes those with mental illness.
- Legal/legislative mandates to support treatment participation and compliance is lacking.
- There is a not a fully developed and resourced continuum of behavioral health care.

What We Propose to Improve Performance

- Increase number of providers in the community that are trained in Evidence-based Practices (EBP).
- Begin longitudinally analyzing data to gain a better understanding of behavioral health services' impacts on employment, success in school, supportive relationships, and housing stability.
- Increase opportunities for individuals with behavioral health disorders to live successfully in, and remain in, the community.

Fiscal Impact

- Some costs may be absorbed within the DHHS budget. Additional resources will likely be required. DHHS' Behavioral Health and Crisis Services intends to work with the Department of Health and Mental Hygiene (DHMH) to explore funding opportunities.

Partnerships

DHHS maintains strong active partnerships with:

- DHMH – Mental Hygiene Administration, Alcohol and Drug Abuse Administration, Medicaid Administration
- Maryland Department of Human Resources
- Maryland Department of Juvenile Services
- Maryland Department of Public Safety and Correctional Services
- Local Collaboration Council

- MCPS, Montgomery County Police Department, DOCR
- General Hospitals and Clinics
- Private Community Partners/Contractors

Innovation

- DHHS continues to seek opportunities to integrate somatic health care clinics into its behavioral health settings. The Department is currently in the preliminary phase of discussions with a local non-profit which could provide housing for up to 35 additional consumers co-located with a somatic clinic.
- All clinicians on the Child and Adolescent Mental Health Home-Based Team will receive a year-long training in Trauma Focused Cognitive Behavioral Therapy (TF-CBT). TF-CBT is an evidence-based treatment protocol for the treatment of trauma in children and adolescents. Additional EBPs include Motivational Interviewing, Drug Court development and expansion, and Mental Health Court.
- BHCS is partnering with DHMH in the development of recovery oriented systems of care.
- As part of ongoing efforts at improved data collection and informed forecasting of service needs, DHHS will partner with the Department of Technology Services for Geographic Information Systems Services.

11. Early Childhood Services and Programs

Basic Facts (FY08)

- Over 65,000 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 over 50,000 parents.
- The Infants and Toddlers Program served 3,632 families.
- 599 children were enrolled in Montgomery County Public Schools (MCPS) Head Start and another 52 were served in community-based Head Start settings.
- 5,327 health screens for newborns were conducted in hospitals by the Baby Steps program contract staff.
- 2,655 program referrals were made to early childhood and family support services by CHILDLINK staff.
- 3,005 child care providers received workshop training and 112 received scholarships to pursue early childhood coursework at Montgomery College.
- 18,440 pieces of early childhood public engagement materials were distributed.
- 100 percent of children receiving DHHS early childhood mental health services avoided expulsion from child care.
- Early Childhood Services: $5.7 million includes $2.8 million in contracts and 17 work years.
- Public Health Services: $7.5 million for Maternity Partnership; Case Management of Pregnant Women and Infants; Head Start Health; and Preschool Immunizations include 70 work years.

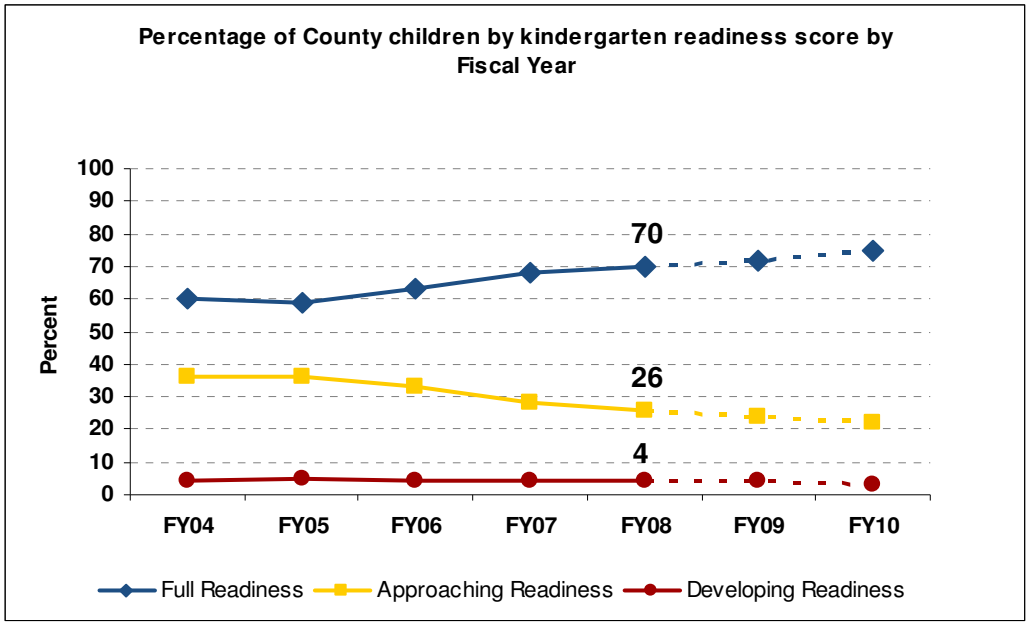
Performance

Percentage of Head Start, licensed child care centers and family-based child care students who demonstrate "full readiness" upon entering kindergarten.

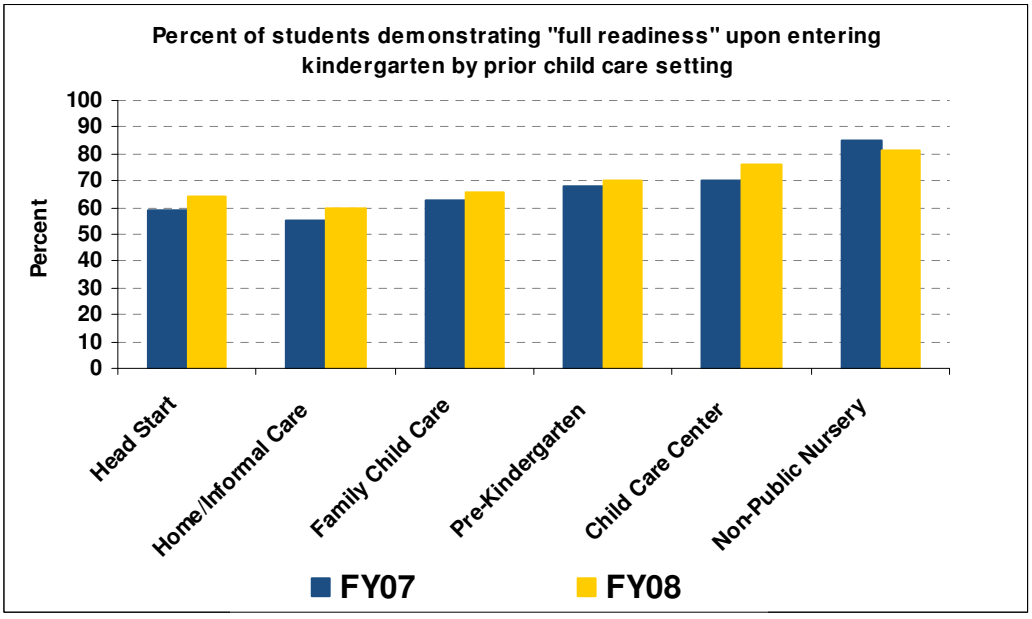
Methodology: Measurement takes place after entry into kindergarten. Hence, prior care is assessed in the context of a child's readiness to learn upon entry to kindergarten.

- The percentage of County children achieving full kindergarten readiness has increased steadily in recent years. The Maryland 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, including FY08 average of 68 percent.
- The percentage of children achieving full kindergarten readiness varies by type of prior child care setting; those in child care centers, nonpublic nursery school and pre-kindergarten demonstrate the highest readiness scores. Children in home/informal care demonstrate the lowest readiness scores. Kindergarten readiness has improved in all settings since January 2002.

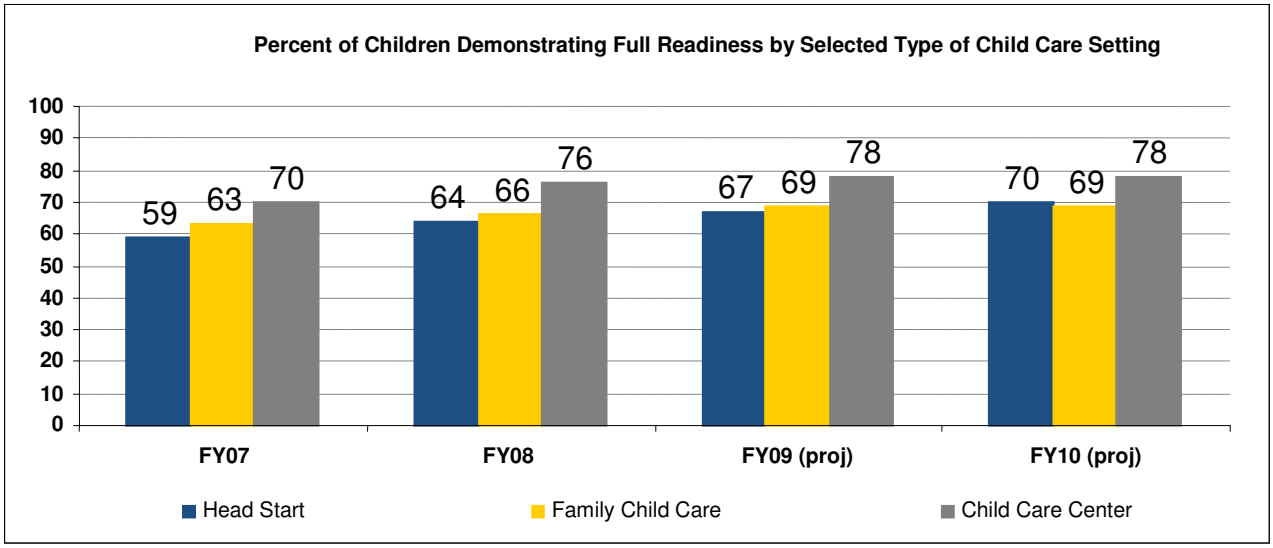
Montgomery County Kindergarten Student Readiness
Source: Maryland Department of Education (MSDE)



Montgomery County Kindergarten Full Readiness by Setting
Source: Maryland Department of Education (MSDE)



Montgomery County Kindergarten Full Readiness by those Settings which Constitute this Measure
Source: Maryland Department of Education (MSDE)



Story Behind Performance

Supporting Factors

- DHHS has collaborative partners at the State (the Governor's Office, MSDE and Maryland Department of Health and Mental Hygiene) and County levels (MCPS, the Department of Libraries, the Department of Recreation and private non-profit partners) who provide a continuum of comprehensive services to support children's successful transition to kindergarten and who 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 five years (FY04-FY08).
- 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 all 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 percent come from single parent families
  - 54 percent come from homes where the primary language is not English
  - In 31 percent of Head Start families, the parents' highest level of education is less than high school; another 36 percent have only high school or General Equivalency Diplomas.

- 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

- DHHS will work with MSDE and community partners to maximize resources.

Partnerships

- Performance is strongly dependent on partnerships with MSDE (Child Care Licensing), MCPS, and the Montgomery County child care provider community.
- In FY08 early childhood leaders from DHHS, MCPS, and the private sector launched an "Early Childhood Congress" to align the work of public and private agencies, parents and the business community to ensure that all Montgomery County children enter kindergarten "ready to learn." Broad-based workgroups operating under the umbrella of the Congress include Public Engagement, the Home Visiting Consortium, the Integrated Budget, and the Maryland Model for School Readiness Data Watch Committee.

Innovation

- The Early Childhood Leadership in Action group established a draft "Early Childhood Action Agenda" and, under the auspices of the Early Childhood Congress, collected input from 239 stakeholders through an online survey. The final Action Agenda sets out broad goals and strategies to strengthen Montgomery County's early childhood system of services.
- The County Council established a Universal Preschool Implementation work group to substantiate needs for pre-kindergarten services and to recommend steps to meet needs.

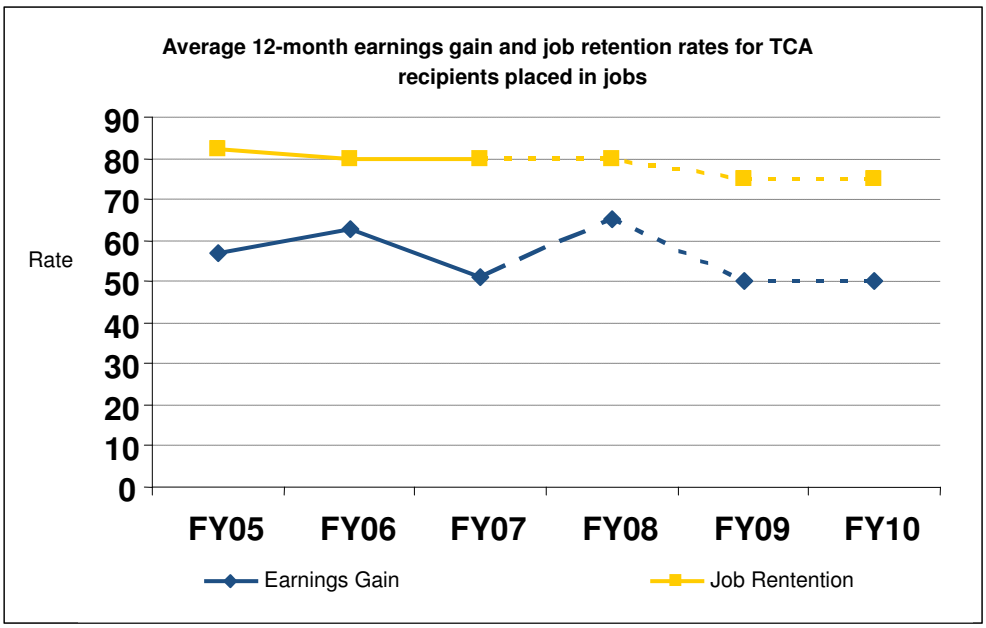
12. Employment Related Services

Basic Facts

- Federal law requires Temporary Cash Assistance (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 and earnings gain rate.
- The County, through its WORKS data management system, tracks 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 work years; FY05: $2.5 million, 7.6 work years; FY06: $2.6 million, 7.8 work years; FY07: $3.0 million, 8.5 work years; FY08, 3.5 million, 9.5 work years.

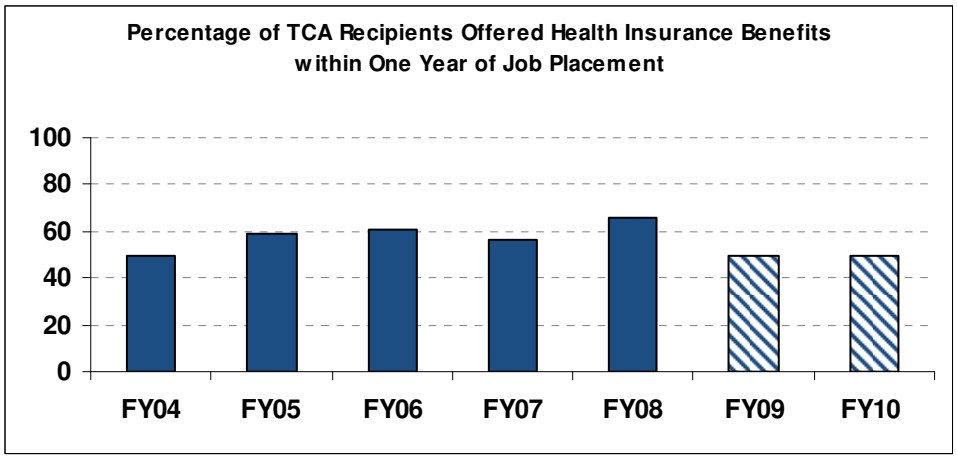
Performance

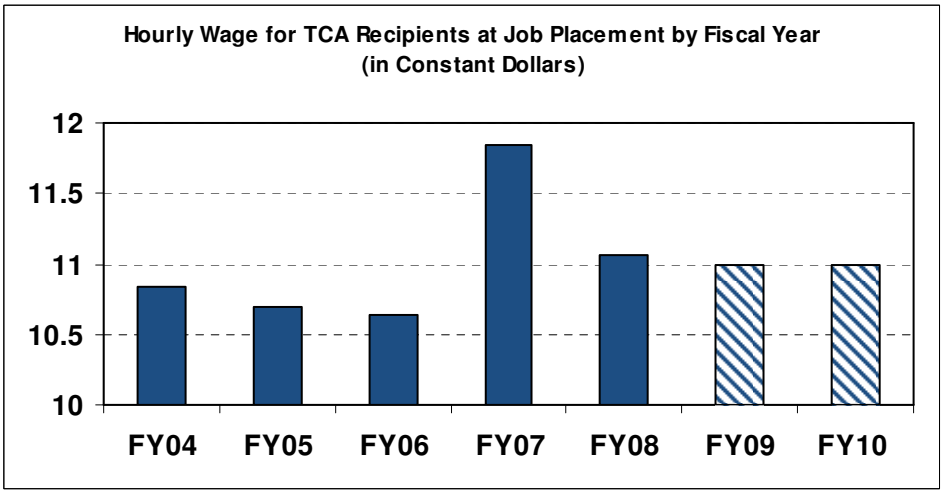
Job Retention Rate and Earnings Gain Rate for current and former TCA recipients who receive job placement



Submeasures showing greater independence:

- Percentage of TCA recipients offered health insurance benefits within one year of job placement
- Average Hourly Wage for TCA recipients at job placement





Story behind the performance

- Between FY04 and FY08 over one-half of all TCA recipients placed in fulltime jobs were offered health insurance benefits within one year of employment.
- Montgomery County has consistently surpassed the State goals in job retention of 70 percent and the earning gain rate of 40 percent in recent years.
- While the hourly wage rate at job placement for Montgomery County TCA recipients rose between FY04-FY07 and decreased slightly in FY08, the wage rate in constant dollars (adjusted for inflation) is actually decreasing.

Supporting Factors

- DHHS intensive case management and follow-up services provided 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 those related to economic development) and with private sector partners as job placement resources for internships and permanent employment support program goals.
- The Department has 10 years of better-than-average performance on all of the State's performance measures.

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 database for data on earnings gain and job retention rates.

What We Propose to Improve Performance

- Strengthen the comprehensive employment services program with continuing supports to TCA clients.
- Work with the Maryland Department of Business and Economic Development (DBED) to bring jobs to the County that employ TCA recipients at a wage level that promotes family self-sufficiency and provides health insurance benefits within one year.

Fiscal Impact

- Costs will be absorbed within the DHHS budget.

Partnerships

- Performance requires strong partnerships between DBED; the County's Welfare Innovation Board; the private business community and DHHS private sector employment training partners; the Maryland Department of Human Resources; the Maryland Department of Labor, Licensing and Regulation; and our customers.

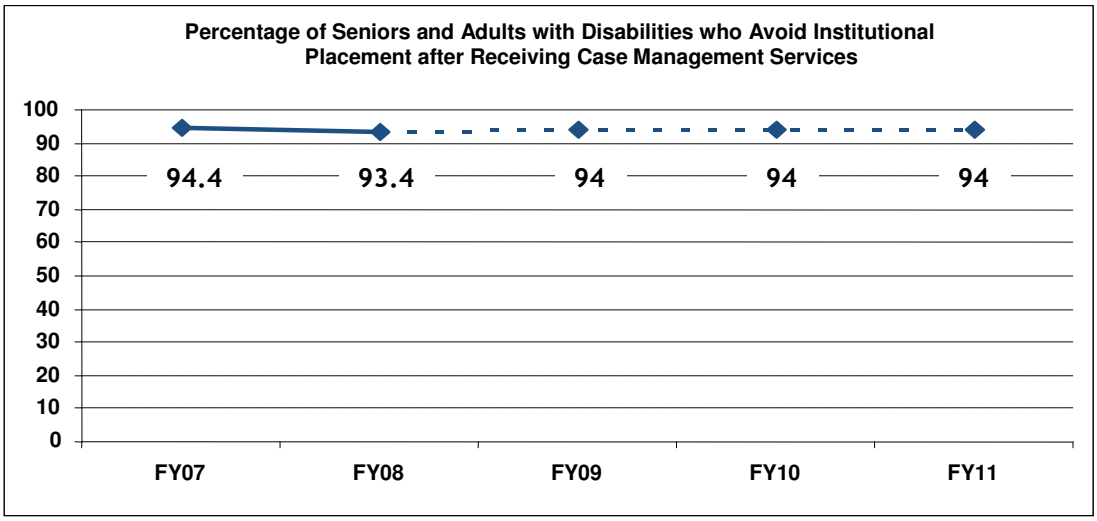
13. Maintaining Independence in the Community

Basic Facts

- One of the primary desires of senior and/or disabled populations is to remain independent in the community (i.e., 80 percent of elders express desire to remain living in their current home for as long as possible).
- In FY2008 DHHS' Aging and Disability staff provided assessment and continuing case management services to 1,690 unduplicated individuals.
- Services were provided by 50 work years of Masters level staff (40 Full Time Equivalent (FTE) social work staff + 10 FTE Community Health Nurse staff)

Performance

Percentage of seniors and adults with disabilities who avoid institutional placement after receiving case management services



Story Behind Performance

Supporting Factors

- Highly trained and knowledgeable staff provides services.
- Social support systems and services (critical factors in determining whether or not an individual will need nursing home placement or other institutional care) are available and accessible.
- An array of services are provided including case management, nursing assessment, personal care, senior care, adult foster care, adult day care, respite care, group home subsidies, support groups for caregivers, home modifications and assistive devices.
- The Older Adult Waiver allows for more in-depth array of services to prevent premature institutionalization.

Barriers

- The size of elderly and disabled populations is increasing, particularly among the oldest-old (age 85+) and those with cognitive impairment.
- The disabled elder population often has multiple and complex health problems (physical and cognitive).
- The waiting list for Older Adult Waiver (federal program administered through the State) is currently 1,095 and is anticipated to grow.
- Demographic projections indicate that as the number of disabled elders continues to increase, the number of informal supports (family or friends) available will decrease. This reduction is due to declining birth rates and greater percentages of adults in the work force.

What We Propose to Improve Performance

- Earn accreditation of State-funded case management services.
- Identify system factors that lead to higher vs. lower quality services through Quality Service Reviews.
- Increase the number of staff available to provide services to more people in need (i.e., reduce waiting lists for services).
- Introduce the Better Living at Home program (which provides environmental assessment by occupational therapist, with provision of assistive devices and home modifications as needed).
- Implement strategies from the Senior Agenda to improve quality of life indicators for seniors in the County.

Fiscal Impact

- Incremental costs to standard services needed to improve performance beyond current level are likely to be prohibitive. Research suggests that individuals strongly self-select against institutional placement (i.e., 30 percent of older adults stated they would rather die than enter a nursing home; Mattimore et al., 1997). Older Adult Waiver programs, while extremely popular, have not produced a cost saving (Weissert et al., 2001) and can cost upwards of $40K per customer served. The best opportunity to improve performance is through gradual implementation of customer-directed services, which have shown promising potential in clinical studies.

Partnerships

- Maryland Department of Aging; Maryland Department of Health and Mental Hygiene; Maryland Department of Human Resources; Respite Care, Inc.; Alzheimer's Association; adult day care centers; home health care agencies.

Innovations

- Better Living at Home (described above) is an emerging Best Practice that the County is evaluating with the assistance of staff from the University of Maryland.
- Customer Directed Care, available through the In-Home Aide Service program, is an Evidence-based Practice that allows customers to design their own care provision plan, and hire family or friends to provide assistance. This innovation has produced better outcomes at lower costs than traditional service delivery.

14. Housing Services

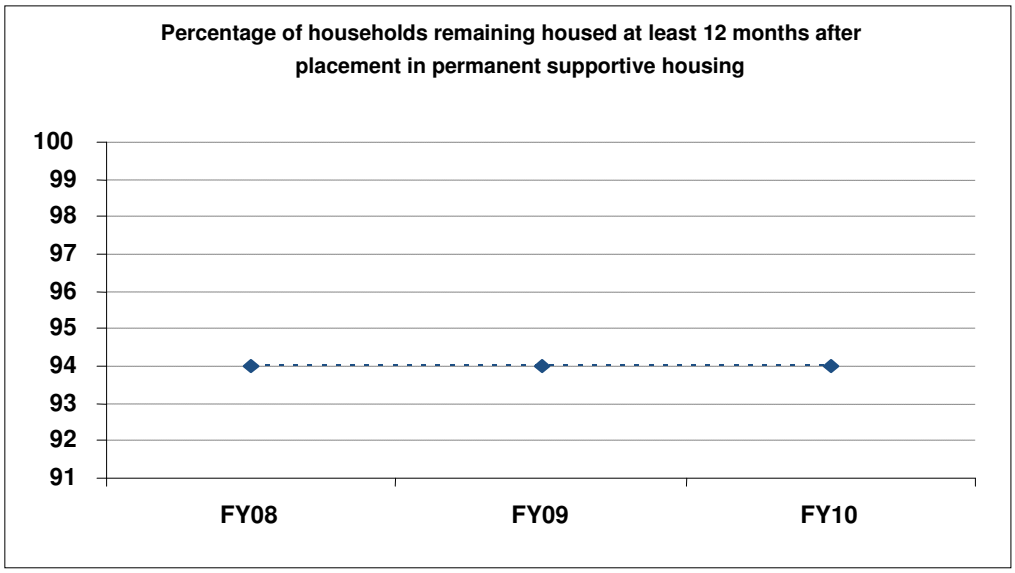
Basic Facts

- Supportive Housing Rental Assistance Program (SHRAP) began housing special needs renter households in late FY07. In FY08, it provided permanent supportive housing to 67 households with incomes below 30 percent of Area Median Income (AMI) and at least one special need (defined as homeless, developmental disability, chronic mental illness 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: County Funds $1.1M.
- In FY09, the Housing First Initiative is funding an additional 150 deep rental subsidies for homeless households enabling DHHS to provide a total of 225 rent subsidies with supportive services. A total of $4.5 million from the County's Housing Initiative Fund supports the Housing First Initiative.
- The Partnership for Permanent Housing 2 (PPH2) began housing homeless households in mid-FY07. In FY08, it provided a "deep" rental subsidy and supportive services for 55 homeless households with incomes at or below 30 percent of AMI. Budget: County Funds $1M.
- In FY08, 5,555 emergency services grants were issued with County and State funds to assist households with preventing evictions and utility cutoffs. Sixty-seven grants also assisted with burial expenses and 242 grants assisted with other emergency issues.
- In FY09, eviction prevention resources will increase with the use of Recordation Tax funds for eviction prevention grants. Ninety-day case management will also be provided to households with multiple court judgments and requests for assistance. Budget: County Funds $1.4M; State Funds $1M.
- Home Energy Assistance Program issued approximately 5,200 Maryland Energy Assistance Program (MEAP) grants and 6,400 Universal Service Program (EUSP) grants in FY08 to households at or below 150 percent of the Federal Poverty Level to help with electricity and heating costs. There were an additional 1,600 households eligible for MEAP; however, Federal Low Income Home Energy Assistance Program (LIHEAP) funds were exhausted State-wide by the end of March 2008. The LIHEAP fund allocation will triple in FY09, therefore an FY09 shortfall is not expected.

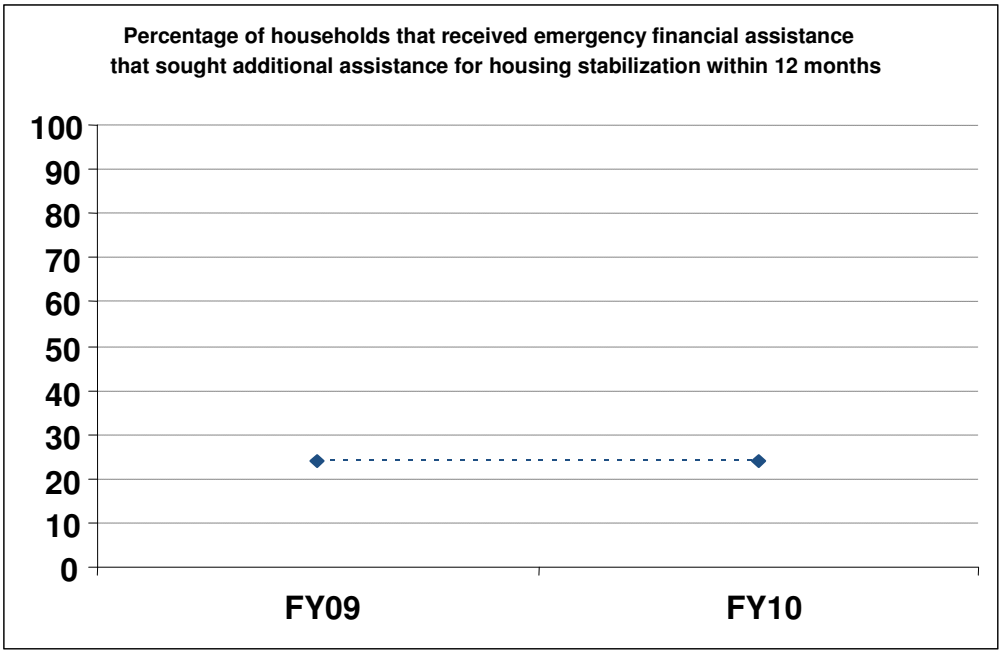
* Deep rental subsidies are permanent supportive housing subsidies in which clients pay no more than 30 percent of their income.

Performance

Percentage of households remaining housed at least 12 months after placement in permanent supportive housing.



Percentage of households that received emergency financial assistance that sought additional assistance for housing stabilization within 12 months.



Story Behind Performance

Supporting Factors

- Specialized case management, mental health and substance abuse counseling and referrals to a range of services such as mediation, training and employment help maintain housing stability for vulnerable households. DHHS 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.
- DHHS provided assistance to an average of 1,668 low-income families and disabled and elderly households whose incomes were below 50 percent of AMI to pay rent through the County's Rental Assistance Program (RAP) in FY08. Its budget was $4.3M.
- DHHS provided assistance to an average of 220 individuals monthly who reside in a group home and have a mental illness through the County's Handicapped Rental Assistance Program (HRAP) in FY08. Its budget was $480K.

Barriers

- The Fair Market Rent ($1,324) for a two bedroom apartment in Montgomery County is high. A household must earn $52,950 annually ($25.46 per hour) to afford this level of rent and utilities without paying more than 30 percent of income on housing.
- There is a shortage of affordable rental units.
- The number of people needing assistance has increased.
- Additional support services and intensive case management beyond rental subsidies are required to ensure special needs populations maintain their housing.
- Immigration status, poor credit history and criminal records impact rapid exit from homelessness.
- Waiting lists exist 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 DHHS partners to implement "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 Housing and Opportunities Commission (HOC) and the County Department of Housing and Community Affairs (DHCA) to explore opportunities to increase the supply of affordable housing units.

Fiscal Impact

- Resources will be determined through the budget process.

Partnerships

- Performance requires strong partnerships between DHHS, DHCA, homeless services coalition members and the non-profit community, HOC, landlords and tenant associations, municipalities within the County for the development of sound County policy with key policy makers and stakeholders.

Innovation

- Implementation of Housing First Initiative has three primary goals:
  - 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.