Performance Measures

Updated December 2009
(FY 2010 Plan)
Final Submission 5-17-10

•

Department of Health and Human Services

Uma S. Ahluwalia, Director

Overview

Contribution to Montgomery County Results

The Department of Health and Human Services (DHHS)' Headline Measures are ordered according to their primary contribution to Montgomery County Results, and their appearance in the plan.

A RESPONSIVE AND ACCOUNTABLE COUNTY GOVERNMENT

SAFE STREETS AND SECURE NEIGHBORHOODS

HEALTHY AND SUSTAINABLE COMMUNITIES

CHILDREN PREPARED TO LIVE AND LEARN

VITAL LIVING FOR ALL OF OUR RESIDENTS

AFFORDABLE HOUSING IN AN INCLUSIVE COMMUNITY

OTHER CONTENTS

DHHS At-A-Glance

DHHS 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 strives to provide services that:
- o Build on the strengths of our customers and the community
- o Are community-based
- o Are accessible
- o Are culturally competent
- o Are responsive to changing needs of our community
- o Are provided in collaboration with our community partners.

What DHHS Does and for Whom	How Much* – FY 10 Budget & Work Years (WY)
Overall 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.	**$268.6 million** 1,577 WYs
Aging and Disability Services (ADS) The mission of ADS 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.	**$38.6 million** 163.7 WYs
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.	**$40.2 million** 209.7 WYs
Children, Youth and Family Services (CYFS) The mission of CYFS is to promote opportunities for children to grow up healthy, and ready for school, and for families to be self-sufficient.	**$70.1 million** 460.3 WYs
Public Health Services (PHS) The mission of PHS is to protect and promote the health and safety of County residents.	**$72.5 million** 561.8 WYs

What DHHS Does and for Whom	How Much* – FY 10 Budget & Work Years (WY)
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**.**	**$18.0 million** **56.2 WYs**
Administration and Support (AS) The mission of AS is to provide overall leadership, administration and direction to the Department, while providing an efficient system of support services to assure effective management and delivery of services.	**$29.2million** **125.4 WYs**

*FY10 Budget & WY figures do not include FY10 Savings Plans

1. Team-based Case Management

Basic Facts

- Cross-systems team-based case management of individual or family cases that receive multiple services:
  - o Offers a more coordinated, systematic and holistic approach to meeting the customer's needs.
  - o Creates efficiencies through communication and coordinated service delivery for customers.
  - o Leads to improved outcomes for customers: risk mitigation, greater independence, improved health, better access to services and successful case closure.
- Data from DHHS' primary database indicate more than 145,800 individuals had encounters with DHHS in FY09, but did not necessarily receive services.
- Over 44,142 of these individuals received services from DHHS, an increase of 7,016 over FY08. More than 26,627 received more than one service (see table below), an increase of 1,171 over FY08.
- HHS has 1,722 full or part-time staff (39 fewer than in FY08) plus contracted partners that, at any time, may be involved in serving customers within and across Service Areas.

Client Record System Data of Active Cases Receiving Multiple Services

Number of Services	Number of Clients		
	FY 07	FY08	FY9
2	9,485	11,412	13,011
3	5,362	6,298	6,905
4	3,078	3,668	3,739
5	1,528	1,738	1,738
6	693	769	742
7	313	365	295
8	151	175	121
9	118	121	76
Total	**20,728**	**25,456**	**26,627**

Performance

Percentage of client cases with multiple services for which effective teamwork is documented.

Percentage of Cases with Acceptable Levels of Team Formation and Functioning					
	FY 08 (n=10)	FY 09 (n=44)	FY10 Estimate based on YTD (n=31)	FY11 Projection	FY12 Projection
Team Formation	50%	82%	83%	78%	78%
Team Functioning	30%	68%	80%	73%	74%

Discussion

Projections for FY11 and FY12 are lower than the current and past years because the results of Quality Service Reviews (a qualitative evaluation tool) vary from review cycle to review cycle because. The sample is both small and non-random. Therefore, it cannot be assumed that results will be consistently progressive.

Story Behind Performance

Contributing Factors
- Team-based case management, a key element in the Department's Service Integration effort (involving staff coordination across programs in collaboration with client receiving multiple services to set goals, achieve those goals, and share decision-making authority and accountability) continues to evolve both informally and formally throughout the Department.
- Major progress was made in refining a confidentiality policy that allows sharing of client information among team members on a need to know basis.
- Progress continued toward an information technology solution that standardizes the intake and screening process. The computer-based model will facilitate more comprehensive screening for the range of customer needs, record standard demographic information on all customers, and enable workers to schedule appointments electronically with participating programs.
- The Department began to draft a case practice model for team-based case management that articulates how it will provide integrated services. This foundation work creates a standard approach and expectations for working within and across programs and services in the Department.

Restricting Factors
- The need to develop a clearly articulated and standardized case practice model with clear guidance and expected competencies was identified as a barrier to creating broad based, understood and standardized team based case management in cases involving multiple services.

- Data cited above to indicate the number of individuals receiving multiple services from DHHS is a partial count. DHHS has multiple separate data systems without connectivity to one another. The actual number of individuals served by the department is higher than noted here. The Department is engaged in a comprehensive process to assess the current information technology system and make improvements that lead to retrieving complete, unduplicated counts of customer volume.
- The lack of a regularly updated, searchable DHHS organization chart was identified as a key missing infrastructure element necessary for staff to operate effectively in an integrated service approach based on knowledge of and connections to the range of programs, services and staff in the Department.

What We Propose to Improve Performance
- Complete development of a formal practice model for team-based case management as the necessary first step before training staff and fully implementing a more comprehensive service integration model. Development activities include building the case practice model and revising it based on staff feedback and focus group recommendations
- Develop and implement team based case management training.
- Develop and implement rollout plan to include staging and a defined organizational structure to support team-based case management.
- Fully implement computer supported intake, screening and referral process to support Service Integration.
- Use grant funds for a staff specialist to coordinate Service Integration efforts.
- Monitor implementation efforts and provide support to staff in the move to a formal team-based case practice approach.

2. Contracted Services Performance Measurement

NOTE: ***REVISED MEASURE***

Basic Facts

- ◆ 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 are more likely to result in better outcomes for clients.
- ◆ Performance measures provide data for future funding and contracting decisions.
- ◆ 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.
- ◆ DHHS has over 550 contracts (competitive and non-competitive)
- ◆ Over $90M of services are procured through contracts (competitive and non-competitive)
- ◆ Beginning in FY09, performance measures were incorporated into new FY09 program-related Requests for Proposals (RFP) and resultant contracts. Beginning in FY10, a count will be made of the number of contracts derived from those RFPs in order to calculate the first result under this revised measure.

Performance

Percentage of current DHHS "health and human services" contracts derived from Requests for Proposals (RFPs) that contain performance measures related to beneficial impact and customer satisfaction.

Methodology

Due to our projected 100% success in FY10 and all future years of measuring the inclusion of performance measures related to beneficial impact and customer satisfaction in new RFPs, DHHS has changed its measure of contracted services performance to a rate which is calculated as follows:

Cumulative # of DHHS "health and human services" contracts from RFPs that contain performance measures related to beneficial impact and customer satisfaction / Total # of current DHHS "health and human services" contracts derived from RFPs

Each year, the rate should increase as the numerator grows, assuming that the total number of applicable contracts remains relatively constant.

Story Behind Performance

Contributing Factors
- Within the existing process, expectations are identified in Requests for Proposals (RFP) and performance measures specific to the Service/Program area are included in final contract.
- Requirements are identified in federal and State funding streams.
- Outputs and deliverable timelines are well identified.
- Service Areas established Department wide definitions for contract performance measures related to both beneficial impact and customer satisfaction.

Restricting Factors
- Additional work is required to standardize processes and provide on-going training. Due to the general economic conditions and budgetary constraints, there are significant resource issues.

What We Propose to Improve Performance
- Continue efforts to refine program-specific performance measures for beneficial impact in partnership with DHHS vendors.
- Continue training Service Area staff on the development of and monitoring for performance measurement.
- Continue to review RFPs and contracts for inclusion of performance measures.

3. Customer Satisfaction

Basic Facts

♦ Due to the transition of its Information and Referral (I&R) responsibilities to the Office of the County Executive under the MC311 initiative, DHHS is replacing its previous measure of "I&R callers who report satisfaction with the I&R assistance they were provided" with a broader measure of customer satisfaction among DHHS service recipients.

Performance

Weighted percent of DHHS customers satisfied with the services they received from DHHS staff.

Submeasure: Weighted percent of DHHS customers satisfied with the language assistance (including sign language) they received when contacting DHHS.

Methodology

A customer satisfaction template has been developed for use with recipients of services provided directly by staff in all DHHS Service Areas. The survey asks whether the respondent's needs were addressed, and whether he or she was:

♦ Served in a timely manner,
♦ Treated politely,
♦ Treated with respect, and
♦ Overall satisfied with services received.

The survey also asks whether the respondent required language (or sign language) assistance when contacting DHHS and, if so, whether they received it and their degree of satisfaction with the assistance received.

Methodologies for selecting potential respondents (to ensure consistent random selection of participants eligible for the survey) and for survey administration (to enhance uniformity and to minimize response bias) are being developed for use in FY11 (and on a limited basis in FY10). Only those programs that planned to measure customer satisfaction in FY10, or can easily do so in the fourth quarter using our template questions, will be collecting and submitting data for a composite measure of customer satisfaction with DHHS staff-provided services. Weights will be applied so as to better reflect results based on program size.

To facilitate DHHS' improvement of its services, we will ask respondents to voluntarily identify their race, ethnicity, gender and age.

Discussion

While customer satisfaction per se is frequently not the intended outcome of human services programs, it is typically used as a proxy outcome that reflects the quality of services provided by an organization. The assumption is that higher quality services are reflected in a greater degree of customer satisfaction. Composite indicators (i.e., those in which multiple questions are collapsed into an overall score) are often cited by researchers as providing greater validity in capturing latent constructs such as "satisfaction", due to the ability to capture different facets of the phenomenon.

Story Behind Performance

Contributing Factors
- Highly trained and knowledgeable staff
- Staff proficiency in a number of non-English languages to facilitate service to customers with Limited English Proficiency (LEP)
- Staff knowledge of language resources provided by the department and appropriate use of resources to facilitate communication with LEP customers

Restricting Factors
- Budget reductions which are likely to reduce the availability of many services, including language resources
- Large numbers of LEP residents and large diversity in languages spoken in the County
- Desired services may not be available, either due to constraints on service availability or the individual's ineligibility for the programs

What We Propose to Improve Performance
- Work with Contracts Management Team to obtain ongoing results of DHHS contractors' customer satisfaction surveys. DHHS has a goal of requiring that all contracts we originate include a requirement for such a survey. A standardized survey and instructions were developed and provided in new Requests for Proposals beginning in FY10
- Continue to train select groups of DHHS staff in Customer Service, and encourage all staff to take Customer Service training offered by the County
- Continue to require new front-line staff to take Customer Service Across Cultures training

4. Contract Monitoring

Basic Facts

- Over 550 business, consulting and direct services contracts are administered by a Contract Management Team (CMT).
- Over 300 of DHHS' contracts are cost reimbursement contracts.
- DHHS has strong program based contract monitoring. As a result of several reports issued by the Office of the Inspector General (OIG) as well as a general climate relating to increased fiscal accountability and transparency, DHHS is implementing changes to our fiscal contract monitoring.
- To facilitate the enhanced fiscal monitoring, DHHS is developing training materials for monitors, managers, supervisors, and other fiscal and contract management DHHS staff. This training is mandatory for contract monitors.
- DHHS will continue to work collaboratively with the DGS' Office of Procurement, County Attorney, Finance, and vendors to streamline processes and refine fiscal monitoring process.

Performance

Active monitors' training completion rates (County-administered and internallyDHHS-administered)

Average response scores from trainees' predictions of whether their work quality will improve as a result of training received (County-administered and DHHS-administered)

Methodology
- OHR sets up electronic registration for all contract monitoring training sessions.
- DHHS obtains the registration list and sign-in sheets from each course and calculates the completion rates quarterly based on sign-in sheets and active contract monitor list.
- OHR inputs end-of-training evaluation responses into database, and calculates average response scores.

Discussion

DHHS is implementing changes to our contract monitoring process to enhance the fiscal monitoring component. Many of our monitors are program-based and do not have a strong fiscal background. The County's Contract administration training does not provide training on the fiscal monitoring aspects of the contracting process.

To provide such training, the Department is developing in-house training materials for fiscal contract monitoring. DHHS fiscal related training covers areas such as required fiscal support documentation, reviewing fringe and overhead rates, and guidance on how to review detailed financial data. DHHS has also developed standardized forms.

Training materials and standardized forms will be posted on the DHHS Financial Operations Intranet site.

Story Behind Performance

Contributing 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.

Restricting Factors

- Vendor capacity with regard to infrastructure various greatly.
- Lack of fiscal background on the part of DHHS contract monitors.
- Limited resources for enhancing fiscal monitoring, both on the part of DHHS and vendors.
- Because of staff turnover and training schedules, training completion rates are subject to frequent variation.
- The volume of contracts monitored is substantial.
- 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

- Report regularly on contract related issues, including training participation, during weekly DHHS Senior Leadership Team meetings.
- Revise DHHS Contract Monitoring Guidelines to enhance the fiscal component of contract monitoring.

## 5. Juvenile Justice Assessments, Screenings and Referrals

Basic Facts (FY08)*

- 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.
- 603 County youth under 18 received an alcohol citation, and 3,589 juvenile arrests were made by the Montgomery County Police Department (MCPD).
- 3,501 of the youthful offenders were referred directly to the DJS, while 922 youth who either received an alcohol citation or committed certain nonviolent misdemeanors (usually for the first time) were "diverted" from DJS to the Montgomery County Department of Health and Human Services (DHHS) where they received substance abuse and mental health screening and referrals, if needed, to a drug and alcohol education program or mental health or substance abuse treatment.
- 97 percent of youth diverted to DHHS by the Montgomery County Police Department (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 partners with the DHHS Access to Behavioral Health unit to provide mental health treatment referrals for Medicaid-eligible youth who are diverted.
- 26 percent of diverted youth entered intensive substance abuse or mental health treatment; an additional 20 percent received intensive substance abuse education, including urinalysis, and 46 percent received less intensive substance abuse education. The remaining eight percent were not referred to community services based on their assessment. These youth may have had to complete teen court or other requirements through MCPD.
- 8.2 work years and $980K 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 1,692 juveniles in FY09.

* This measure is by definition a 12-month follow-up of clients, so actual FY09 data do not become available until FY11.

Performance

Percentage of offenders under age 18 that 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.

Percentage of youthful offenders under 18 who are diverted into HHS substance abuse programs that do not re-enter the juvenile justice or adult correction system within 12 months of being assessed compliant with requirements
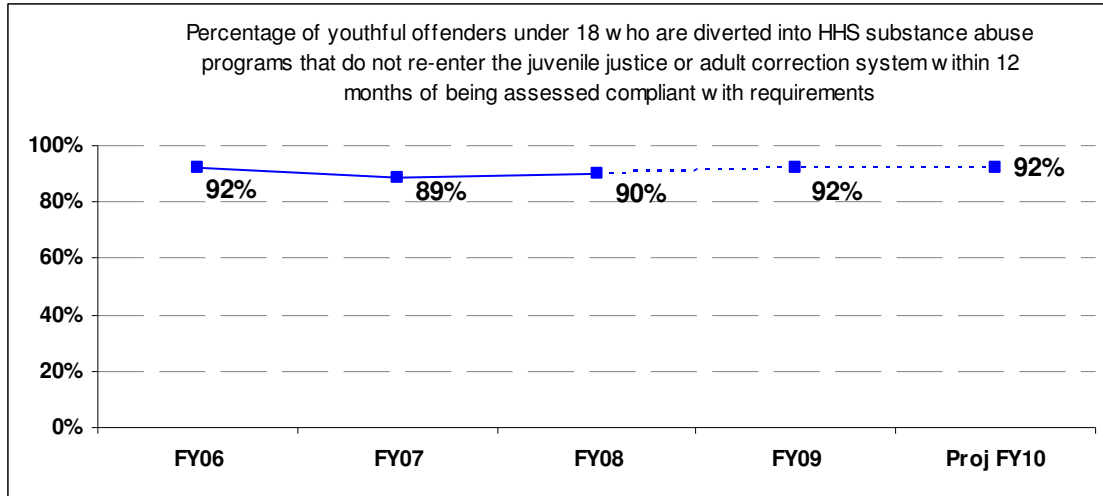
Discussion

Results reflect youth screened for mental health and substance abuse disorders and diverted from the Juvenile Justice System into community education and treatment services that did not become re-involved in the juvenile justice or criminal justice systems within a 12-month follow-up period. In FY06 the recidivism rate in the criminal and juvenile justice systems combined for youth who were compliant with diversion requirements was 8%; in FY07 the recidivism rate was 11%; and in FY08 10% of the 897 youthful mostly first-time offenders who were compliant with the SASCA program requirements became re-involved within 12 months.

Story Behind Performance

Contributing 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, whether or not the youth is a first time offender, and whether the youth admits to the offense.
- DHHS has a 10-year track record in providing "diversion" services and an experienced substance abuse and mental health screening and assessment staff.

Restricting Factors
- 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 that are cited again or re-arrested may eventually be dropped by DJS.

♦ The SASCA program has only one case manager. Additional case management services could decrease the reoccurrence of offender behavior.

What We Propose to Improve Performance
♦ Continue partnership with the Montgomery County Collaboration Council and the State to assure future funding for the case manager position. This position works with families to increase the number of SASCA diversions that become engaged in the diversion process, and increase the retention rate in treatment among diversion program participants.
♦ Analyze Juvenile Justice Information System (JJIS) data for diversity trends and outcomes in diversion will be completed in early FY10.
♦ Explore with the MCPD, DJS, and the State's Attorney's Office the potential for expanding the eligibility for diversion to include more juvenile offenders.
♦ Continue work with the MCPD, the Montgomery County Collaboration Council, the State's Attorney's Office for Montgomery County, and Maryland DJS to explore expanding eligibility to diversion in order to serve more youth and families, and divert more youth from DJS.

6. Direct DHHS Services

Basic Facts

♦ 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.

♦ Data from DHHS' primary database indicate more than 145,800 individuals had encounters with DHHS in FY09.

♦ Of these, over 44,142 individuals received services from DHHS, an increase of 7,016 over FY08. More than 26,627 received more than one service, an increase of 1,171 over FY08.

Performance

Weighted composite scores 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).*

Weighted score of client cases that demonstrate beneficial impact from received services
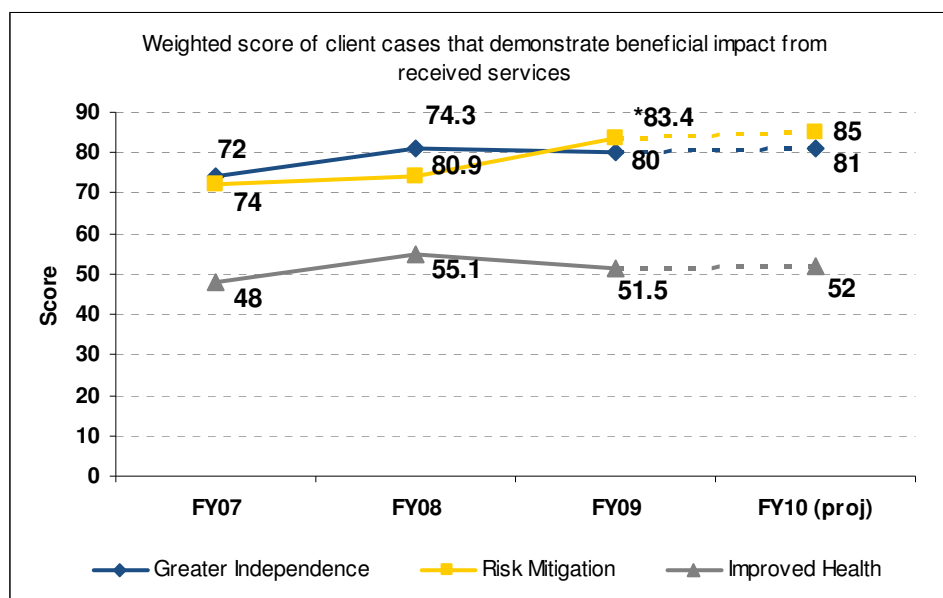
*The selection of programs for calculating this composite measure was slightly revised from FY08. Results for FY09 are for the new program selection. Using the FY08 selection, the Risk Mitigation score would be 78.1, not 83.4.

Quality Service Review (QSR) cases considered "acceptable" are those that show some degree of beneficial impact, i.e., received a rating of 4-6 (on a 6 point scale), based on the consensus judgment of two reviewers after evaluating client status and system performance across 16 defined indicators.

Percent of QSR cases rated as acceptable, by degree of beneficial impact
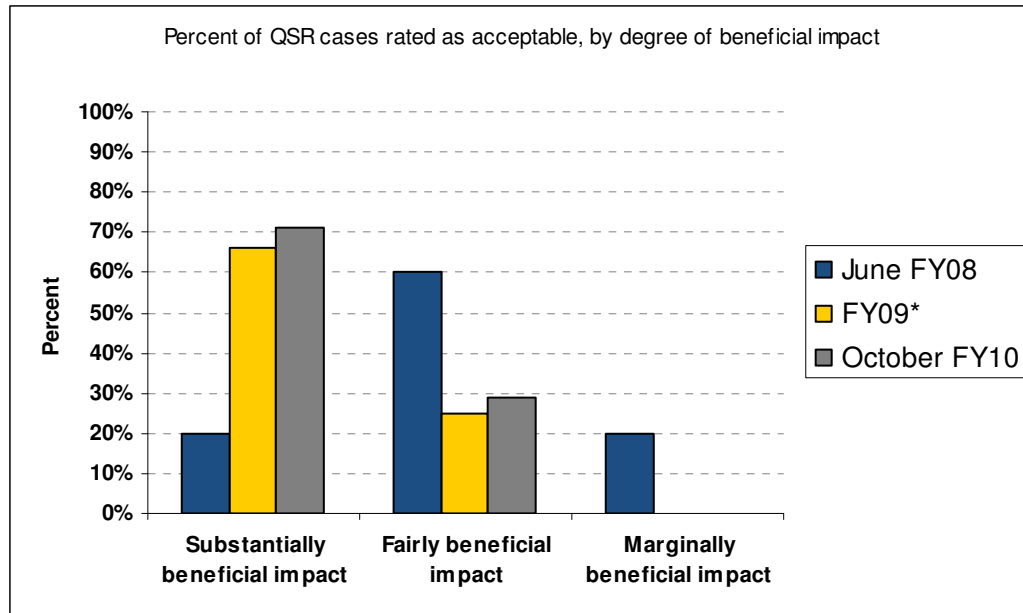
*Percentages for FY09 equal 100% with the addition of a fourth category of 9% "unclear or unknown beneficial impact."

Percent of QSR Cases Showing Beneficial Impact, by Service Area

Service Area	FY08	FY09	FY10
Aging and Disabilities Services	50% (1/2)	81% (13/16)	100% (2/2)
Behavioral Health and Crisis Services	100% (2/2)	100% (14/14)	100% (2/2)
Children, Youth and Family Services	75% (3/4)	75% (3/4)	100% (5/5)
Public Health Services	100% (1/1)	100% (4/4)	100% (2/2)
Special Needs Housing	100% (1/1)	83% (5/6)	100% (3/3)
Total	80% (8/10)	89% (39/44)	100% (14/14)

Discussion

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.

Story Behind Performance

Contributing Factors
- Development and implementation of an integrated DHHS case practice model is ongoing.
- Progress continued toward an information technology solution that standardizes the intake and screening process. The computer-based model will facilitate more comprehensive screening for the range of customer needs,
- Expectations for case management, including intake and referral, assessment, case planning, service delivery and evaluation are standardized.
- Best practice models are used in many programs.
- Team-based case management, a key element in the Department's Service Integration effort (involving staff coordination across programs in collaboration with the client receiving multiple services to set goals, achieve those goals, and share decision-making authority and accountability) continues to evolve both informally and formally throughout the Department.
- Four QSR review cycles were conducted over the year and more reviewers were trained. A process was established to review and use results for continuous improvement.

Restricting Factors
- 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 while public resources are more limited.
- Evidence-based Practices empirically validated as effective in addressing some social problems are limited in number.

What We Propose to Improve Performance

- Refine indicators that are annually "rolled up" into composite measures of beneficial impact.
- Continuously seek efficiencies to deal with pressure on the system to serve more people with ever-decreasing resources.
- Monitor implementation efforts and provide support to staff in the move to a formal team-based case practice approach.
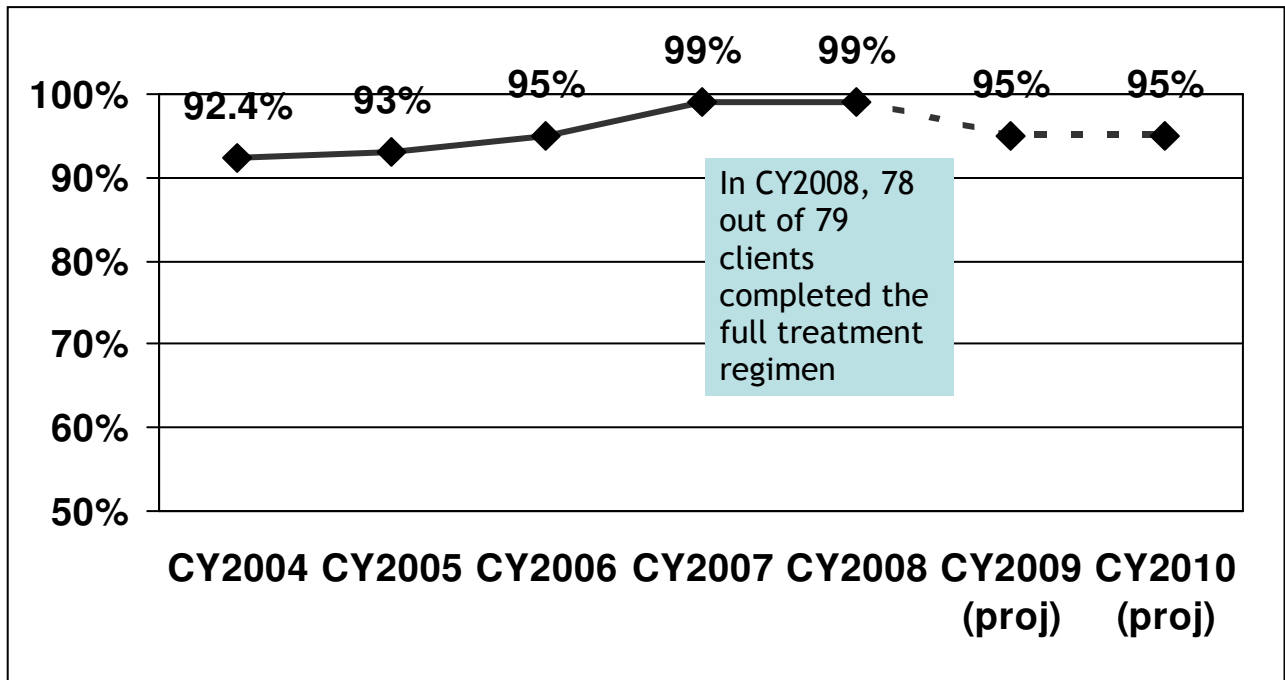
7. Communicable Diseases Control

Basic Facts

- 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.
- 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 147 of the national TB cases (approximately 25-30 percent of Maryland cases). There were 88 cases diagnosed and treated in calendar year 2008.
- In FY09, the DHHS Immunization Program administered 20,510 vaccines to 12,596 children and 1,613 vaccines to 1,372 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 require 8-10 investigators to control.
- Foodborne diseases and Illnesses are being addressed in an integrative approach with Licensure and Regulatory Services.

Performance:

Percent of clients with active infectious tuberculosis that received and were scheduled to complete Directly Observed Therapy and that successfully completed the treatment regimen

Chart values by year:
- CY2004: 92.4%
- CY2005: 93%
- CY2006: 95%
- CY2007: 99%
- CY2008: 99%
- CY2009 (proj): 95%
- CY2010 (proj): 95%

In CY2008, 78 out of 79 clients completed the full treatment regimen

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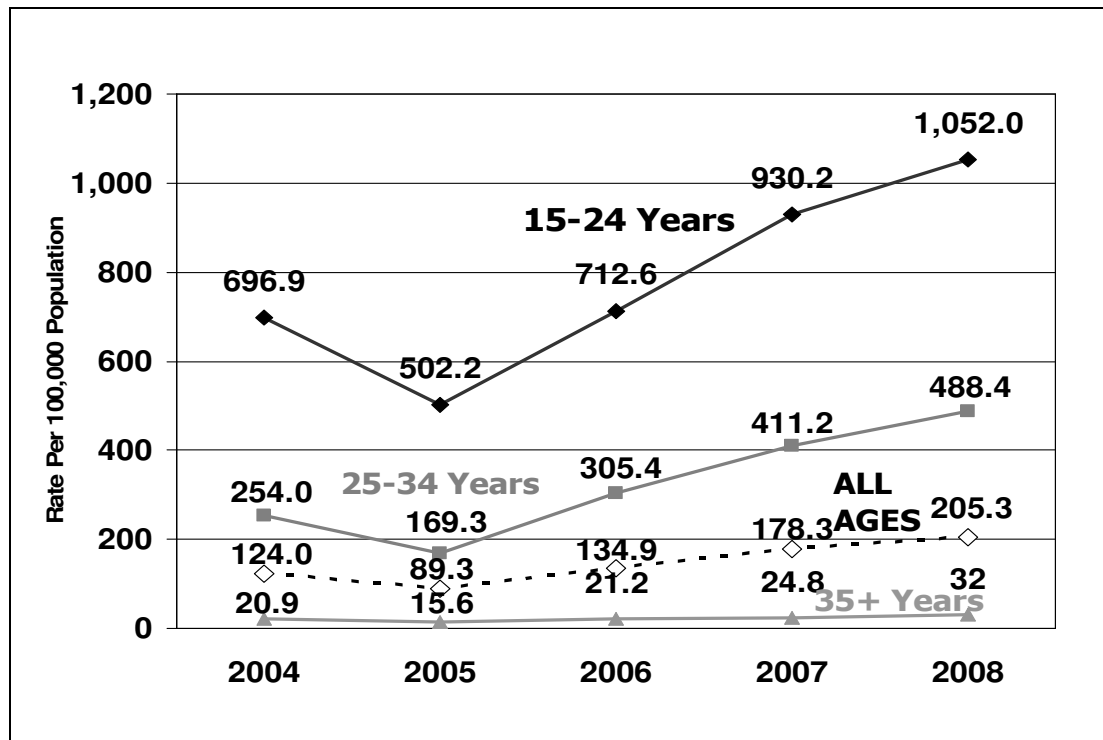
Discussion

New cases of Chlamydia continue to rise, especially among persons (males and females) 15-24 years of age. The rate of increase has slowed from previous years, but Chlamydia incidence is expected to continue to rise. DHHS chooses not to estimate future results. At some unknown point, Chlamydia incidences should begin to fall as a result of decreased exposure to the disease resulting from such program activities as community education and partner notification.

Starting in 2009, in accordance with State guidelines, the State laboratory will only cover the processing of Chlamydia tests for women 25 years and younger. This measure has been revised from previous years to only cover females ages 15-24 to reflect the revised guidelines.

Women 26 and older, and all males who present with symptoms or report contact with a case will be treated following Chlamydia treatment guidelines, but will not be tested (unless the submitting site covers the testing expense). For those untested cases, there will be no trigger to initiate contact tracing or any retesting.

Story Behind Performance

Contributing Factors
- PHS engages in multiple activities 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.
- 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.
- 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.

Restricting Factors
- 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 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.
- ♦ Compliance with TB directly observed therapy (DOT) relies heavily upon the client's ability to remain in DHHS service area for the duration of treatment.
- ♦ 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 Process.
- ♦ 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. 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.

8. Social Connectedness and Emotional Wellness

Basic Facts

♦ DHHS provides a comprehensive system of mental health and substance abuse treatment services to children, youth, adults, seniors and families. Services incorporate evidence-based practices and targeted preventive intervention along a continuum of care.

♦ Crisis and victim services are available around the clock to clients victimized 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 clients with public health insurance and priority populations are monitored, including outpatient mental health clinics, senior outreach, homeless outreach, psychiatric rehabilitation and residential rehabilitation programs.

♦ In FY09, the Crisis Center served a total of 56,663 contacts including 52,926 phone contacts and 3,707 walk-in contacts. A total of 361 students was referred by their schools to be assessed for level of risk to themselves or their community; 92 percent of these students did not require emergency department services, were stabilized in the community and could return to school.

♦ A total of 1,359 individuals in Montgomery County reported an incident of partner abuse to legal authorities in Calendar Year 2008. Additionally, there were 144 outreaches to sexual assault victims, assisting 294 victims and their loved ones in FY09. All 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 Services (CATS), one components of the DHHS Criminal Justice programs, in collaboration with Department of Correction and Rehabilitation (DOCR) staff, oriented and screened 8,760 (FY09) offenders entering the Montgomery County Detention Center (MCDC) to determine suicide risk.

♦ A 100 percent success rate was achieved in preventing suicide both at the MCDC and Montgomery County correctional facilities since January 2000, thanks to diligent collaboration between DHHS and DOCR staff.

♦ The Child and Adolescent Mental Health Home-Based Team served a total of 161 children in FY09. Of those served, 97.5 percent were able to be maintained in the current placement. Only 2.5 percent (n=4) of the children had to be referred to out-of-home care.

♦ From FY08 to FY09, the number of Montgomery County consumers accessing the Public Mental Health System grew by 7.7 percent from 7,839 to 8,448. 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 positive outcomes in the domains of housing, quality of life, legal encounter, and employment/education as measured by:

- **Housing**
  - *Gained/Retained Housing,* a measure of current housing situation, as shown by percentage of people who live independently
  - *Housing Stability*, a single measure of percentage of people who moved less than 3 times in the past six months.
- **Quality of Life**
  - *Curbing Alcohol Use*, defined as percentage of people who do not drink alcohol daily or more frequently in last 30 days. (For children & adolescent, this measure is modified to be Alcohol Free).
  - **Drug Free**, defined as percentage of people who did not use illegal drugs in last 30 days.
- **Legal Encounter**
  - *Legal System Encounter*, defined as percentage of people who have no or decreased encounter with legal system.
  - *Arrest Free*, defined as percentage of people who have not been arrested last 12 months
- **Employment/Education**
  - *Gained/Retained Employment*, defined as percentage of people who worked 1- 40+ hours on a weekly basis. (Adult consumers only)
  - *Staying in School*, defined as percentage of children aged 6-17 who stay in school. (Children & Adolescents only)

Methodology for Composite Score and Component Measures

In FY09, initial computation of composite scores focus on Outpatient Mental Health Clinics' (OMHC) outcome measurement data developed by Maryland's Department of Health and Mental Hygiene (DHMH) to collect information on individuals ages 6-64 receiving outpatient mental health treatment from OMHC, Federally Qualified Health Centers and hospital-based mental health centers. In FY09, 2,712 (54% of all adult outpatients) adults ages 18-64 years accessed outpatient services at OMHCs and completed an OMS questionnaire. Additionally, outcomes data was collected on 1,984 child and adolescent consumers ages 6-17 years (65% of all child and adolescent consumers).

Eight individual measures were chosen from DHMH's Outcome Measurement System (OMS) Data Mart to demonstrate consumer self-reported improvement in several domains comprised of housing, employment/education, legal encounter, and quality of life outcomes to represent a full spectrum of consumers' treatment and recovery experience.

The scores for each of the four domains of social connectedness are evaluated to ensure consistency and comparability in scale and directionality. The individual scores are summarized together in the form of a weighted mean of percentages to obtain an overall composite score. The weight used in calculating the weighted mean is the sample size for each of the eight questions in the OMS survey.

Two separate composite scores were computed for adults and children. The measure of Staying in School is only applied to children and adolescents' scores to ensure relevancy. Similarly, Gained/Retained employment is only used in calculating composite scores for adults.

Due to time constraints for providers to gather data, outcome data from OMHCs is the primary data source supporting this Headline Measure in this first year of implementation. In the future, DHHS will implement a short version of the OMS survey with eight questions to incorporate more BHCS programs specialized in addiction treatment, crisis response and intervention, adult mental health, senior mental health and jail-based services.

Performance

Social Connectedness and Emotional Wellbeing Headline Measure for
Adult Consumers
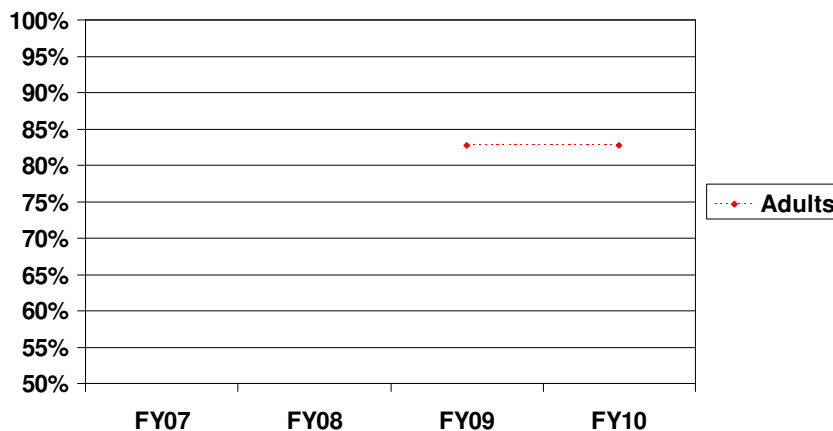
Social Connectedness and Emotional Wellbeing Headline Measure for
Child and Adolescent Consumers
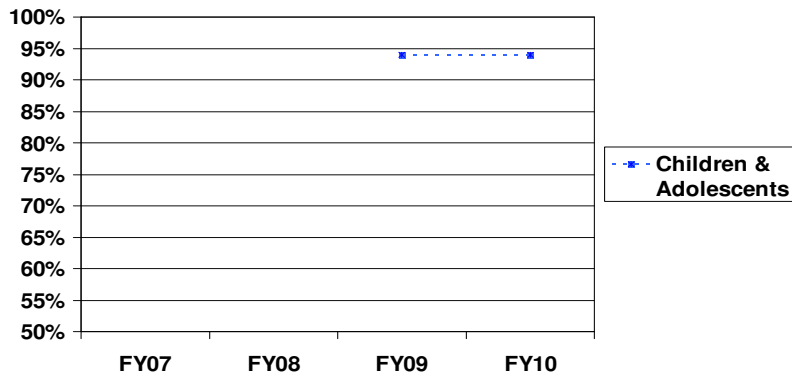
Discussion

Among adult consumers seen at OMHCs, 82.8% reported positive or improved outcomes in Social Connectedness and Emotional Wellbeing in FY09, as aggregated from individual measures in domains of housing, employment, legal encounter and quality of life. Ninety-four percent of child and adolescent consumers reported positive improvement in Social Connectedness and Emotional Wellbeing in domains of housing, education, legal encounter and quality of life. The difference in the two age groups is attributable to the drastically low employment rate (37.6%) among adult consumers. A full 92.3% of child and adolescent outpatients still manage to stay in school despite all the challenges they face.

Story Behind Performance

Contributing 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 (MCPS), Department of Corrections and Rehabilitation (DOCR) 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 recognized either as evidence-based or promising practices.
- All clinicians on the Child and Adolescent Mental Health Home-Based Team received a year-long training in Trauma Focused Cognitive Behavioral Therapy (TF-CBT), an evidence-based treatment protocol for the treatment of trauma in children and adolescents.

Restricting Factors

- 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.
- 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.
- Continue to seek opportunities to integrate somatic health care clinics into our behavioral health settings.
- Continue to partner with the Department of Technology Services for Geographic Information Systems Services as part of ongoing efforts at improved data collection and informed forecasting of service needs.

9. Providing Health Care Access

NOTE: ***REVISED MEASURE***

Basic Facts

- ♦ Montgomery County had 109,244 uninsured residents in 2008, including 10,371 children. Approximately 38,000 children and 24,500 adults 18-64 years old were covered by some public health insurance option (including Medicaid, Medicare, or other government assistance plans).
- ♦ Providing access to health care to all residents has many benefits: healthier, more productive residents; less absenteeism from school or work; more disease prevention, earlier detection and better management of diseases such as asthma, diabetes, cancer and heart disease, and cost savings that arise from prevention and more appropriate use of hospital emergency rooms for true emergencies.
- ♦ Montgomery County has led the way in the State and is probably one of the few jurisdictions nationally to attempt to address the issue of access to health care at the local level.
- ♦ The DHHS Service Eligibility Units (SEUs) process medical assistance applications for the Medicaid for Families program and the Maryland Children's Health Program (MCHP) that are funded and administered through the Maryland Department of Health and Mental Hygiene (DHMH) to cover minor children under the age of 21 and their parents or caretaker relatives and pregnant women. SEUs also process applications for Care for Kids, the Maternity Partnership, and Senior Dental.
- ♦ Additional Medical Assistance coverage groups that fall under the Aged, Blind, and Disabled (ABD) and Families and Children (FAC) categories are administered by the Maryland Department of Human Resources (DHR) and processed by the DHHS Income Support program, along with eligibility for other public assistance programs like Food Stamps, Temporary Assistance for Need Families (TANF), and Temporary Disability Assistance Program (TDAP).
- ♦ In FY09, DHHS processed 70,016 medical assistance applications and 7,335 county healthcare program applications. Of these, 45,487 medical assistance and 7,135 county health care programs applications were approved. Currently, the three SEUs lead the state in the number of enrolled medical assistance cases which averages 38,000 monthly. In the same year, Income Supports offices processed an additional 35,793 applications for other forms of public assistance.
- ♦ DHHS staff enrolled 3,600 uninsured children, who are not eligible for State or federally funded programs, into the County's Care for Kids program in FY09 and enrolled an additional 2,375 pregnant women in the Maternity Partnership Program to ensure access to prenatal care and delivery services. The Montgomery Cares Program provided access to primary health care and prescriptions plus limited specialty care to 21,077 uninsured adults in FY09.

Performance

- Percent of select uninsured vulnerable populations that have a primary care or prenatal care visit

	FY2009 Results
Children	34.7%
Adults	22.0%
Pregnant Females	UNDER DEVELOPMENT

- Percent of Montgomery County medical assistance applications approved for enrollment.

Jul-08	Aug-08	Sep-08	Oct-08	Nov-08	Dec-08	Jan-09	Feb-09	Mar-09	Apr-09	May-09	Jun-09	Avg. FY09
86%	84%	88%	89%	84%	84%	87%	81%	78%	87%	81%	78%	84%

In FY09, 37,276 new applications were submitted for enrollment into Maryland's medical assistance programs (Community Care and Long-Term Care) with 31,192 applications (84%) approved. The annual average approval statewide was 77%.

Percent of Medical Assistance Applications Approved for Enrollment in Community Care and Long-Term Care, by Month, Montgomery County and Maryland
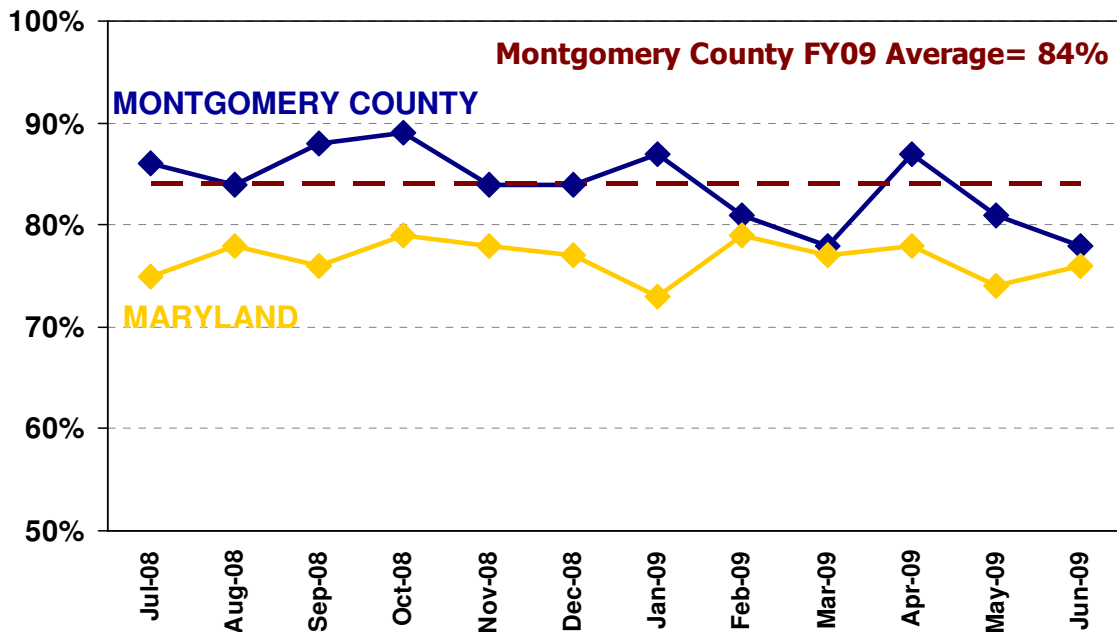
Methodology

--Access to care for the uninsured
Due to improvement in data on the uninsured, DHHS changed the data source for the estimated number of uninsured residents in Montgomery County from U.S. Census Bureau's periodic Small Area Health Insurance Estimates (SAHIE) to the Census Bureau's American Community Survey (ACS), an annual source that started measuring the health insurance status of county residents by age and insurance type in 2008. Results for this measure will not be comparable to those reported for a similar measure in previous DHHS Annual Performance Plans.

DHHS identified and tabulated the following population-based estimates from the 2008 ACS:

♦ Number of Montgomery County residents without any type of health insurance (0-17 yrs, 18-64 yrs, 65+ yrs, and females of reproductive age)
♦ Number of Montgomery County residents with public health insurance (0-17 yrs, 18-64 yrs, 65+ yrs, and females of reproductive age)

Using 2008 ACS uninsured estimates as the denominators to each county program (Montgomery Cares, Care for Kids, and Maternity Partnership Program), rates were calculated based on the enrollment figure for the respective program:

Care for Kids:
Enrollment = 3,600 (under 19 years) FY2009
Uninsured persons under 18 years = 10,371 CY2008 ACS
Percent of uninsured children with access to primary care= 34.7%

Montgomery Cares:
Enrollment = 21,077 FY2009
Uninsured persons 18+ years = 98,872 CY2008 ACS
Percent of uninsured adults with access to primary care= 22.0%

Maternity Partnership Program:
Enrollment = 2,375 females,
Number of uninsured females of reproductive age UNDER DEVELOPMENT (this estimate is not available at this time).
Percent of uninsured pregnant females with access to primary care= UNDER DEVELOPMENT.

--Processing enrollment into medical assistance and other similar medical entitlement programs
DHHS also has selected a measure for capturing the County's contribution to processing the medical assistance and other similar medical entitlement programs' enrollment and redetermination applications that are processed by DHHS SEUs Income Support program. The percent of applications for medical assistance that are processed and approved are based upon Maryland DHR Family Investment Program Network (FIPNet) Monthly Statistical Report data on Monthly Application and Recipient Data, State FY2006-FY2010

posted on DHR Intranet (http://fipnet1.dhr/mnthappdata/index.htm). The number of applications approved is divided by the total number of applications received in the same year to derive the 84 percent approved in FY09.

Story Behind Performance

Supporting Factors

Eligibility

♦ DHHS enrolls uninsured residents who are not eligible for State or federally funded programs into the County Care for Kids program or refers adults to the County's Montgomery Cares program to ensure access to primary health care and related prescriptions, or to the Maternity Partnership Program for prenatal care.

♦ County residents may enroll in specific health care access programs at multiple sites.

♦ SEU procedures were streamlined to accommodate recent Children's Health Insurance Reauthorization Act (CHIPRA) and family Medicaid policy expansions.

♦ DHHS provides language interpretation for large numbers of applicants with Limited English Proficiency. In addition, the Department supports residents in using an online application to enroll in medical assistance programs. Health Promoters from the community and other outreach staff also help to link residents to health access programs.

Education

♦ DHHS provided medical assistance/County healthcare programs outreach training and activities across the County throughout the year serving specific geographical and cultural communities including "Linkages to Learning" school based health centers, Holy Cross Hospital multi-cultural healthcare promoters, and infant mortality reduction healthcare promoters in FY10.

Funding

♦ County leadership continues to support the current capacity for Montgomery Cares clinics for uninsured adults; a large number of volunteer medical providers contribute time to support Montgomery Cares; additional specialty care providers contribute discounted care; and local clinics and hospitals contribute services and facilities.

♦ Enrollment of eligible County residents in State- and federally-funded health insurance programs - including medical assistance and similar programs- leverages County dollars for enrollment workers with State and federal dollars to cover health care administrative? Costs. Hospitals cover half the cost of County eligibility staff working in the hospitals; and State grants and federal reimbursement cover full or partial costs of many County eligibility staff.

Staffing

♦ DHHS resolved a backlog of 5,000 overdue medical assistance renewal applications by utilizing overtime funds and filling five staff vacancies. To maintain compliance, DHHS is expected to timely process 96% of applications. DHHS continues to be under close scrutiny from DHR and DHMH to meet compliance for all new and renewal applications, but with additional

overtime, temporary manpower and monitoring tools DHHS is better positioned to meet the compliance level.

Restricting Factors

Eligibility
- State and federal agencies establish eligibility criteria for entitlement programs that limits enrollment.
- Proof of citizenship or appropriate resident alien status that is required to obtain federal/state medical assistance presents challenges for applicants and additional work for staff.

Education
- Many residents are not aware they are eligible for a federal/state program, which results in higher unmet demand for County safety net programs.

Funding
- A lack of funding prevents sufficient staffing and office resources to sustain increased medical assistance caseloads.
- The Montgomery Cares, Maternity Partnership, and Care for Kids programs currently have limited funding and capacity to meet the demand for services should every eligible low-income uninsured person enroll.

Staffing
- DHHS does not have sufficient eligibility staff to adequately process new and renewal applications within prescribed timeframes, resulting in delays and additional expense to individuals, hospitals and the County.
- Twenty-five SEU caseworkers are responsible for maintaining a monthly average of 1,707 cases each in order to sustain 42,664 federal and county actively enrolled cases. Currently, the SEU staff receives a monthly average of 5,500 (66,000 annually) new county and federal applications to be processed.
- Income Support caseworkers are generalists responsible for servicing medical assistance benefits along with the cash assistance and food supplement benefits for the same families. Eighty-seven caseworkers are responsible for handling these combined caseloads with an estimated 60,000 ongoing assistance units each month and an average of 2,280 new applications for medical assistance each month.
- For the first three quarters in FY10, 82% of applications were approved for Montgomery County while statewide 78% were approved.

Information Technology
- Seamless interoperability and integration of medical assistance and County-specific healthcare programs eligibility screening and processing is needed to improve efficiencies and to provide accurate caseload and client demographic information.

What We Propose to Improve Performance

Eligibility/Information Technology
- Continue to streamline procedures for residents applying for programs; advocate for resources to develop and implement an integrated and interoperable medical assistance and County-specific computerized eligibility system

Education

♦ Increase individual awareness of eligibility for medical assistance programs through the Montgomery County MC311 information line and updates to the County Web site; by continuing to support the online information about resources available to County residents through the Collaboration Council's www.InfoMontgomery.org; and by providing information in multilingual formats like the Montgomery Cares Web site (www.MontgomeryCares.org) and brochures.

♦ Advocate for and train additional volunteer Health Promoters to assist residents in applying for available publicly-funded health insurance/primary care programs.

Funding

♦ Advocate for funding to support sufficient staffing and office resources to sustain increased medical assistance caseloads.

Staffing

♦ Advocate for hiring and training additional eligibility workers as supported by workload data. The actual number of people enrolled that also require caseload management is far greater than the number of applications processed since applications are typically initiated by the head of household and the average household usually includes two or more minor dependent children.

♦ Advocate for resources to increase administrative support and caseworker staffing to provide timely processing of client applications, effective caseload management, adequate case record filing and storage management, and provide dedicated staff to address and resolve client issues.

10. Early Childhood Services and Programs

### Basic Facts

- DHHS Public Health Services (PHS) provides health, vision, hearing and dental screening and treatment services and 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.
- Over 65,000 children ages 0-4 resided in the County (U.S. Census); 12,374 County 5-year-olds were enrolled in public and private kindergarten programs.
- Child care resource and referral information was provided to over 35,000 parents.
- The Montgomery County Infants and Toddlers Program served 3,825 families.
- 714 children were enrolled in Montgomery County Head Start: there were 684 served through the Montgomery County Public Schools (MCPS) Head Start and another 30 were served in community-based Head Start settings.
- 2,164 four-year-old children were served in the MCPS Pre-Kindergarten program.
- 4,907 health screens for newborns were conducted in hospitals by the Baby Steps program contract staff.
- 2,698 program referrals were made to early childhood and family support services by CHILDLINK staff.
- 1,309 child care providers received workshop training through the Montgomery County Child Care Resource and Referral Center and 99 child care providers received scholarships to pursue early childhood coursework at Montgomery College.
- 14,154 pieces of early childhood public engagement materials were distributed through integrated outreach efforts.
- Onsite Early Childhood Mental Health Consultation Services were provided to 52 child care programs serving over 3,000 children.
- Early Childhood Services documented that 187,043 services were delivered to young children, their families and caregivers in FY09.
- Early Childhood Services budget: $5.7 million includes $3.6 million in contracts and 23 work years.

Performance

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

Montgomery County Kindergarten Student Readiness
Source: Maryland Department of Education (MSDE)
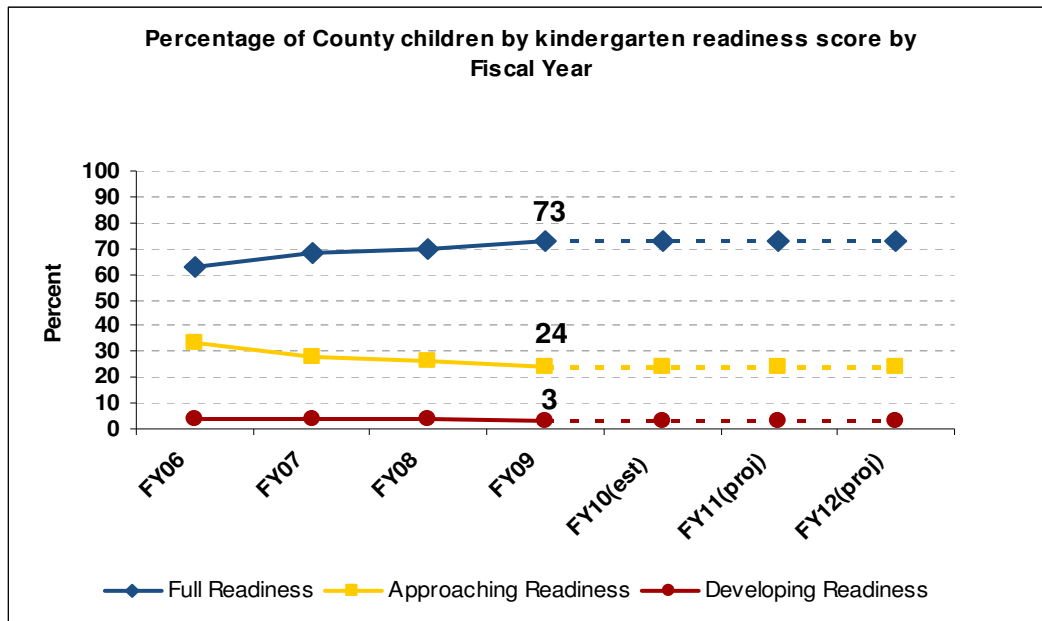
Note: This chart shows the Full Readiness results and projections for the three settings which constitute this Headline Measure.
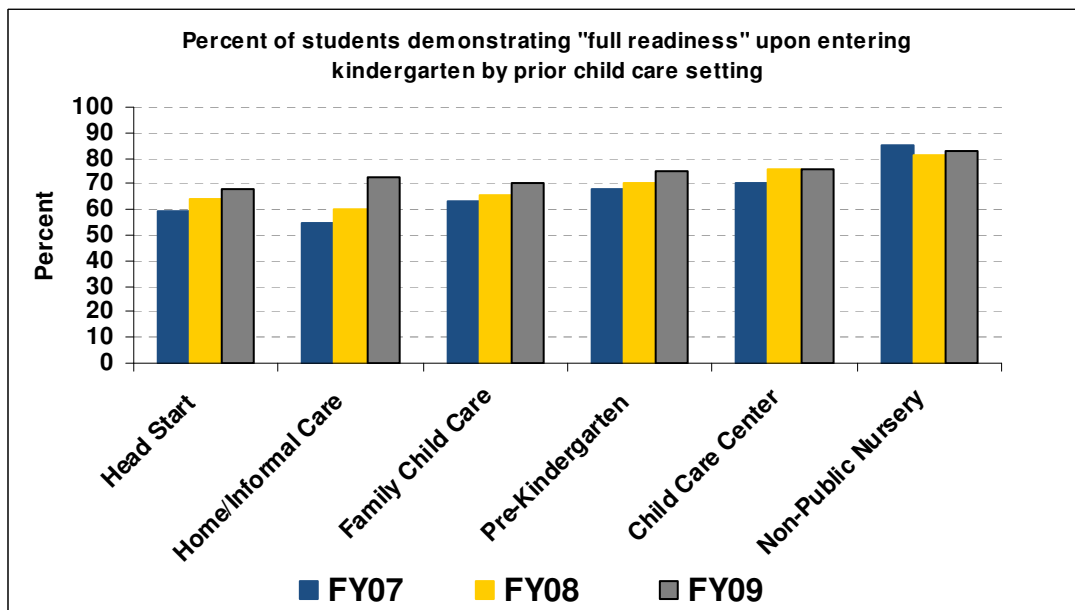
Note: This chart shows the Full Readiness results for all six settings.

Percent of Children Demonstrating Full Readiness by Selected Type of Child Care Setting

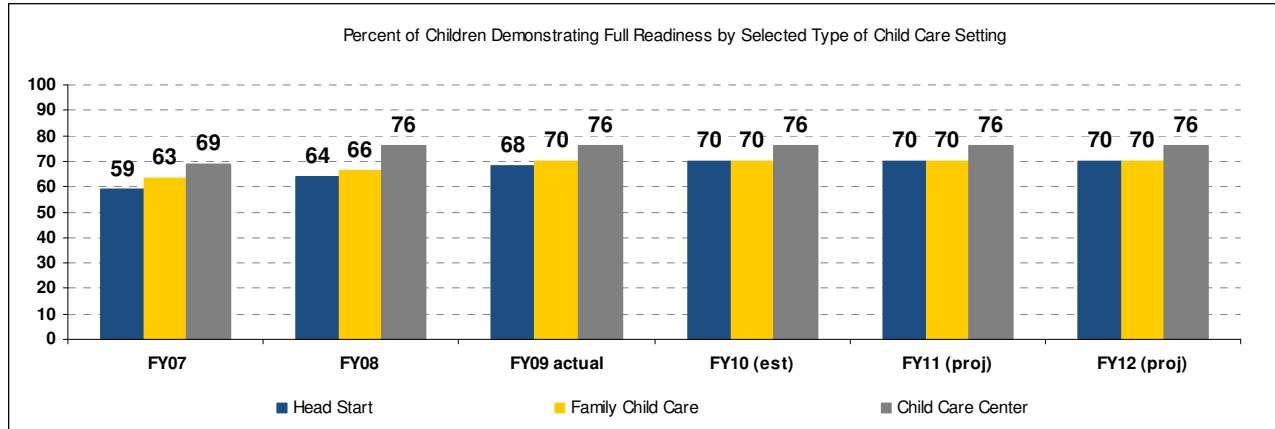|	FY07	FY08	FY09 actual	FY10 (est)	FY11 (proj)	FY12 (proj)
Head Start	59	64	68	70	70	70
Family Child Care	63	66	70	70	70	70
Child Care Center	69	76	76	76	76	76

Note: This chart shows the Full Readiness results and projections for the three settings which constitute this Headline Measure.

Discussion

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 kindergarteners assessed as fully ready has exceeded the State's average for the last four years, including the FY09 average of 73 percent. The percentage of children achieving full kindergarten readiness varies by type of prior child care setting; those in nonpublic nursery school and pre-kindergarten demonstrate the highest readiness scores. Kindergarten readiness has improved in all settings since January 2002.

Story Behind Performance

Contributing Factors
- ♦ DHHS collaborates with partners at the State (the Governor's Office, MSDE and Maryland Department of Health and Mental Hygiene) and County levels (Montgomery County Public Schools (MCPS), the Department of Libraries, the Department of Recreation and private non-profit partners) to provide a continuum of comprehensive services to support successful transition of children to kindergarten and continue to show annual improvement in coordination and service delivery. Increased focus on collaboration among partners led to improvements in academic performance over the past six years (FY04-FY09).
- ♦ 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.

Restricting Factors

- 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:
  - 55 percent come from single parent families
  - 57.6 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 32 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.
- Under the auspices of the Early Care and Education Congress, an Action Agenda was adopted with strategies listed under three main goals: 1) Everyone will understand the need to support school readiness and their role in preparing children for school. 2) All young children will have access to high quality and culturally competent early care and education programs and health services that meet the needs of families, especially low-income families, families with children with disabilities and English language learners. 3) All professionals who work with young children will be appropriately educated in promoting and understanding a comprehensive approach for the development of the whole child, including physical, social-emotional and cognitive well-being as a basis for school readiness.
- Contingent upon State and local funding, expand publicly funded preschool education using a balanced approach, as recommended by the Montgomery County Universal Preschool Implementation Work Group appointed by the County Council.
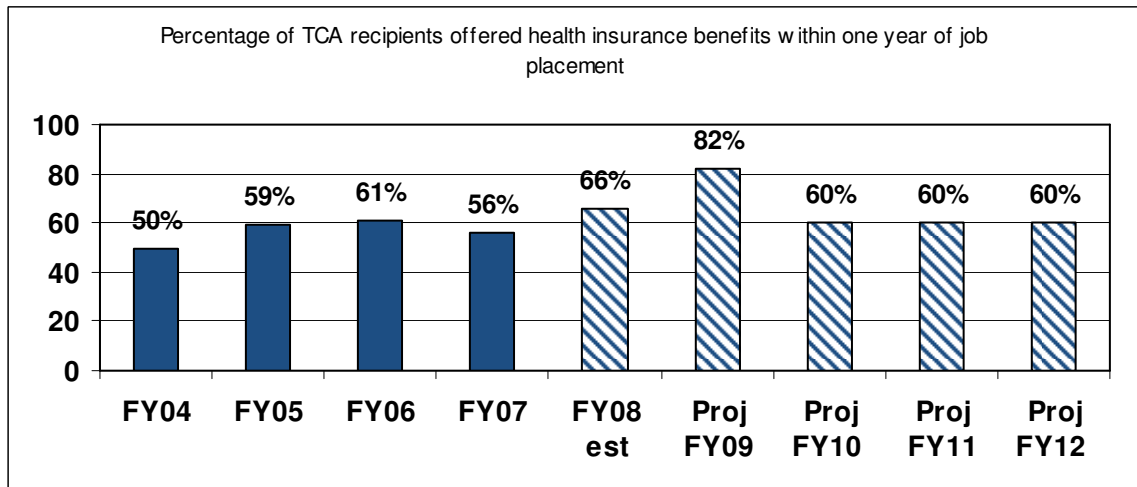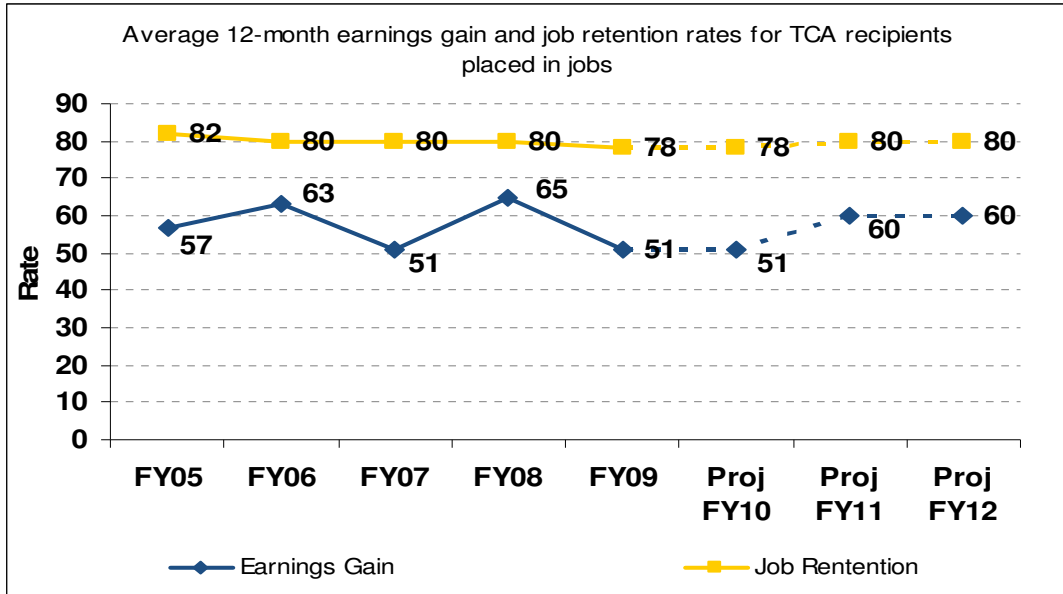
11. Employment Services

Basic Facts

- 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.
- Federal law requires Temporary Cash Assistance (TCA) recipients that not exempted from the work program, 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 supplements (formerly known as 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 that 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 of individuals with full-time employment that are offered health insurance benefits within one year of case closure.
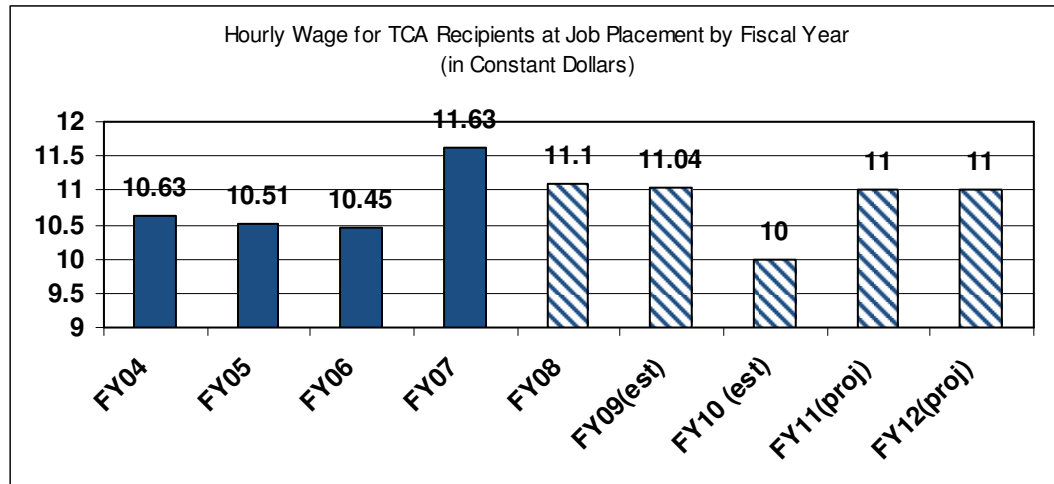
Performance

Average 12 month Job Retention Rate and Earnings Gain Rate for current and former TCA recipients who are placed in jobs

Sub-measures of greater independence:
- Average Hourly Wage for TCA recipients at job placement
- Percentage of TCA recipients offered health insurance benefits within one year of job placement.

Average 12-month earnings gain and job retention rates for TCA recipients placed in jobs

Job Retention: FY05 82, FY06 80, FY07 80, FY08 80, FY09 78, Proj FY10 78, Proj FY11 80, Proj FY12 80

Earnings Gain: FY05 57, FY06 63, FY07 51, FY08 65, FY09 51, Proj FY10 51, Proj FY11 60, Proj FY12 60

Legend: Earnings Gain — Job Rentention

Percentage of TCA recipients offered health insurance benefits within one year of job placement

FY04 50%, FY05 59%, FY06 61%, FY07 56%, FY08 est 66%, Proj FY09 82%, Proj FY10 60%, Proj FY11 60%, Proj FY12 60%

Hourly Wage for TCA Recipients at Job Placement by Fiscal Year (in Constant Dollars)

Fiscal Year	Value
FY04	10.63
FY05	10.51
FY06	10.45
FY07	11.63
FY08	11.1
FY09(est)	11.04
FY10 (est)	10
FY11(proj)	11
FY12(proj)	11

Discussion

The Federal Fiscal Year 2008 2nd Quarter has the most current data available for these measures, reporting the job retention rate was 80% and the earning gain rate was 68%. Montgomery County surpassed the State goals of 70% and 40% respectively for both of these measures. Additionally, during Fiscal Year 2009, Montgomery County's average hourly rate for TCA recipients at job placement was $11.04. The percentage of all TCA recipients that found employment and were offered health insurance within one year of employment was 49% (the rate for those employed full-time receiving health insurance was nearly 80%). Between FY04 and FY09 over one-half of all TCA recipients placed in full-time jobs were offered health insurance benefits within one year of employment.

One other significant measure leading to the success of the County's employment services performance is the work participation rate -which measures the percentage of work eligible individuals receiving Temporary Cash Assistance who are participating in countable work activities leading to self-sufficiency.

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. The hourly wage rate at job placement for Montgomery County TCA recipients rose in FY09, after a slight decrease in FY08, and was the highest hourly wage average amongst all Maryland jurisdictions.

Story behind the performance

Contributing Factors
- DHHS contracts out the Employment Services program to vendors that are subject matter experts in employment support services.
- A team of DHHS staff with knowledge of Income Support programs, Welfare to Work policies and contract management oversees the daily operations of the Welfare to Work program.

♦ There is a strong commitment to facilitate the vendor's operation through a team approach with DHHS and vendor staff that emphasizes goal orientation, seamless processes, excellent customer service, transparency and accountability.
♦ Intensive case management and follow-up services provided to TCA applicants and recipients increase 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 (such 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.

Restricting Factors
♦ 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.
♦ The significant increase over the last two years (FY09 and FY08) in the number of TCA applicants (42.2% two-year increase) and the TCA caseload (24.4% two-year increase) create significant barriers to serving the most vulnerable customers and those with the most complex cases (specifically customers with potential or undiagnosed mental health issues).
♦ Earned Income data are not available for some time periods for current or former TCA recipients that 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.
♦ Develop paid internships/apprenticeships for a cohort of TCA customers.
♦ Work with the Department of Business and Economic Development to bring jobs to the County that would employ TCA recipients at a wage level that promotes family self-sufficiency and provides health insurance benefits within one year.

12. Maintaining Independence in the Community

Basic Facts

- DHHS provides assessment, 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.
- 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 homes for as long as possible).
- In FY2009 DHHS' Aging and Disability staff provided assessment and continuing case management services to over 1,500 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)
- The DHHS Older Adult Waiver program allows for a more in-depth array of services to prevent premature institutionalization.

Performance

Percentage of seniors and adults with disabilities who avoid institutional placement while receiving case management and other support services.

Percentage of seniors and adults with disabilities who avoid institutional placement while receiving case management and other support services

94.4   92.3   91.6   92   92

FY07   FY08   FY09   FY10   FY11
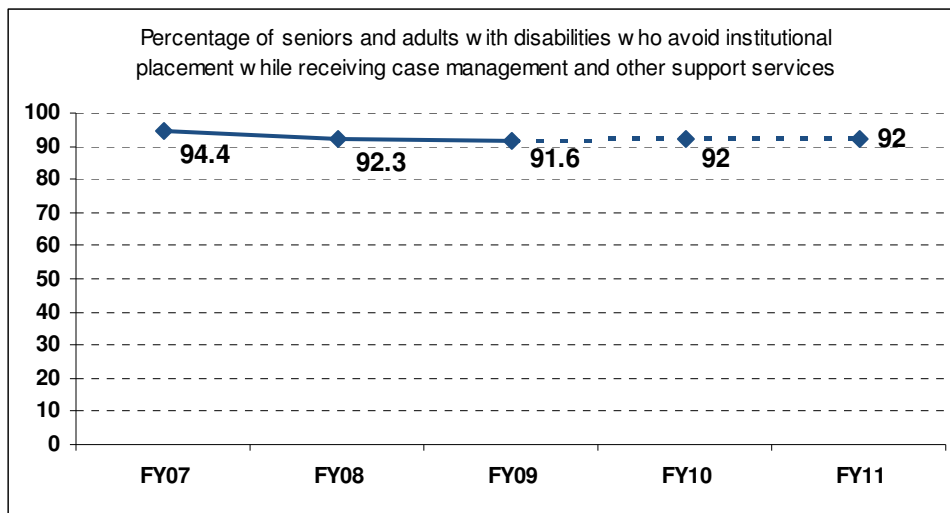
Story Behind Performance

Contributing 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.

Restricting Factors
- Budget constraints have progressively restricted service delivery to individuals at higher levels of functional impairment and risk for institutionalization. As a result, the percentage of individuals that avoid institutional placement has gradually declined as the population served has become more impaired.
- 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 1,330 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
- Identify system factors that lead to higher vs. lower quality services through Quality Service Reviews.
- 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.
- 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.
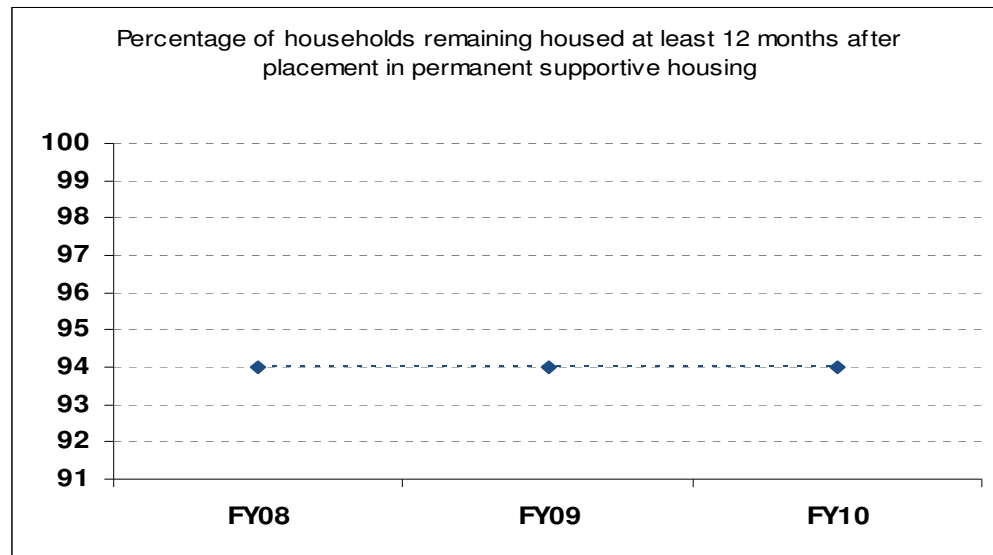
13. Housing Services

Basic Facts

- DHHS Housing Services work 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.
- In FY09, the Housing First Initiative began its first year of implementation with a focus on (1) reducing the length of stay in homelessness and providing stable housing for those exiting from homeless programs and (2) preventing homelessness by increasing emergency assistance resources and housing supports to stabilize housing for at risk households.
- In FY10, $5.2 million of the non-revolving program appropriation to the Department of Housing and Community Affairs Housing Initiative Fund is reserved to support Housing First and provide 225 "deep" rental subsidies for homeless households.   County Funds of $1 million also continue to support Partnership for Permanent Housing (PPH2), which provides an additional 55 "deep" rental subsidies to homeless households.
- In FY09, 6,995 crisis intervention grants were issued to assist households with preventing evictions, utility cutoffs and other emergency issues. $1.2 million in Recordation Taxes were targeted to help prevent evictions, and funded 1,662 of these grants. Households with a history of multiple court judgments that received assistance from Recordation Tax funds received 90 day case management. County Funds of $1.8 million and State funds of $1.1 million funded 5,333 grants.
- In FY09, the Home Energy Assistance Program issued grants to help with electricity and heating costs to 8,077 households at or below 150 percent of the Federal Poverty Level.

Performance

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

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.

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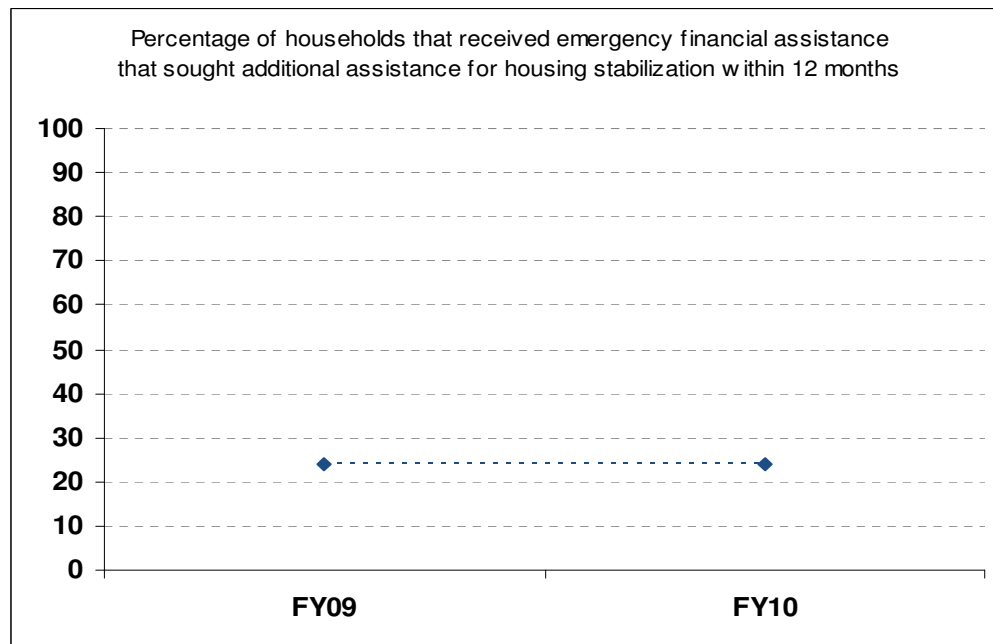
Discussion

The denominator of the second of the two headline measures is the number of households requesting eviction prevention assistance. That number rose from 6,730 in FY08 to 7,025 in FY09, an increase of 4.4%. However, when the first six months of FY09 is compared to the first six months of FY10, the increase inflates to 11.4% (from 3,420 to 3,809). At the current FY10 rate, 593 more households will have requested eviction prevention assistance by the end of this fiscal year than requested it in FY09.

The numerator for this measure is the number of households who received assistance and then requested additional assistance within 12 months. Any disproportionate increase in returnees this year would cause the FY11 result to rise, reflecting a growing need by households for repeated financial assistance in order to maintain their housing. If the denominator rises disproportionately, it would reflect a growing need by County householders to request assistance for the first time in at least 12 months.

Story Behind Performance

Contributing Factors
- Specialized case management, mental health and substance abuse counseling and referrals to a range of services, such as mediation, training and employment help, supports the maintenance of 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 people.
- DHHS provided assistance to an average of 1,727 low-income families and disabled and elderly households, whose incomes were below 50 percent of Average Median Income, to pay rent through the County's Rental Assistance Program (RAP) in FY09.
- 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 FY09.

Restricting Factors
- The economic downturn has greatly increased the demand for eviction prevention services.
- Increasing unemployment has resulted in an increase in the number of families and individuals that are losing their housing and becoming homeless.
- The Fair Market Rent ($1,288) for a two bedroom apartment in Montgomery County is high. A household must earn $51,500 annually ($24.76 per hour) to afford this level of rent and utilities without paying more than 30 percent of income on housing.
- 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.

What We Propose to Improve Performance
- Collaborate with DHHS partners to fully implement the "Housing First" model to expedite the movement of homeless families and single adults into permanent housing.
- Provide case management services to support vulnerable households that seek financial assistance more than twice in a calendar year.
- Collaborate with HOC and DHCA to explore opportunities to increase the supply of affordable housing units.
- Coordinate the Housing First Plan with the Neighborhood Safety Net Initiative to bring emergency assistance to those neighborhoods most impacted by the current recession.
- Implement the Housing First Initiative's 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.

DHHS Performance Plan

Appendix A
Budget Details for Proposed Strategies

All costs for strategies listed under "What We Propose to Improve Performance" for each measure will be absorbed by the Department's operating budget except as noted below.

Measure	Strategy	Budget	Page
Juvenile Justice System Screening, Assessments and Referrals	Continue partnership with the Montgomery County Collaboration Council and the State to assure future funding for the case manager position. This position works with families to increase the number of SASCA diversions that become engaged in the diversion process, and increase the retention rate in treatment among diversion program participants.	Collaboration Council budget, with funding from the State Governor's Office of Crime Control and Prevention.	15
Employment Services	Work with the Department of Business and Economic Development to bring jobs to the County that would employ TCA recipients at a wage level that promotes family self-sufficiency and provides health insurance benefits within one year.	Subsidized Employment Project (in partnership with Montgomery Works) identifying employers willing to train, mentor and hire TCA customers with a short term wage subsidy as an incentive for the employer, funded through a special grant from DHR/DLLR	34

DHHS Performance Plan

Appendix B
Implementation Timeline for Proposed Strategies

The timeline for strategies listed under "What We Propose to Improve Performance" for each measure is "ongoing" except as noted below.

Measure	Strategy	Timeline	Page
Employment Services	Work with the Department of Business and Economic Development to bring jobs to the County that would employ TCA recipients at a wage level that promotes family self-sufficiency and provides health insurance benefits within one year.	Subsidized Employment Project (in partnership with Montgomery Works) identifying employers willing to train, mentor and hire TCA customers with a short term wage subsidy as an incentive for the employer, from March 2009 to June 2010	34

DHHS Performance Plan

Appendix C
Headline Measures under Construction
and Steps for Developing Needed Data

EQUITY MEASURE

Contribution to Montgomery County Results

GREATER RESPONSIVENESS AND ACCOUNTABILITY

Background

Towards a systematic approach to promoting equity and social justice and reducing disparities and disproportionalities in our vulnerable populations, the Department is developing a department-wide Equity and Social Justice Strategic Plan and logic model that:

- o Identifies long term problems, contributing factors, strategies, impacts/outcomes, and goals and objectives, and
- o Prioritizes activities based on resources and client/community needs.

Performance

To be determined.

Steps for development of Equity measure

The following is an indication of how the work of identifying measures might proceed:

During FY10, we will:

1. Seek a grant
2. Bring a consultant on board to guide the work
3. Build a work plan with the consultant's help
4. Begin Strategic Planning work for next 12 months from start of grant to deepen understanding of equity at DHHS

During FY11, we will:

1. Establish and publicize an overarching Mission/Purpose/Vision
2. Engage Senior Leadership

3. Engage DHHS managerial systems
    a. Persuasion - show the benefits of reducing disparities/promoting equitable approaches to promoting positive outcomes - to fulfillment of systems' mission.
    b. Provide training opportunities and material resource assistance
    c. Scan the current environment
        i. What infrastructure components already exist?
        ii. Compile list of existing programs supported by DHHS.
        iii. Determine what steps can be taken to adjust existing infrastructure in the immediate term to advance the vision of promoting Equity and Social Justice.
4. Early organization:
    a. Develop a steering or advisory body that meets quarterly.
    b. Convene a working group that includes on-the-ground staff and consumers
    c. Work closely with the Community Health Improvement Process to align efforts to include internal/external focus.

During FY12, we will:

1. Get a baseline measure
    a. Identify current programs/systems/organizational measures
    b. Decide on best way to quantify, i.e., what is the unit of measurement (Service Area, program initiative, Unit)?
    c. Get feedback from steering/advisory committee and working group
    d. Develop prototype
    e. Present it to senior leadership for feedback
    f. Incorporate feedback into final draft of measure
    g. Pilot
2. Develop a final strategic framework/logic model for continued measurement and realignment toward overall, long-term goal of reducing disparities and disproportionalities and promoting equity.