HHS COMMITTEE #2
April 10, 2014

M E M O R A N D U M

April 8, 2014

TO: Health and Human Services Committee

FROM: Linda McMillan, Senior Legislative Analyst

SUBJECT: **FY15 Operating Budget: Department of Health and Human Services**
Overview
Administration and Support (includes Minority Health Initiatives, does not include Community Action Agency)

Those expected for this worksession:
Uma Ahluwalia, Director, Department of Health and Human Services
Stuart Venzke, DHHS Chief Operating Officer
Patricia Stromberg, DHHS Management and Budget
Pofen Salem, Office of Management and Budget

1. DEPARTMENT OVERVIEW

Excerpts from the County Executive's FY15 Recommended Budget are attached at ©1-8 (overview information) and ©9-10 (Administration and Support).

EXPENDITURES

For FY15, the County Executive is recommending an appropriation of $277,734,808 for the Department of Health and Human Services. This is an increase of $16,330,330 (6.2%) from the FY14 original approved budget. General Fund expenditures increase by 11,146,238 (5.8%). Grant Fund expenditures (which include State funded expenditures as authorized through HB669) increase by $5,184,092 (7.6%). There is an increase of 24 full-time positions and a decrease of 2 part-time positions. FTEs increase by 18.11 (1.2%).

The following table shows the six year trends for the Department. Since FY10, the overall expenditures for DHHS have increased 8.2%; however, positions are below their FY10 levels.

DHHS	FY10	FY11	FY12	FY13	FY14	FY15	Change	Change
(in $000s)	Actual	Actual	Actual	Actual	Budget	CE Rec	FY14-15	6 Yrs
Expenditures:								
General Fund	181,834	170,023	170,088	177,995	193,225	204,371	5.8%	12.4%
Grant Fund	74,908	70,841	75,758	72,109	68,179	73,363	7.6%	-2.1%
Total Expenditures	**256,742**	**240,864**	**245,846**	**250,104**	**261,404**	**277,734**	6.2%	8.2%
Positions:								
General Fund FT	811	784	753	763	792	806	1.8%	-0.6%
Grant Fund FT	561	564	559	558	534	544	1.9%	-3.0%
Subtotal FT	**1372**	**1348**	**1312**	**1321**	**1326**	**1350**	1.8%	-1.6%
General Fund PT	303	302	292	288	288	289	0.3%	-4.6%
Grant Fund PT	47	45	45	44	43	40	-7.0%	-14.9%
Subtotal PT	**350**	**347**	**337**	**332**	**331**	**329**	-0.6%	-6.0%
Total Positions	1722	1695	1649	1653	1657	1679	1.3%	-2.5%

REVENUES

Revenues Credited to the General Fund

For FY15, General Fund revenues that are attributed to DHHS are projected to be $26,998,594, an increase of 21.1% from FY14 budget. The largest increase is in revenues from Federal Financial Participation. The FY15 Recommended revenue is in line with the Actual revenues received in FY13. The following table shows the changes in selected General Fund Revenues.

	FY13	FY14	FY15	$	%
SELECTED GEN FUND REVENUES:	**Actual**	**Budget**	**Recommend**	**FY14-15**	**FY14-15**
Core Health Services Funding	3,666,098	3,838,256	3,975,150	136,894	3.6%
Federal Financial Participation	11,488,656	8,331,210	11,660,530	3,329,320	40.0%
Medicaid/Medicare Reimbursements	1,511,636	5,276,359	5,514,816	238,457	4.5%
Other Intergovernmental Aide	41,208	44,077	843,178	799,101	1813.0%
Health and Human Services Fees	1,381,824	1,447,928	1,426,320	(21,608)	-1.5%
Health Inspections: Restaurants	1,696,121	1,580,540	1,808,680	228,140	14.4%
Health Inspections: Living Facilities	246,660	234,370	240,730	6,360	2.7%
Health Inspections: Swimming Pools	500,571	535,165	501,220	(33,945)	-6.3%

Revenues Credited to the Grant Fund

The Grant Fund revenues presented in the operating budget book reflect actual amounts received in FY14 and known changes for FY15; but do not include changes from the 2014 General Assembly session. The Recommended Budget estimates $73,363,353 in grants and state revenues for FY15, an increase of 7.6% from FY14.

The FY15 Budget assumes that State reimbursements provided because Montgomery County is authorized to have a unified Department of Health and Human Services (HB669) will increase by 3.5%.

GRANT FUND REVENUES:	FY13 Actual	FY14 Budget	FY15 Recommend	$ FY14-15	% FY14-15
Federal Grants	21,108,201	15,169,917	15,615,146	445,229	2.9%
HB669 Social Services Reimbursement	33,793,535	33,187,682	34,356,477	1,168,795	3.5%
Medicaid/Medicare Reimbursements	614,085	0	0	0	0.0%
Miscellaneous	467,023	0	0	0	0.0%
State Grants	19,430,468	19,681,662	23,261,730	3,580,068	18.2%
Other Charges and Fees	127,899	0	0	0	0.0%
Other Intergovernmental	1,365,994	140,000	130,000	(10,000)	-7.1%

DEPARTMENT WIDE INCREASES

The FY15 Budget includes a net increase of $5.9 million from department wide cost changes, such as compensation adjustments and changes to charges for things like motorpool and printing and mailing. The following table summarizes these changes for the whole department. These costs are generally included in the "Multi-program Adjustments" included for each service area. Compensation changes are reviewed by the GO Committee. The risk management adjustment is substantial and is addressed in the Chief Operating Officer's budget section.

Department wide adjustments (General Fund)	Dollars
FY15 Compensation Adjustments	4,490,427
Retirement Adjustment	418,805
Group Insurance Adjustment	206,316
Annualization of FY14 Lapsed Positions	153,996
Annualization of Personnel and Operating Costs	(147,269)
Motorpool Rate Adjustment	31,133
Printing and Mail Adjustment	32,858
Risk Management Adjustment	719,241
NET CHANGE	**5,905,507**

Cross Department Issue – Increase to Certain Contracts

In FY14, the Council provided $960,000 in additional funding to increase most contracts with non-profits by 3%. The Council included the following language in the FY14 Appropriation Resolution:

This resolution appropriates $960,000 for inflation adjustments for tax-supported contractors with the Department of Health and Human Services (DHHS) and to eligible contractors with the Department of Housing and Community Affairs that are providing Special Needs Housing programs. Any inflation adjustment awarded under this paragraph must not exceed 3% of the total contract price. Any contract funded by a non-County grant is not eligible for an inflation adjustment under this paragraph. Each contractor must meet the following eligibility criteria.

(a) Non-profit service provider, or
(b) Contract that provides meals on wheels, court appointed special advocates, direct mental health services to seniors, and homeless outreach.
(c) The increase is to the General Fund value of the contract (Grant Fund value not included).
(d) The contract must not be in its first year or have an automatic inflation adjustment built into the contract.
(e) This increase does not apply to contracts for Montgomery Cares (except administration), Maternity Partnership, or Care for Kids (except for the services associated with the Latino Health Initiative) as their budgets have been adjusted for expected FY 2014 levels of service.
(f) This increase does not apply to contracts that are a specific match to a grant.
(g) This increase does not apply to contracts covered by the DD Supplement. This resolution appropriates $596,615 to increase the DD Supplement.
(h) This increase does not apply to contracts covered by the Residential Treatment Provider Supplement. This resolution appropriates $29,895 to increase the Residential Treatment Provider Supplement.

The total amount included in the FY14 Operating Budget for inflationary increases to tax-supported contracts with non-profits, DD Providers, and Residential Treatment Providers was $1,586,510.

The County Executive has included $1,100,888 in his Recommended Budget for a 2% inflationary adjustment to tax-supported contracts with non-profits, DD Providers, and Residential Treatment Providers.

Council staff is not recommending an increase above the 2% level. However, Council staff believes that the amount of funding should be reviewed by Council staff and HHS staff to make sure that all eligible contracts have been included as some contracts may have been executed since this recommendation was developed.

2. ADMINISTRATION and SUPPORT SERVICES (© 9-10)

This service area provides department-wide administration and is home to the Office of Community Affairs. The following table provides an overview of the budget trends for this service section.

Administration and Support Services Expenditures in $000's	FY 11 Budget	FY12 Budget	FY13 Budget	FY14 Budget	FY15 Rec	Change FY14-FY15
Office of the Director	2,630	2,227	2,350	2,270	5,310	133.9%
Office of the Chief Operating Officer	16,110	15,524	16,197	17,672	19,296	9.2%
Office of Community Affairs	6,740	6,795	6,839	7,226	7,325	1.4%
TOTAL	**25,480**	**24,546**	**25,386**	**27,168**	**31,931**	17.5%

A. Office of the Director

The County Executive is recommending a total of $5,310,637 and 22.35 FTEs for the Office of the Director.

1. Maryland Public Health Benefit Exchange
$2,900,000 and 5.0 FTEs

The FY15 Recommended Budget shows an increase of $2.9 million and 5.0 FTEs for the addition of the Maryland Health Benefit Exchange Grant. The Committee has received regular updates on the implementation of the Affordable Care Act and the Department's agreement with the State of Maryland to be the Connector Entity for Montgomery and Prince George's Counties.

In FY14, Montgomery County received a total of $7,752,825 ($2,881,915 in State funds and $4,870,910 in Federal funds). These funds were received after the original FY14 Budget was approved. The budget book tracks changes from original approved to recommended budget and so the $7.7 million is not included in the base from which the recommended changes are described. The $2.9 million that is "recommended" is a place-holder estimate of what the County thought might be provided by the State for a second-year agreement.

Montgomery County will serve as the Connector Entity for the Capital Region (Montgomery and Prince George's) for FY15. The Department now expects that $5.9 million in funding will be received. **Council staff recommends that the FY15 budget reflect the $5.9 million expected. This is a program in the Grant Fund; it does not require additional General Funds.**

The Department has provided, on the following page, the summary of expenses for County staff and operating expenses through February 2014 and partner organizations through December 2013. The Department expects that the FY14 funds will be fully expended. In addition, $125,000 was provided to Prince George's County for outreach and education services.

SUMMARY OF EXPENSES			
	Staff	Other Operating Expenses (OE)	Total Staff and OE
DEPARTMENT/Thru February 2014			
	976,912.49	244,504.52	**1,221,417.01**
PARTNERS/thru December 2013			
BDT	42,710.90	19,692.00	**62,402.90**
Marys Center	80,399.50	8,810.85	**89,210.35**
CASA	144,921.42	61,333.80	**206,255.22**
Korean Community	73,984.33	22,465.60	**96,449.93**
Family Services	163,894.92	32,939.60	**196,834.52**
CCI	121,397.95	65,543.90	**186,941.85**
Interfaith	126,892.71	28,167.99	**155,060.70**
PCC	47,233.03	42,791.83	**90,024.86**
TOTAL Partners	**801,434.76**	**281,745.57**	**1,083,180.33**
Note: Partner expenditure details are collected on a quarterly basis			

2. Charges from PIO to DHHS for MC311
- $24,227

DHHS must cover the cost of certain staff serving in the 911 Call Center as they must be a DHHS employee in order to access HHS information systems. This is an adjustment to the amount being charged to the Department. **Council staff recommends approval.**

2. Multi-program Adjustments
$165,181 and -1.00FTE

Multi-program adjustments account for compensation changes, annualizations and other items impacting more than one program. FTEs are the sum of full-time and part-time positions. **Council staff recommends approval.**

B. Office of the Chief Operating Officer

The County Executive is recommending a total of $19,296,194 and 89.75 FTEs for the Office of the Chief Operating Officer.

1. Risk Management Adjustment
$719,241

The adjustment to the Risk Management contribution from DHHS is substantial for FY15. OMB has provided the following explanation.

Finance - Risk Management has implemented a new method to determine agency/department contribution amounts to the Self-Insurance fund. This new method has resulted in contributions significantly different from past experience for many contributors, but Risk has seen no drop outs from the plan. Risk held educational meetings with the agencies/departments to inform them of the change, and the feedback received indicated they appreciated the predictability of the new method. The change in funding in FY15 is not the result of any issue with claims or claims costs, simply an adjustment to the allocation methodology. FY15 represents a transition year for the new contribution allocation method. FY16 will complete the transition, and departments/agencies can expect another difference in their contributions in FY16. Beyond FY16, the new method will result in little variance, a result of the predictability of the new method.

Council staff recommends approval.

2. Financial Reporting and Management Institute and Operating Support for the Non-Profit Roundtable
$156,620

The Executive is recommending that funding for this effort be included in the DHHS budget. In FY14, this program was funded by a $116,620 Community Grant approved for the Nonprofit Roundtable. The mid-year outcome report says that FIRM is a program in financial leadership training for nonprofits serving Montgomery County in partnership with DHHS. Two sessions, each able to serve 12 to 18 organizations, were provided train non-profit Board and Staff leadership. Year-to-date 25 non-profits have participated. Three sessions for FIRM alumni will be held to reinforce FIRM training.

In previous sessions with the Committee, Director Ahluwalia has reported that in FY14 to date, DHHS has executed 559 contracts with 302 vendors. She has described how FIRM training has helped organizations better understand good financial practices and compliance with program monitoring and audit requirements.

This contract will also include general operating support for Non-Profit Roundtable. In FY14, the Council approved a $35,000 Community Grant for this purpose. Previously both grants/contracts (FIRM and operating support) were administered by the Department of Economic Development.

The total amount recommended for FY15 is $5,000 (3%) more than approved for FY14.

Council staff recommends approval.

3. Increased charge for Printing and Mail
$32,858
4. Motorpool Rate Adjustment
$31,133

As previously noted, these charges are not set by the Department. **Council staff recommends approval for the changes required to the DHHS budget.**

3. Multi-program Adjustments
$684,268 and +0.5FTE

Multi-program adjustments account for compensation changes, annualizations and other items impacting more than one program. FTEs are the sum of full-time and part-time positions. **Council staff recommends approval.**

C. Office of Community Affairs

Note: Community Action Agency and Head Start are reviewed separately

The County Executive is recommending a total of $7,324,719 and 22.5 FTEs for Office of Community Affairs.

1. Enhance the Welcome Centers
$46,752

The Welcome Centers were previously called the Temporary Workers' Centers. Two centers are located in Shady Grove and Wheaton. In FY14 the Council appropriated $173,420 for each of these centers as non-competitive contracts. The provider for the third location in Silver Spring was selected through a competitive process. The provider for all three centers is CASA de Maryland.

Last year, the Committee was told that DHHS issued an RFP for operation of all three Temporary Workers Centers (Wheaton, Shady Grove, Silver Spring). DHHS has selected CASA de Maryland to operate the three County centers at a cost of about $709,000 based on the RFP. The Executive is recommending an additional $46,752. The Executive says that the reason for this additional funding is to allow the program to restore intake and staff training and support services such as financial literacy and legal counseling that were eliminated as part of budget reductions required over the past few years. The CASA Worker Center started to call their centers the Welcome Center. This is not to be confused with the Suburban Maryland Welcome Back Center with the Latino Health Initiative.

Council staff does not recommend this additional funding. This contract was just competitively bid. If the Department or responding vendors believed that these additional services were needed they should have been negotiated during the RFP process and competitive award. If this additional funding was available, it might have changed vendor responses. This is about a 6.5% increase in funding in addition to the 2% inflationary adjustment that is being recommended by the Executive.

2. ***Temporary Emergency Food Assistance Grant***
-$35,000

The budget indicates that this grant has been "shifted." In this case, the grantor is now awarding the grant funds directly to the Capital Area Food Bank rather than through a contract with DHHS. **Council staff recommends approval.**

3. ***Multi-program Adjustments***
$86,800 and 0FTE

Multi-program adjustments account for compensation changes, annualizations and other items impacting more than one program. FTEs are the sum of full-time and part-time positions. **Council staff recommends approval.**

Other issues

1. ***Leadership Institute for Equity and Elimination of Disparities (LIEED)***
$100,000

As a part of the FY14 Operating Budget, the Council approved the Executive's recommendation for $100,000 to begin the work of the LIEED. This funding is continued for FY15. Director Ahluwalia provided an update to the Committee on this effort at its March 13 session. As discussed last year, the Advisory Group that was convened and issued the February 2013 report formulated this outcome goal for its review process:

> *To enhance HHS practice, policy and infrastructure to best serve racially, linguistically and ethnically diverse communities, including emerging populations, and explore and recommend the roles of the MHI/P as integral to the department.*

The February 2013 (©32-44) report has recommendations around four priority areas:

1. **Systemic and Systematic Approach** – Use systemic and systematic approaches to develop, implement, review and adjust/improve practices, policies and infrastructure of the department and its contractors to better serve racial/ethnic minorities and emerging populations with the goal of eliminating disparities.

2. **Access to and Delivery of Quality and Equitable Services** – Ensure equitable access to and delivery of quality services and programs provided by HHS and its contractors to serve racial/ethnic minorities and emerging populations.

3. **HHS Workforce** – Ensure that the diversity of the DHHS workforce at all levels of staff, from leadership to program delivery, is proportional to the County's demographics. In addition, ensure that staff has the skills, experience, and capacity to effectively serve racial/ethnic minorities and emerging populations with the goal of eliminating disparities.

4. **Accountability** – Identify accountability processes to monitor progress of the implementation of the final recommendations.

As requested by the Committee, a membership list of the LIEED is attached at ©18-21. In addition, The LIEED Advisory Committee Framework is provided at ©22-31. The mission of the LIEED is to "address social determinants of health with the goal of eliminating disparities and achieving equity among residents of Montgomery County." LIEDD works within DHHS. The functions of the LIEDD Advisory Committee are to: (1) Provide strategic leadership and coordination; (2) Serve as a capacity builder; (3) Act as resource partner and collaborator; (4) Promote effective community engagement; (5) Promote innovation and support linkages/opportunities; and (6) Support community advocacy.

The LIEED Advisory Committee meets quarterly. An invitation will be extended to the Council to attend the May 7, 2104 meeting.

An Interim Progress Report is attached at ©11-16. From July to February the LIEED addressed organizational issues and completed internal operational tasks. **LIEED specifically addressed the issue of Behavioral Health Workforce Diversity, a topic of much discussion by the HHS Committee. The Committee may be particularly interested in the activities around this topic that are included at ©11-12.** A summary of activities at the Welcome Back Center is included at ©17. LIEED also created outreach goals for the implementation of the Affordable Care Act.

2. Minority Health Initiatives – Minority Health Initiatives/Program Advisory Committee Report $3,087,001

The LIEED report focuses on how best to reduce disparities and the importance of working with and across the three Minority Health Initiatives/Programs and indeed shows how resources from each is being leveraged to support the LIEED. The following table shows the recommended FY15 funding.

	FY12 Approved	FY13 Approved	FY13 Actual	FY14 Approved	FY15 Rec
African American Health Program	1,365,877	1,382,076	1,217,999	1,337,578	1,403,357
Asian American Health Initiative	403,290	413,837	303,331	464,073	473,450
Latino Health Initiative	1,171,964	1,211,661	1,026,088	1,181,694	1,210,194
Total	**2,941,131**	**3,007,574**	**2,547,418**	**2,983,345**	**3,087,001**

For FY14, the Council approved several enhancements: (1) an AAHP SMILE Nurse ($30,000); (2) an AAHP Diabetes Educator for the African Community; (3) additional funding for the LHI Asthma Management Program; (4) additional funding for the LHI Smoking Cessation Program; and (5) additional funding for the AAHI Hepatitis B Vaccine Program.

The FY13 Annual Report for the African American Health Program is attached at ©45-61, the Asian American Health Initiative at ©62-97, and the Latino Health Initiative at ©98-137.

Health and Human Services

MISSION STATEMENT

The Department of Health and Human Services (HHS) assures delivery of a full array of services to address the somatic and behavioral health, economic and housing security, and other emergent needs of Montgomery County residents. To achieve this, the Department (directly and/or via a network of community partners) develops and implements policies, procedures, programs, and services that: 1) offer customer-focused direct care and supports; 2) maximize financial and staffing resources to deliver services through effective management, coordination and pursuit of strategic funding opportunities; 3) pilot and evaluate innovative approaches to service delivery and systems integration; and 4) develop, enhance, and maintain a broad network of community-based organizations, public, and private agencies to promote and sustain partnerships, which increase the availability of needed services.

BUDGET OVERVIEW

The total recommended FY15 Operating Budget for the Department of Health and Human Services is $277,734,808, an increase of $16,330,330 or 6.2 percent from the FY14 Approved Budget of $261,404,478. Personnel Costs comprise 56.4 percent of the budget for 1350 full-time positions and 329 part-time positions, and a total of 1586.87 FTEs. Total FTEs may include seasonal or temporary positions and may also reflect workforce charged to or from other departments or funds. Operating Expenses account for the remaining 43.6 percent of the FY15 budget.

In addition, this department's Capital Improvements Program (CIP) requires Current Revenue funding.

LINKAGE TO COUNTY RESULT AREAS

While this program area supports all eight of the County Result Areas, the following are emphasized:

- ***A Responsive, Accountable County Government***
- ***Affordable Housing in an Inclusive Community***
- ***Children Prepared to Live and Learn***
- ***Healthy and Sustainable Neighborhoods***
- ***Vital Living for All of Our Residents***

DEPARTMENT PERFORMANCE MEASURES

Performance measures for this department are included below, with multi-program measures displayed at the front of this section and program-specific measures shown with the relevant program. The FY14 estimates reflect funding based on the FY14 approved budget. The FY15 and FY16 figures are performance targets based on the FY15 recommended budget and funding for comparable service levels in FY16.

Measure	Actual FY12	Actual FY13	Estimated FY14	Target FY15	Target FY16
Multi-Program Measures					
Percent of reviewed HHS client cases that demonstrate beneficial impact from received services	86.0	92.0	92.0	92.0	92.0
Percentage of client cases needing assistance with multiple services for which effective team formation is documented[1]	78.0	67	71	71	71
Percentage of client cases needing assistance with multiple services for which effective team functioning is documented[2]	67.0	50	67	67	67
Percent of Medical Assistance applications approved for enrollment	71.0	N/A	N/A	N/A	N/A
Percentage of seniors and adults with disabilities who avoid institutional placement while receiving case management services	94.9	95.0	95.0	95.0	95.0
Weighted composite of HHS client cases that demonstrate beneficial impact from received services: Improved health and wellness (1-100 scale)	55.2	55.2	55.0	55.0	55.0
Weighted composite score of HHS client cases that demonstrate beneficial impact from received services: Greater independence (1-100 scale)	86.1	87.7	86.0	86.0	86.0

	Actual FY12	Actual FY13	Estimated FY14	Target FY15	Target FY16
Weighted composite score of HHS client cases that demonstrate beneficial impact from received services: Risk mitigation (1-100 scale)	82.5	84.7	84	84	84
Weighted percent of DHHS customers satisfied with the services they received from DHHS staff	96.4	96.2	95	95	
Percentage of current "health and human services" contracts derived from Requests for Proposals that contain performance measures related to beneficial impact and customer satisfaction[3]	97.7	98.0	98.0	98.0	98.0

[1] Service Integration percentage: FY13-92; FY14-93; FY15-93; FY16-93
[2] Service Integration percentage: FY13-60; FY14-65; FY15-70; FY16-70
[3] Beneficial impact will be specific to the program and will focus on risk mitigation, greater independence, and improved health.

ACCOMPLISHMENTS AND INITIATIVES

- ***Expand the Kennedy Cluster Project to the Watkins Mill Cluster, a multi-agency collaborative service model, to enhance early childhood services, add one Linkages to Learning site at South Lake Elementary School, and increase staff support to reduce institutional barriers for students and families in the high-need areas to engage school activities and improve academic achievement.***

- ***Create the Children's Trust, which will support services to improve educational outcomes for children (from birth to age 18) and families by addressing social determinants that impact the educational achievement gap. The Executive is launching this multi-disciplinary partnership approach to support student and family success. The approach is a collaboration led by a Governing Board made up of County leaders and supported by Department Directors through an Operations Committee with financial management and private sector fund leveraged through the Community Foundation.***

- ***Replace the federal Emergency Solutions Grant shortfall to continue providing housing services to individuals and families experiencing a housing crisis or homelessness.***

- ***Replace the federal Community Services Block Grant shortfall to continue service provision for low income persons to achieve greater self-sufficiency through technical assistance and case management so they can access public and community resources.***

- ***Add funding to support a 2% inflationary adjustment for the developmental disability supplement and other tax-supported contracts with non-profit organizations and residential treatment providers.***

- ***Add funds for a Social Worker position in the Adult Protective Services/Social Services to Adults Program to address an increase in investigations of financial exploitation resulting from new bank mandatory reporting requirements.***

- ***Raise the Adult Foster Care reimbursement rate to reduce the gap between the County and State subsidy for senior assisted living group homes.***

- ***Add funds for a Program Manager in the Long Term Care Ombudsman Program, allowing the program to add volunteers and provide more long-term care facility residents with protection and advocacy.***

- ***Add funds for Adult Day Care subsidies to increase the number of clients able to attend an Adult Day Care program two days per week for socialization and medical supervision.***

- ***Add funds for a Caregiver Support Senior Fellow to coordinate outreach to seniors and persons with disabilities regarding the available services to ease the burden on caregivers.***

- ***Provide nurse monitoring services to more than 2,000 senior and disabled clients receiving services through the State's new Medicaid waiver program, Community First Choice.***

- ***Add funds to the Developmental Disability Supplement to support program growth due to increased enrollment and expanding service requirements among current clients.***

- ***Add funds to support the Financial Reporting and Management Institute for Nonprofit Montgomery to improve the capacity of nonprofit organizations and strengthen collaborations among all stakeholders.***

- ***Enhance the Saturday School program through the George B. Thomas Learning Academy to serve Montgomery County Public School students who need educational supports.***

- ***Enhance the County's Welcome Centers to provide a wide array of support services, including financial literacy, legal counseling, and job placement and training, to meet the needs of low-wage and contingent workers.***

- ***Support the addition of a Therapist II position in Trauma Services to expand clinical service capacity in the Abused Persons Program and address waitlists for victims of domestic violence.***

- ***Increase contract psychiatric service rates to improve the County's ability to attract skilled psychiatrists to provide qualified services for Behavioral Health programs.***

- ***In addition to the funding for this department, the recommended budget includes funds for community organizations that augment County services including $1.1 million for community organizations serving the disabled, $1.4 million for organizations extending senior services, $600,967 for organizations providing public health services, $926,050 for community organizations supplementing County Behavioral health services, and $1.9 million for organizations providing safety net services to County residents. These community organizations are critical to an effective network of services and are often able to provide these services in a more cost-effective, culturally appropriate and flexible way than County Government is able to. They also are able to leverage community resources that are unavailable to County Government.***

- ***In FY13, the Montgomery County Core Service Agency in collaboration with Aging and Disability Services developed training for volunteers working for the villages which provide services such as transportation and grocery shopping for seniors who desire to continue to live in their own homes. Montgomery County presently has six Senior Villages with six more in development.***

- ***The Senior Nutrition Program extended congregate meals to the newly opened White Oak Community Center three days per week, serving 25-30 meals per day. In addition, 6,900 cold box meals were served in low-income buildings without an established lunch program.***

- ***The Montgomery County Commission on People with Disabilities worked to have a special hiring authority to promote the hiring of qualified people with disabilities similar to the federal government, which was overwhelmingly supported by County voters during the 2012 election. Since July 2013, nine persons with severe disabilities have been hired using the special hiring non-competitive process. An additional four persons have been hired under contract.***

- ***The Montgomery County Continuum of Care held its third "Homeless Resource Day" in November 2013, continuing its efforts to utilize innovative ways to reach out to and provide assistance to persons experiencing homelessness. More than 300 households attended this highly successful event.***

- ***With the addition of two new therapist positions, Clinical Assessment and Triage Services (CATS) expanded hours to provide assessment services to incoming inmates with behavioral health needs during weekends and evenings. In FY13, CATS provided needs/risk assessment services to 2,151 incoming inmates. The Transition team provided discharge planning services to 373 exiting inmates requiring services in the community.***

- ***The Montgomery County Public Health Emergency Preparedness and Response Program achieved 100% on the 2012 Centers for Disease Control and Prevention (CDC) Local Technical Assistance Review that measures continued readiness and capacity for functions considered critical.***

- ***All food service inspection results since FY11 were made available for public access in electronic format through the Montgomery County Open Data System.***

- ***The Street Outreach Network served a total of 382 clients in FY13, increased by 75% from FY12. The Crossroads and UpCounty Youth Opportunity Centers combined served a total of 617 clients in FY13, an increase of 80% from FY12.***

- ***The new Montgomery County Early Childhood Advisory Council (ECAC) was formed in spring 2013 to advise the County on issues related to the well-being of children and families and to assist in the development of initiatives that help children enter school ready to learn.***

- ***The Commission on Veterans Affairs (CVA) obtained 65 Veterans Affairs Supported Housing (VASH) Vouchers from U.S. Department of Housing and Urban Development, which is worth $13,122 per voucher in housing subsidies for the County's homeless veterans. CVA also partnered with the District of Columbia Department of Veterans Affairs Medical Center to establish a Community-Based Outpatient Clinic in the County by Fall of 2014.***

- ***Special Needs Housing (SNH), on behalf of the County, partnered with Montgomery County Coalition for the Homeless to join the 100,000 Homes Campaign in FY13. SNH also expanded the Housing Initiative Program (HIP) by 45 households in FY13, including a new initiative for 25 medically vulnerable adults.***

- ***SNH provided more than 4,100 emergency assistance grants totaling $3.0 million dollars to resolve housing and utility emergencies in FY13.***

❖ ***Productivity Improvements***

- ***SNH's Office of Home Energy Program implemented a new eligibility screening process to improve efficiency and enable faster processing of applications for assistance.***

- ***Under a Memorandum of Agreement with Montgomery County Public Schools, the Community Support Network's Autism Waiver Program provides Service Coordination to 235 MCPS students including 34 children added for FY14. The program has had two consecutive "perfect" audit ratings from the State of Maryland.***

- ***Adult Protective Services saw a 33% increase in investigations of financial exploitation due to new law mandating financial institutions to report suspected financial exploitation of seniors.***

- ***Through the Primary Care Coalition, the Montgomery Cares Program provided support to eight of its affiliated clinical provider organizations to convert to an electronic health record system. Conversion began in July 2013, and is slated to be completed by the end of 2014.***

- ***Licensure and Regulatory Services increased completion rate of mandated food services inspections from 72% in FY12 to 88% in FY13. Greater inspection completion rates help to ensure the safety of food served to the public and reduce the chances of serious food borne disease outbreaks.***

- ***In FY13, Income Supports and Child Care Subsidy staff have met or exceeded 96% compliance in application processing while experiencing a 77% increase in applications and an 85% increase in caseloads.***

- ***In FY13, the Kinship Navigator Program diverted 68 families, including 108 children, from becoming court-involved Child Welfare Service cases. The Program also assisted 16 families in gaining legal custody and guardianship for the relative children in their homes.***

- ***In FY14, HHS completed initial design and a formal readiness assessment of its planned Enterprise Integrated Case Management (EICM) system, with system implementation to begin in FY15. When complete, the EICM will streamline intake for many HHS programs and provide HHS with a more complete picture of its clients and their circumstances, and will support more collaborative, cost-effective care with better client outcomes.***

PROGRAM CONTACTS

Contact Stuart Venzke of the Department of Health and Human Services at 240.777.1211 or Pofen Salem of the Office of Management and Budget at 240.777.2773 for more information regarding this department's operating budget.

BUDGET SUMMARY

	Actual FY13	Budget FY14	Estimated FY14	Recommended FY15	% Chg Bud/Rec
COUNTY GENERAL FUND					
EXPENDITURES					
Salaries and Wages	74,072,149	78,351,423	76,154,831	82,626,705	5.5%
Employee Benefits	26,467,464	29,261,722	28,777,127	30,641,875	4.7%
County General Fund Personnel Costs	***100,539,613***	***107,613,145***	***104,931,958***	***113,268,580***	***5.3%***
Operating Expenses	77,455,111	85,612,072	87,685,143	91,102,875	6.4%
Capital Outlay	0	0	0	0	—
County General Fund Expenditures	***177,994,724***	***193,225,217***	***192,617,101***	***204,371,455***	***5.8%***
PERSONNEL					
Full-Time	763	792	792	806	1.8%
Part-Time	288	288	288	289	0.3%
FTEs	1,117.09	1,150.14	1,150.14	1,159.66	0.8%
REVENUES					
Core Health Services Funding	3,666,098	3,838,256	3,975,150	3,975,150	3.6%
Federal Financial Participation Reimbursements	11,488,656	8,331,210	11,660,530	11,660,530	40.0%
Health and Human Services Fees	1,381,824	1,447,928	1,413,090	1,426,320	-1.5%
Health Inspection: Restaurants	1,696,121	1,580,540	1,808,680	1,808,680	14.4%
Health Inspections: Living Facilities	246,660	234,370	240,730	240,730	2.7%
Health Inspections: Swimming Pools	500,571	535,165	501,220	501,220	-6.3%
Marriage Licenses	286,240	286,100	286,100	286,100	—
Medicaid/Medicare Reimbursement	1,511,636	5,276,359	6,735,470	5,514,816	4.5%
Miscellaneous Revenues	-15,721	0	0	0	—
Nursing Home Reimbursement	630,422	649,000	666,850	666,850	2.8%
Other Fines/Forfeitures	1,400	0	1,400	1,400	—
Other Intergovernmental	41,208	44,077	726,873	843,178	1813.0%
Other Licenses/Permits	74,472	71,915	73,620	73,620	2.4%
County General Fund Revenues	***21,509,587***	***22,294,920***	***28,089,713***	***26,998,594***	***21.1%***
GRANT FUND MCG					
EXPENDITURES					
Salaries and Wages	31,926,193	31,574,363	31,574,363	31,469,476	-0.3%
Employee Benefits	11,102,453	10,993,704	10,993,704	11,782,129	7.2%
Grant Fund MCG Personnel Costs	***43,028,646***	***42,568,067***	***42,568,067***	***43,251,605***	***1.6%***
Operating Expenses	29,080,563	25,611,194	25,611,194	30,111,748	17.6%
Capital Outlay	0	0	0	0	—
Grant Fund MCG Expenditures	***72,109,209***	***68,179,261***	***68,179,261***	***73,363,353***	***7.6%***
PERSONNEL					
Full-Time	558	534	534	544	1.9%
Part-Time	44	43	43	40	-7.0%
FTEs	441.51	418.62	418.62	427.21	2.1%
REVENUES					
Federal Grants	21,108,201	15,169,917	15,169,917	15,615,146	2.9%
HB669 Social Services State Reimbursment	33,793,535	33,187,682	33,187,682	34,356,477	3.5%
Medicaid/Medicare Reimbursement	614,085	0	0	0	—
Miscellaneous Revenues	467,023	0	0	0	—
State Grants	19,430,468	19,681,662	19,681,662	23,261,730	18.2%
Other Charges/Fees	127,899	0	0	0	—
Other Intergovernmental	1,365,994	140,000	140,000	130,000	-7.1%
Grant Fund MCG Revenues	***76,907,205***	***68,179,261***	***68,179,261***	***73,363,353***	***7.6%***
DEPARTMENT TOTALS					
Total Expenditures	**250,103,933**	**261,404,478**	**260,796,362**	**277,734,808**	**6.2%**
Total Full-Time Positions	**1,321**	**1,326**	**1,326**	**1,350**	**1.8%**
Total Part-Time Positions	**332**	**331**	**331**	**329**	**-0.6%**
Total FTEs	**1,558.60**	**1,568.76**	**1,568.76**	**1,586.87**	**1.2%**
Total Revenues	**98,416,792**	**90,474,181**	**96,268,974**	**100,361,947**	**10.9%**

FY15 RECOMMENDED CHANGES

	Expenditures	FTE
COUNTY GENERAL FUND		
FY14 ORIGINAL APPROPRIATION	**193,225,217**	**1150.14**
Changes (with service impacts)		
Add: Community First Choice Nurse Monitoring Services [Community First Choice]	2,266,000	0.00
Enhance: Enrollment Increases and Service Delivery for Developmental Disability Supplement Providers [Community Support Network for People with Disabilities]	500,000	0.00
Add: The Financial Reporting and Management Institute and Operating Support for Nonprofit Montgomery [Office of the Chief Operating Officer]	156,620	0.00
Enhance: Linkages to Learning Site at South Lake Elementary School to Support the Expansion of the Kennedy Cluster Project [Linkages to Learning]	122,377	0.00
Enhance: Staffing Need for the Expansion of the Kennedy Cluster Project [Child and Adolescent School and Community Based Services]	111,565	2.50
Enhance: Early Childhood Services for the Expansion of the Kennedy Cluster Project [Early Childhood Services]	104,156	0.00
Add: Children's Trust Fund [Service Area Administration]	100,000	0.00
Enhance: The Saturday School Program through the George B. Thomas Academy Learning [Child and Adolescent School and Community Based Services]	100,000	0.00
Enhance: Therapist II Position to expand service capacity [Trauma Services]	72,445	1.00
Enhance: One Social Worker III Position to Reduce Adults Waitlist for Social Services [Assessment and Continuing Case Management Services]	69,324	1.00
Add: One Program Manager I Position to Long Term Care Ombudsman Program [Ombudsman Services]	65,385	1.00
Enhance: Adult Day Care Subsidy [Assessment and Continuing Case Management Services]	52,500	0.00
Add: One Caregiver Support Senior Fellow [Senior Community Services]	50,835	0.38
Enhance: School Health Staffing for New Clarksburg Elementary School [School Health Services]	49,500	0.73
Enhance: Welcome Centers Program through CASA de Maryland [Office of Community Affairs]	46,752	0.00
Other Adjustments (with no service impacts)		
Increase Cost: FY15 Compensation Adjustment	4,490,427	0.00
Increase Cost: 2% Inflationary Adjustment to Tax-Supported Contracts with Non-profit Organizations, Developmental Disability Supplement, and Residential Treatment Providers	1,100,888	0.00
Increase Cost: Risk Management Adjustment [Office of the Chief Operating Officer]	719,241	0.00
Increase Cost: Retirement Adjustment	418,805	0.00
Increase Cost: Group Insurance Adjustment	206,316	0.00
Increase Cost: Annualization of New FY14 Lapsed Positions	153,996	0.40
Replace: Emergency Solutions Grant Shortfall [Rental & Energy Assistance Program]	125,044	0.00
Replace: Community Services Block Grant Shortfall [Office of Community Affairs]	110,674	1.06
Increase Cost: Raise the Adult Foster Care Reimbursement Rate [Assisted Living Services]	105,000	0.00
Increase Cost: Psychiatric Services Contract [Outpatient Behavioral Health Services - Adult]	63,682	0.00
Increase Cost: Printing and Mail [Office of the Chief Operating Officer]	32,858	0.00
Increase Cost: Motor Pool Rate Adjustment [Office of the Chief Operating Officer]	31,133	0.00
Technical Adj: Align FTEs with Hyperion	0	2.85
Decrease Cost: Victims Compensation Fund [Trauma Services]	-1,361	0.00
Decrease Cost: Public Information Office MC311 Staffing Charges to HHS [Office of the Director]	-24,227	-0.40
Decrease Cost: Elimination of One-Time Items Approved in FY14	-34,900	0.00
Shift: Transitional Shelters to A Leased Facility and Paid Through the Leases Non-Departmental Account [Shelter Services]	-71,528	0.00
Decrease Cost: Annualization of FY14 Personnel Costs	-72,445	-1.00
Decrease Cost: Annualization of FY14 Operating Expenses	-74,824	0.00
FY15 RECOMMENDED:	**204,371,455**	**1159.66**
GRANT FUND MCG		
FY14 ORIGINAL APPROPRIATION	**68,179,261**	**418.62**
Changes (with service impacts)		
Add: Maryland Health Benefit Exchange Grant (2001651) [Office of the Director]	2,900,000	5.00
Add: Maryland Infants & Toddlers - Consolidated Local Implementation (Medicaid) Grant (0F64169) [Infants and Toddlers]	1,011,322	0.00
Add: ADAA Recovery Support Expansion Grant (2001431) [Treatment Services Administration]	925,094	0.00
Add: HHS Expanded Breast & Cervical Cancer Diagnosis Grant (2000992) [Women's Health Services]	293,812	0.00
Add: Early Childhood Advisory Council Grant (2001450) [Early Childhood Services]	142,830	0.00
Add: Senior Center Operating Grant (2001047) [Senior Community Services]	79,088	0.00
Add: Maryland Access Point Expansion (MAP) Grant (2000519) [Senior Community Services]	18,843	0.00
Reduce: Maryland Infant and Toddlers Grant (0F61507) [Infants and Toddlers]	-58,271	0.00

	Expenditures	FTEs
Reduce: Community Services Block Grant [Office of Community Affairs]	-110,674	-1.06
Eliminate: Minority Infant Mortality Reduction Grant (0F64175) [Women's Health Services]	-135,000	0.00
Other Adjustments (with no service impacts)		
Increase Cost: House Bill 669 Funding	1,168,795	5.40
Technical Adj: Tuberculosis Control Grant (0F62014) and Immunization Hepatitis B Grant (0F62081) [Tuberculosis Services]	80,357	0.00
Technical Adj: Community Mental Health Grant Consolidation (0F60032) [Behavioral Health Planning and Management]	55,395	0.00
Shift: Maryland Strategic Prevention Framework Grant (2001063) [Treatment Services Administration]	-33,475	0.00
Shift: Temporary Emergency Food Assistance Program (TEFAP) Grant (0F61304) [Office of Community Affairs]	-35,000	0.00
Decrease Cost: HHS Money Follows the Person Options Counseling Grant (2001061) [Community First Choice]	-105,600	0.00
Shift: Alcohol and Drug Abuse Administration (ADAA) Federal Treatment Grant (2000773) [Treatment Services Administration]	-122,562	0.00
Technical Adj: Miscellaneous Grant Changes	-401,810	-0.75
Technical Adj: Alcohol and Drug Abuse Administration (ADAA) Grant Consolidation (0F64044) [Treatment Services Administration]	-489,052	0.00
FY15 RECOMMENDED:	**73,363,353**	**427.21**

FUNCTION SUMMARY

Program Name	FY14 Approved Expenditures	FY14 Approved FTEs	FY15 Recommended Expenditures	FY15 Recommended FTEs
Aging and Disability Services	39,230,036	160.55	43,112,933	164.93
Behavioral Health and Crisis Services	39,447,338	209.70	40,524,790	209.70
Children, Youth, and Family Services	62,407,923	433.53	73,628,754	525.43
Public Health Services	73,394,361	571.98	68,398,678	489.71
Special Needs Housing	19,756,896	62.50	20,138,104	62.50
Administration and Support	27,167,924	130.50	31,931,550	134.60
Total	**261,404,478**	**1568.76**	**277,734,809**	**1586.87**

FUTURE FISCAL IMPACTS

Title	CE REC. FY15	FY16	FY17	($000's) FY18	FY19	FY20
This table is intended to present significant future fiscal impacts of the department's programs.						
COUNTY GENERAL FUND						
Expenditures						
FY15 Recommended	**204,371**	**204,371**	**204,371**	**204,371**	**204,371**	**204,371**
No inflation or compensation change is included in outyear projections.						
Annualization of Positions Approved in FY15	**0**	**174**	**174**	**174**	**174**	**174**
New positions in the FY15 budget are generally lapsed due to the time it takes a position to be created and filled. Therefore, the amounts above reflect annualization of these positions in the outyears.						
Elimination of One-Time Items Approved in FY15	**0**	**-37**	**-37**	**-37**	**-37**	**-37**
Items approved for one-time funding in FY15 that will be eliminated from the base in the outyears.						
Labor Contracts	**0**	**1,194**	**1,194**	**1,194**	**1,194**	**1,194**
These figures represent the estimated annualized cost of general wage adjustments, service increments, and associated benefits.						
Labor Contracts - Other	**0**	**-125**	**-125**	**-125**	**-125**	**-125**
These figures represent other negotiated items included in the labor agreements.						
Children's Resource Center (P641300)	**0**	**27**	**54**	**54**	**54**	**54**
These figures represent the impacts on the Operating Budget of projects included in the FY15-20 Recommended Capital Improvements Program.						
Dennis Avenue Health Center (P641106)	**0**	**102**	**204**	**204**	**204**	**204**
These figures represent the impacts on the Operating Budget of projects included in the FY15-20 Recommended Capital Improvements Program.						
High School Wellness Center (P640902)	**0**	**872**	**904**	**904**	**904**	**904**
These figures represent the impacts on the Operating Budget of projects included in the FY15-20 Recommended Capital Improvements Program.						
Progress Place Relocation and Personal Living Quarters (P601401)	**0**	**0**	**69**	**69**	**69**	**69**
These figures represent the impacts on the Operating Budget of projects included in the FY15-20 Recommended Capital Improvements						

Title	CE REC. FY15	FY16	FY17	($000's) FY18	FY19	FY20
Program.						
School Based Health & Linkages to Learning Centers (P640400)	0	0	108	131	131	131
These figures represent the impacts on the Operating Budget of projects included in the FY15-20 Recommended Capital Improvements Program.						
Subtotal Expenditures	***204,371***	***206,580***	***206,918***	***206,941***	***206,941***	***206,941***

ANNUALIZATION OF PERSONNEL COSTS AND FTES

	FY15 Recommended Expenditures	FTEs	FY16 Annualized Expenditures	FTEs
Add: One Caregiver Support Senior Fellow [Senior Community Services]	25,835	0.38	34,447	0.38
Add: One Program Manager I Position to Long Term Care Ombudsman Program [Ombudsman Services]	63,485	1.00	84,647	1.00
Enhance: One Social Worker III Position to Reduce Adults Waitlist for Social Services [Assessment and Continuing Case Management Services]	66,124	1.00	88,165	1.00
Enhance: Staffing Need for the Expansion of the Kennedy Cluster Project [Child and Adolescent School and Community Based Services]	100,000	2.50	200,000	2.50
Enhance: Therapist II Position to expand service capacity [Trauma Services]	66,125	1.00	88,167	1.00
Total	**321,569**	**5.88**	**495,426**	**5.88**

Administration and Support

FUNCTION

The function of Administration and Support Services is to provide overall leadership, administration, and direction to the Department of Health and Human Services (HHS), while providing an efficient system of support services to assure effective management and delivery of services.

PROGRAM CONTACTS

Contact Stuart Venzke of the HHS - Administration and Support at 240.777.1211 or Pofen Salem of the Office of Management and Budget at 240.777.2773 for more information regarding this service area's operating budget.

PROGRAM DESCRIPTIONS

Office of the Director

The Office of the Director provides comprehensive leadership and direction for the Department, including policy development and implementation; planning and accountability; service integration; customer service; and the formation and maintenance of partnerships with non-governmental service providers. Further, the Office of the Director facilitates external liaison and communications, provides overall guidance and leadership of health and social service initiatives, and assures compliance with relevant laws and regulations including the Americans with Disabilities Act (ADA) and the Health Insurance Portability and Accountability Act (HIPAA).

FY15 Recommended Changes	Expenditures	FTEs
FY14 Approved	**2,269,683**	**18.75**
Add: Maryland Health Benefit Exchange Grant (2001651)	2,900,000	5.00
Decrease Cost: Public Information Office MC311 Staffing Charges to HHS	-24,227	-0.40
Multi-program adjustments, including negotiated compensation changes, employee benefit changes, changes due to staff turnover, reorganizations, and other budget changes affecting multiple programs.	165,181	-1.00
FY15 CE Recommended	**5,310,637**	**22.35**

Office of the Chief Operating Officer

This Office provides overall administration of the day-to-day operations of the Department, including direct service delivery, budget and fiscal management oversight, contract management, logistics and facilities support, human resources management, and information technology support and development.

FY15 Recommended Changes	Expenditures	FTEs
FY14 Approved	**17,672,074**	**89.25**
Increase Cost: Risk Management Adjustment	719,241	0.00
Add: The Financial Reporting and Management Institute and Operating Support for Nonprofit Montgomery	156,620	0.00
Increase Cost: Printing and Mail	32,858	0.00
Increase Cost: Motor Pool Rate Adjustment	31,133	0.00
Multi-program adjustments, including negotiated compensation changes, employee benefit changes, changes due to staff turnover, reorganizations, and other budget changes affecting multiple programs.	684,268	0.50
FY15 CE Recommended	**19,296,194**	**89.75**

Office of Community Affairs

This office supports expanding access to and improving the quality of services, increasing Individuals/families' independence, promoting equity and reducing disparities. The office accomplishes the mission through education, outreach, system navigation assistance, effective referrals, language services, cultural competency training, and policy advocacy. The office includes the Community Action Agency, Head Start, TESS Center, the Leadership Institute of Equity and Elimination of Disparities (LIEED) within which are the African American Health Program, Latino Health Initiative, and the Asian American Health Initiative.

Program Performance Measures	Actual FY12	Actual FY13	Estimated FY14	Target FY15	Target FY16
Percentage of African Americans who demonstrate an increase in knowledge after taking diabetes education classes	92	90	90	90	90

FY15 Recommended Changes	Expenditures	FTEs
FY14 Approved	**7,226,167**	**22.50**
Replace: Community Services Block Grant Shortfall	110,674	1.06
Enhance: Welcome Centers Program through CASA de Maryland	46,752	0.00
Shift: Temporary Emergency Food Assistance Program (TEFAP) Grant (0F61304)	-35,000	0.00
Reduce: Community Services Block Grant	-110,674	-1.06
Multi-program adjustments, including negotiated compensation changes, employee benefit changes, changes due to staff turnover, reorganizations, and other budget changes affecting multiple programs.	86,800	0.00
FY15 CE Recommended	**7,324,719**	**22.50**

PROGRAM SUMMARY

Program Name	FY14 Approved Expenditures	FY14 Approved FTEs	FY15 Recommended Expenditures	FY15 Recommended FTEs
Office of the Director	2,269,683	18.75	5,310,637	22.35
Office of the Chief Operating Officer	17,672,074	89.25	19,296,194	89.75
Office of Community Affairs	7,226,167	22.50	7,324,719	22.50
Total	**27,167,924**	**130.50**	**31,931,550**	**134.60**

Leadership Institute for Equity and the Elimination of Disparities (LIEED)
Interim Progress Report
July 1, 2013- February 15, 2014

The LIEED organizational start-up plan brings together the goals, plans, strategies, and resources of creating LIEED. During the first six months of operations, LIEED staff began to build the foundation in order to: 1) focus ideas; 2) create a tracking mechanism to follow in the early stages of growth; 3) create benchmarks against which progress could be measured; and 4) document progress for fiscal accountability and attract potential funding to further support the goals and objectives of LIEED.

Accomplishments during this reporting period are identified below and include: a) building the LIEED infrastructure; b) responding to the lack of diversity in the behavioral health workforce; and c) playing a major contributory role in the ACA outreach activities.

A. Building LIEED's Infrastructure

1. **Organizational/Structural Activities**
   - Created a six-month project management tool (Gantt Chart) that tracked tasks/activities and timelines. These included:
     - Setting up administrative and clerical support services
     - Utilization of technical Contractors/Consultants to assist w/process
     - Drafting protocols/guidelines for taking on LIEED projects
     - Identifying and negotiating office space for LIEED team's operation including furnishing space with equipment and basic furniture
     - Working with Budget, Procurement and Contract Management to properly encumber LIEED funds
     - Workforce staffing provided an estimated 15% time effort and included work produced by the MHI/P staff during this time

2. Internal Operations/Organization
   - During this initial phase, performed operational functions and activities as follow:
     - Development of job description for LIEED program specialist position.
     - Drafted LIEED operational structure (Mission statement/purpose/ roles/functions, etc.)
     - Researched and drafted potential LIEED project ideas related to the 2013 MHIP Report.
     - Development of the LIEED Advisory Council's framework
     - Identified and implemented recruitment strategies in the formation of the LIEED Advisory Committee
     - Created materials for LIEED Advisory Committee Orientation Notebooks
     - Convened two LIEED Advisory Committee meetings and one LIEED Advisory Orientation for new members
     - Prepared agenda, meeting notes, report presentations and handled logistics for LIEED Advisory Committee

B. Behavioral Health Workforce Diversity

The low number of bilingual/bicultural health care professionals working in behavioral health care settings continues to present an unacceptable barrier to addressing health disparities and improving the health of the racial and ethnic populations. There is a well documented correlation between racial and

(11)

ethnic diversity in health care delivery systems and its ability to provide quality care to socio-culturally diverse patient populations.

In response to concerns pertaining to the lack of diversity in the behavioral health workforce, the LIEED, through its Welcome Back Center for internationally-trained health professionals is in the process of developing a component for the incorporation of behavioral health professionals (BHPs) into the public and private workforce.

During the reporting period the LIEED:

1. Secured the commitment of Behavioral Health and Crisis Services (BHCS) at HHS to work in a collaborative fashion to develop the component for the incorporation of BHPs.

2. Worked with Maryland licensure boards to understand the licensure process for foreign-trained psychologists (Licensed Clinical Psychologists); social workers (Licensed Certified Social Worker - Clinical-LCSW-C, Licensed Certified Social Worker-LCSW, Licensed Graduate Social Worker-LGSW, Licensed Social Worker Associate-LSWA); Therapists (i.e. Licensed Clinical Marriage and Family Therapist-LCMFT, Licensed Graduate Marriage and Family Therapist-LGMFT); Counselors (i.e. Mental Health Counselor, Licensed Clinical Professional Counselor-LCPC, Licensed Graduate Professional Counselor-LGPC, Alcohol and Drug Counselor, Licensed Graduate Alcohol and Drug Counselor, LGADC, Certified Rehabilitation Counselor); and Career Planning and Placement for Youth Transition.

3. Worked with Behavioral Health and Crisis Services in HHS to identify job classifications for potential employment opportunities for foreign-trained behavioral health professionals including Clinical Coordinator, Family Case Manager, Utilization Reviewer, Ambassador Family Specialist, Vocational Counselor Residential/Outreach Integrated Dual-Diagnosis Treatment (IDDT) Counselor, Manager III, Manager II, Program Specialist I and II, Program Manager, Behavioral Health Addiction Counselor-BHAC.

4. Convened a meeting with the support of Behavioral Health and Crisis Services to present the WBC model, and identify potential partners for the development and implementation of the behavioral health professional component. Twelve service providers attended the meeting.

5. Began the process of conducting an assessment of critical occupation and skill needs in the behavioral health industry and relevant workforce issues related to Human Resources, individual and structural barriers preventing prospective employees from obtaining employment, demographic challenges, and identifiable skill needs for incumbent workers that are likely to lead to future job advancement.

6. Secured the participation of 6 internationally-trained behavioral health professionals to understand how to best work to guide these professionals about advancing the career ladder with valuable job options that will lead in the long term to using their full professional capacity and experience in their field of expertise.

7. Began the preparation of a proposal for the Employment Advancement Right Now (EARN) Maryland grant to be submitted at the end of March to the Maryland Department of Labor, Licensing and Regulation (DLLR) to support, among other things, the implementation of a pilot for the incorporation of internationally-trained BHPs into the workforce.

C. LIEED's Connection to the Affordable Care Act (ACA) Outreach

The Montgomery County Department of Health and Human Services (MCDHHS) was selected to be the Connector Entity for the Capital Region, serving Montgomery and Prince George's Counties. The Department's Office of Community Affairs (OCA) has a long history of successful outreach to County residents, especially those in traditionally "hard-to-reach" or underserved communities. As would be expected given its depth of knowledge and community involvement, OCA played an integral role in the MCDHHS outreach activities for ACA.

Below are highlights of ACA related outreach performed by LIEED staff:

1. LIEED developed ACA specific outreach goals, roles and responsibilities to support ACA work. The LIEED ACA outreach goals are twofold: a) to increase awareness and b) to promote enrollment.

2. LIEED initiated an internal ACA Outreach Committee to provide a more structured coordination of various activities. The convening of the ACA Outreach Committee brought together key managers within HHS to be responsible for 4 areas of outreach work: Outreach to Communities; Internal Communication; Marketing/PR; Liaison with Legislators. The ACA Outreach Committee was responsible for developing and recommending weekend strategies and providing consistency in messaging.

3. Coordination of outreach activities to the communities yielded the following results between August to January:
   - 101 number of events organized
   - 6,255 individuals received information about ACA
   - 5,748 ACA awareness flyers distributed
   - 4,357 enrollment flyers distributed

   Many of the outreach activities orchestrated by LIEED staff and the Minority Health Initiative/Program health promoters took detail planning and execution because they are tailored to targeted communities to maximize better reception of message.

4. Development of an outreach flowchart that was used to standardize a department-wide outreach practice for ACA. See Appendix A.

5. LIEED developed the electronic request and reporting forms for outreach to track and facilitate a reporting out mechanism. See Appendix A.
   - LIEED developed online forms to coordinate the planning and reporting of ACA outreach activities. The online forms are used by the Minority Health Initiatives/ Program, DHHS ACA partners, and the general public. The forms can be found on the official website www.capitalhealthconnection.org.

6. Development of culturally and linguistically appropriate health promotion education and trainings. See Appendix A.
   - As a result, there were 39 health promoters trained that were able to communicate to Montgomery County residents in various languages. These included: English Spanish, French, Amharic, Chinese, Korean, Vietnamese, Hindi, Urdu, and Tagalog.

8. Development of ACA outreach materials that also included 2 flyers in 7 languages (English, Chinese,

French, Korean, Spanish, Vietnamese, and Amharic). See Appendix B.

9. Development, coordination, and implementation of the Empowering Community Health Organizations (ECHO) workshop, which reached 125 attendees representing about 62 organizations from the community. See Appendix B.

10. Participated as panelist for the October 28, 2013 Montgomery County ACA Leadership Summit - LIEED representative attended and presented at the Summit to discuss the strategies on enrolling hard-to-reach populations and enhancing outreach encounters.

11. Active participation of Health Promoters in the delivery of the ACA information, education and outreach activities included the following:

    a) Asian American Health Initiative- 33 health promoters contributed 297 hours to ACA outreach
    b) African American Health Programs – 29 health promoters contributed 205 hours to ACA outreach
    c) Latino Health Initiative – 13 LHI health promoters contributed 120 hours of their time to support ACA outreach activities

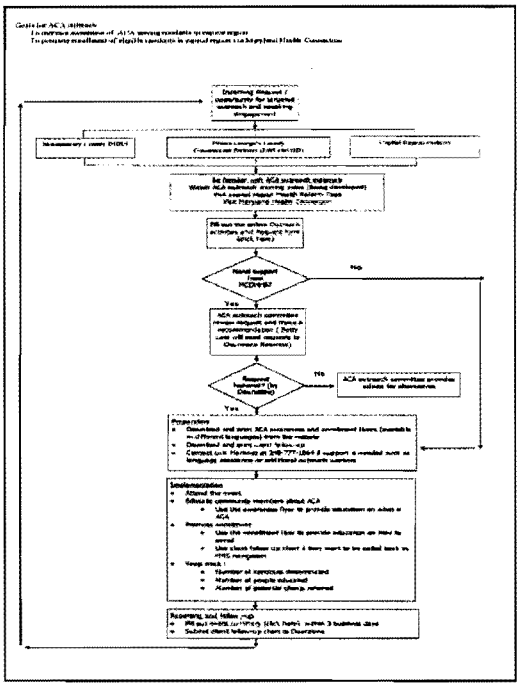
Leveraged Internal Resources to Conduct LIEED's Work:

On average, the Office of Community Affairs (OCA) staff, including the Chief and three program managers devoted 35-50% of time to LIEED related activities. Specifically:

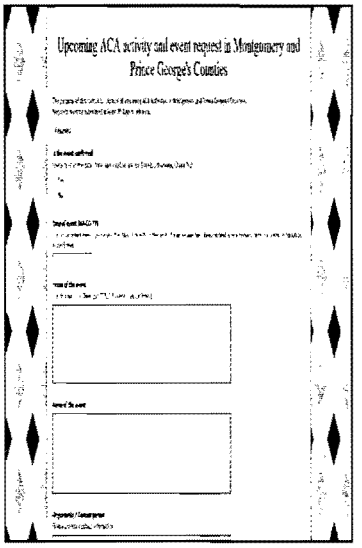
- OCA Program Manager II – average 45% of time from Sept to Feb to support LIEED ACA related outreach
- African American Health Programs, (AAHP) Program Manager II – average 30% of time from August to Feb to support LIEED ACA related outreach
- Asian American Health Initiative (AAHI) Program Manager II – average 40% of time from August to Feb to support LIEED ACA related outreach
- OCA Chief – average 40% of time from August to Dec to support LIEED ACA related outreach
- LHI Manager/WBC Administrator --- 40% of her time dedicated to LIEED activities
- Latino Health Initiative (LHI) Senior Program Specialist—30% of time dedicated to LIEED ACA activities
- LHI Intern—25% of her time dedicated to LIEED ACA activities
- Welcome Back Center Manager—5% of her time dedicated to LIEED's Behavioral Health Workforce Project

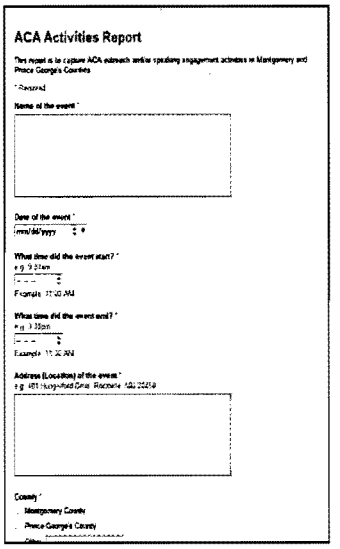
Appendix A

ACA Flowchart Form

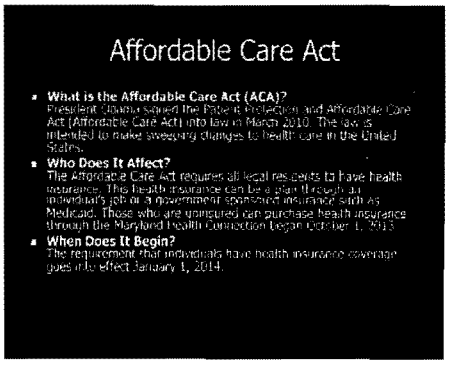


Computerized ACA Activities Report



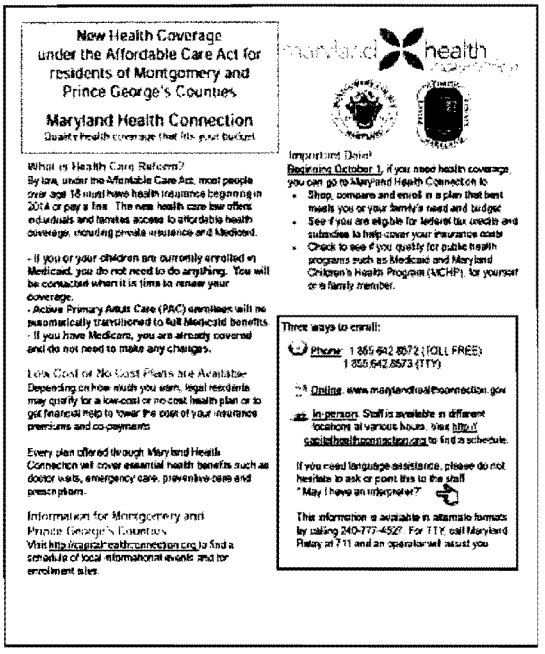


Health Promoter Education and Trainings



Appendix B

Development of Outreach Materials



New Health Coverage under the Affordable Care Act for residents of Montgomery and Prince George's Counties

Maryland Health Connection

Quality health coverage that fits your budget

What is Health Care Reform?

By law, under the Affordable Care Act, most people over age 18 must have health insurance beginning in 2014 or pay a fine. The new health care law offers individuals and families access to affordable health coverage, including private insurance and Medicaid.

- If you or your children are currently enrolled in Medicaid, you do not need to do anything. You will be contacted when it is time to renew your coverage.
- Active Primary Adult Care (PAC) enrollees will be automatically transitioned to full Medicaid benefits.
- If you have Medicare, you are already covered and do not need to make any changes.

Low Cost or No Cost Plans are Available

Depending on how much you earn, legal residents may qualify for a low-cost or no cost health plan or to get financial help to lower the cost of your insurance premiums and co-payments.

Every plan offered through Maryland Health Connection will cover essential health benefits such as doctor visits, emergency care, preventive care and prescription.

Information for Montgomery and Prince George's Counties

Visit http://marylandhealthconnection.org to find a schedule of local informational events and for enrollment sites.

maryland health connection

Important Dates!

Beginning October 1, if you need health coverage, you can go to Maryland Health Connection to:

- Shop, compare and enroll in a plan that best meets you or your family's need and budget
- See if you are eligible for federal tax credits and subsidies to help lower your insurance costs
- Check to see if you qualify for public health programs such as Medicaid and Maryland Children's Health Program (MCHP) for yourself or a family member.

Three ways to enroll:

Phone: 1 855 642 8572 (TOLL FREE)
1 855 642 8573 (TTY)

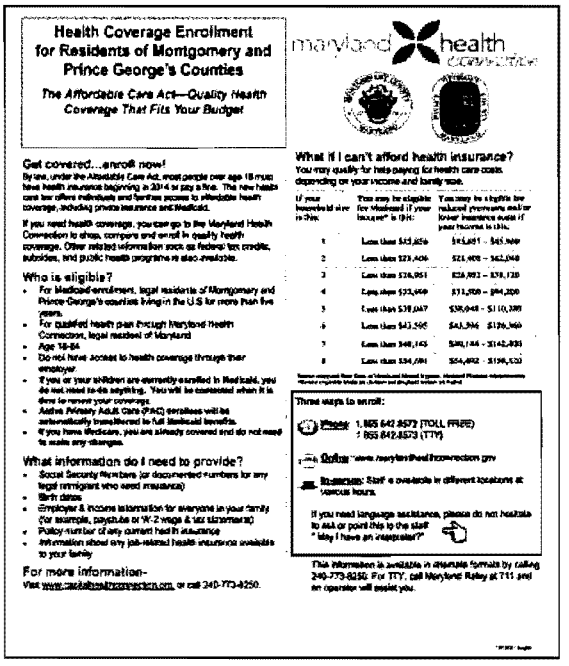
Online: www.marylandhealthconnection.gov

In-person: Staff is available in different locations at various hours. Visit http://localhealthconnection.org to find a schedule.

If you need language assistance, please do not hesitate to ask or point this to the staff
"May I have an interpreter?"

This information is available in alternate formats by calling 240-777-4527. For TTY, call Maryland Relay at 711 and an operator will assist you.

Awareness flyer



Health Coverage Enrollment for Residents of Montgomery and Prince George's Counties

The Affordable Care Act—Quality Health Coverage That Fits Your Budget

maryland health connection

Get covered...enroll now!

By law, under the Affordable Care Act, most people over age 18 must have health insurance beginning in 2014 or pay a fine. The new health care law offers individuals and families access to affordable health coverage, including private insurance and Medicaid.

If you need health coverage, you can go to the Maryland Health Connection to shop, compare and enroll in quality health coverage. Other related information such as federal tax credits, subsidies, and public health programs is also available.

Who is eligible?

- For Medicaid enrollment, legal residents of Montgomery and Prince George's counties living in the U.S for more than five years.
- For qualified health plan through Maryland Health Connection, legal resident of Maryland
- Age 18-64
- Do not have access to health coverage through their employer
- If you or your children are currently enrolled in Medicaid, you do not need to do anything. You will be contacted when it is time to renew your coverage.
- Active Primary Adult Care (PAC) enrollees will be automatically transitioned to full Medicaid benefits.
- If you have Medicare, you are already covered and do not need to make any changes.

What information do I need to provide?

- Social Security Numbers (or documented numbers for any legal immigrant who need insurance)
- Birth dates
- Employer & income information for everyone in your family (for example, paystubs or W-2 wage & tax statements)
- Policy number of any current health insurance
- Information about any job-related health insurance available to your family

For more information-

Visit www.marylandhealthconnection.com or call 240-773-8250.

What if I can't afford health insurance?

You may qualify for help paying for health care costs depending on your income and family size.

If your household size is this:	You may be eligible for Medicaid if your income* is this:	You may be eligible for reduced premiums and/or lower insurance costs if your income is this:
1	Less than $15,856	$15,857 – $45,960
2	Less than $21,406	$21,408 – $62,040
3	Less than $26,951	$26,952 – $78,120
4	Less than $32,496	$32,500 – $94,200
5	Less than $38,047	$38,048 – $110,280
6	Less than $43,595	$43,596 – $126,360
7	Less than $49,143	$49,144 – $142,920
8	Less than $54,691	$54,692 – $158,520

Three ways to enroll:

Phone: 1 855 642 8572 (TOLL FREE)
1 855 642 8573 (TTY)

Online: www.marylandhealthconnection.gov

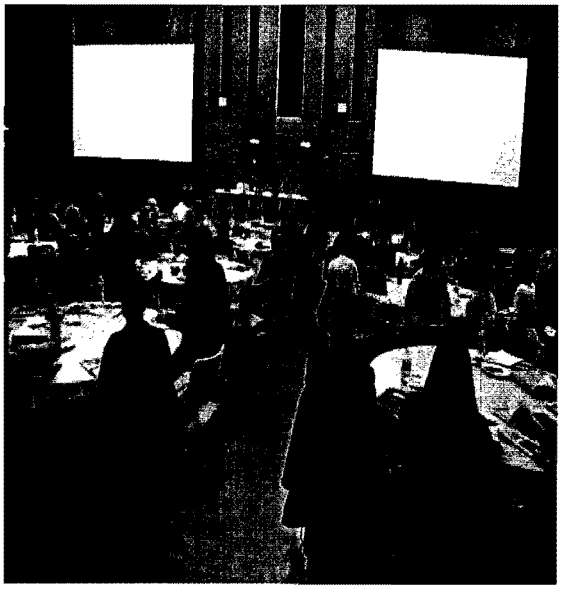
In-person: Staff is available in different locations at various hours.

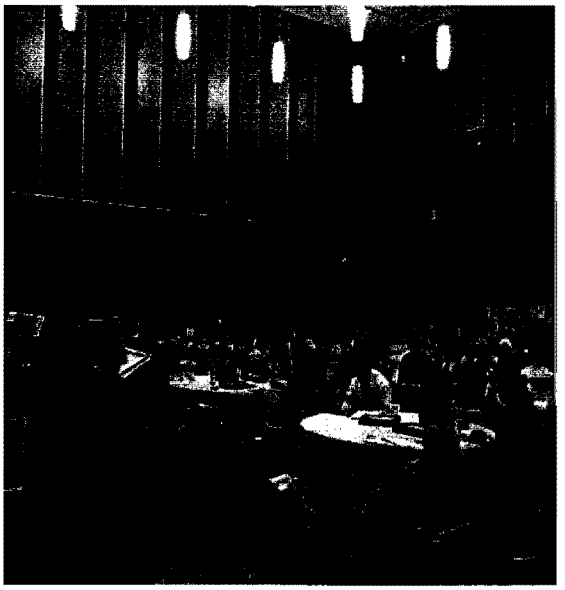
If you need language assistance, please do not hesitate to ask or point this to the staff
"May I have an interpreter?"

This information is available in alternate formats by calling 240-773-8250. For TTY, call Maryland Relay at 711 and an operator will assist you.

Enrollment flyer

Empowering Community Health Organizations (ECHO) Workshop





SUBURBAN MARYLAND
WELCOME BACK CENTER
FOR FOREIGN-TRAINED HEALTH PROFESSIONALS

Montgomery County
Department of Health and Human Services
Welcome Back Center of Suburban Maryland

The Welcome Back Center of Suburban Maryland (WBC) provides support to internationally-trained health professionals to reintegrate them into the health field, address workforce shortages, and enhance cultural and linguistic competency in the healthcare delivery and related services. There are more than **900** internationally-trained healthcare professionals registered in the WBC database from which approximately 60% are nurses, 20% are physicians, and 20% are from other healthcare professions.

There are **129** nurses who have been receiving intensive services since the program started in 2006. Services offered to participants include guidance and support providing individualized case management and financial assistance; academic support including English as a Second Language (ESL), and refresher/exam preparation courses; workforce development providing internships at local hospitals and assistance with job placement; and leadership development.

WBC contributes to immigrant integration into a highly-skilled healthcare labor force in Maryland. Close to 50% of WBC participants have more than 4 years of nursing training equivalent to a Bachelor's degree or above, and close to 60% of the participants have more than 6 years of nursing work experience abroad. The demographic information of this group of 129 nurses is 45% individuals from Latin American and the Caribbean, 36% from Africa, 15% from Asia, and 4% from Europe.

The following are cumulative results and accomplishments by the WBC:

- **51** participants already passed the licensure examination and obtained Registered Nurse (RN) license.
- Average time needed from entering the program until passing RN licensure exam is **19 months** including ESL Montgomery College, which takes 24 months after fulfilling any prerequisite which may include ESL, or/and other if needed.
- A total of **38** participants have secured jobs as RNs in Maryland and obtained an average increase in wages of **169%** (from $10.97/hour when entering the program to $29.55/hour when hired as RNs).
- When WBC participants start working as RNs, the higher taxes paid as per their increased income provides a return in the investment in the program.
- Average training and support cost of $3,540 compared to $15,000 cost to complete a nursing associate degree at Montgomery College.
- **101** WBC nurses successfully secured jobs in the health field in Maryland (**38** RNs, **48** Nurses-in-training, **15** Certified Nursing Assistants (CNAs), Patient Care Technicians (PCTs), or other capacity in the health care field.
- **55** fluent native speakers of languages beyond English – Spanish, French, Amharic, Hindi, Portuguese, Russian, Ukrainian, Tigrinya, Sinhala, Tagalog, Swahili, and Mandarin – contribute to improve health outcomes through the delivery of culturally and linguistically appropriate health services as part of a workforce that is dealing with an increasingly diverse patient population.
- The retention rate of WBC participants is **94%**.

Department of Health and Human Services
Leadership Institute for Equity and Elimination of Disparities (LIEED)
Advisory Committee Roster

As of April, 2014

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Montgomery County Department of Health and Human Services

Leadership Institute for Equity and Elimination of Disparities (LIEED)

LIEED Advisory Committee Framework

January 2014

Approved Date: February 5, 2014

Leadership Institute for Equity and Elimination of Disparities (LIEED)
Advisory Committee Framework

I. BACKGROUND

Under the auspices of the Office of Community Affairs (OCA), the Leadership Institute for Equity and Elimination of Disparities (LIEED) of the Montgomery County Department of Health and Human Services (DHHS) was established in July 2013, with the guidance of community leaders and support of the County Executive and County Council.

The overall functions of the LIEED are to:

- *Provide Strategic Leadership and Coordination* - Serve as the coordinating entity pertaining to health and social disparities reduction and equity in HHS and outside the Department, as appropriate.

- *Serve as a Capacity Builder*- Provide technical assistance, guidance, and support to public and private entities to enhance services to racial and ethnic minorities in addressing disparities.

- *Act as Resource Partner and Collaborator*- Collaborate with internal and external partners in specific projects related to addressing health disparities and equity. Serve as a resource to others.

- *Promote Effective Community Engagement*-Assist with the flow of communication and establishment of relationships between HHS programs and members of the racial and ethnic communities.

- *Promote innovation and support linkages/opportunities*-Develop models of programs and services to adequately serve racially and ethnically diverse groups, including the identification and leveraging of new networks, partnerships and funding opportunities.

- *Support Community Advocacy* - Advocate for policies and services to eliminate health and social disparities among racially/ethnic diverse groups and other communities in need.

The LIEED has two major operational components:

A. Minority Health Initiatives/Program (MHI/P) Programs and Other Community Projects/Activities— These initiatives, programs and outreach activities provide direct population-specific interventions to the African American, Asian, Latino, and racial/ethnic populations (African Immigrants, Caribbean, Middle Eastern and other new groups). Of critical importance is performing outreach services to increase access and to improve health for the underserved communities.

B. Systems Enhancement – A critical component that addresses DHHS policies which impacts access to health and social services and its delivery, practices, infrastructure, and distribution of related resources equitably; and focuses the work on the use of fair policies, decisions and actions. Furthermore, fosters collaborative community and public/private sector partners to cultivate opportunities for capacity building and sustainability efforts. This includes partners at the local, state and national levels, as appropriate.

Through these two major components, LIEED brings together the strengths of MHI/P, the Equity Work Group and Outreach functions of the OCA in order to foster greater collaboration and coordination among these closely-related key activities; and to better serve as a bridge to the underserved communities.

Under the general supervision of the Chief of the OCA, and with support and guidance from the LIEED Advisory Committee, the Institute will strengthen its population-specific interventions and services to effectively and efficiently address disparities, outreach, and promote equity.

II. MISSION

The charge of the LIEED within DHHS is to address social determinants of health with the goal of eliminating disparities and achieving equity among residents of Montgomery County.

III. LIEED ADVISORY COMMITTEE

A. Purpose

The role of the LIEED Advisory Committee is to provide expert guidance and support to the Institute in its effort to implement the recommendations set forth by the Minority Health Initiatives/Program Advisory Committee in its 2013 report, "Eliminating *Disparities and Providing Equitable and Quality Services to Racial/Ethnic Communities in Montgomery County*." The recommendations include four major undertakings.

- *Systemic and Systematic Approach* – Use systemic and systematic approaches to develop, implement, review and adjust/improve practices, policies and infrastructure of the department and its contractors to better serve racial/ethnic minorities and emerging populations.
- *Access to and Delivery of Quality and Equitable Services* – Ensure equitable access to and delivery of quality services and programs provided by HHS and its contractors to serve racial/ethnic minorities and emerging populations.
- *HHS workforce* – Ensure that the diversity of the DHHS workforce at all levels of staff, from leadership to program delivery, is proportional to the County's

demographics. In addition, ensure that staff has the skills, experience, and capacity to effectively serve racial/ethnic minorities and emerging populations.

- *Accountability* – Identify accountability processes to monitor progress of the implementation of priority areas and final recommendations.

B. Membership

1. Members - The LIEED Advisory Committee membership shall consist of up to 20 members. Currently there are twelve community members and seven content area experts. Community membership shall include: two representatives from each of the racial and ethnic minority populations including African American, Asian American, Caribbean American, Continental African, Latino, and the Middle Eastern communities. Expanded membership will be considered based on needs. Content area experts shall include the DHHS Director, the DHHS Service Area Chiefs, and an appointed DHHS staff to serve as Co-Chair of the Advisory Committee. Content area experts are members who will not have voting privileges. Vacancies shall not prevent the LIEED Advisory Committee from conducting business.

2. Selection of Community Members - Representatives from the African American, Asian American and Latino communities will be appointed to the LIEED Advisory Committee by the African American Health Program Executive Committee, the Asian Health Initiative Steering Committee, and the Latino Health Steering Committee of Montgomery County, respectively. Individuals representing the Continental African, Caribbean and Middle Eastern communities will be appointed by the Continental African, Caribbean and Middle Eastern Advisory Committees of the County Executive. Each represented community member shall have voting privileges.

3. Co-chairs and Co-Chair-Elect - At a meeting of the LIEED Advisory Committee, a Community Co-Chair and Co-Chair-elect will be identified and elected to serve on the MCDHHS LIEED Advisory Committee. See Section C-Leadership, (a) on selection of County Co-Chair.

4. Length of Commitment- Community Members - LIEED community members will serve a term of two fiscal years beginning in July; and they may be reappointed to serve one more consecutive term, for a maximum of 4 years. The first year will be an interim term which ends on June 30, 2014. The start of the first full term begins in July, 2014 through June 2016 and constitutes one term of service.

5. Meeting Attendance - The LIEED Advisory Committee shall meet on a quarterly basis with additional meetings scheduled, as necessary. Represented members are expected to attend all regular meetings of the Advisory Committee. All regular advisory meetings are open to the public.

6. Alternates – Represented community entities may designate alternates, as needed, to attend a meeting in the absence of primary members.

7. Appointment and Vacancies - Vacancies of membership are to be filled within two regular meetings of the LIEED Advisory Committee.

C. Leadership

1. Selection of County Co-Chair-The Montgomery County Department of Health and Human Services will select an employee, or a designated representative to serve as a Health and Human Services Department Co-Chair. The MCDHHS representative continues to serve at the request of the HHS Director.

2. Community Co-Chair and Co-Chair-Elect - will be elected by the representatives from Community entities of the LIEED Advisory Committee. All community representatives in good attendance standing can self-nominate or be nominated by another member for the Community Co-Chair position. In the event that the community Co-Chair declines or is unable to serve, the Co-Chair-elect will automatically become the new Community Co-Chair.

3. Length of Commitment - The Community Co-Chair is elected for a term of one year beginning in July, 2014. The Co-Chair-elect will also be elected for a one-year term beginning in July 2014 and become the Co-Chair of the LIEED Advisory Group after the first year of his/her term. This constitutes a one year commitment of service by those serving as Co-chairs

4. Roles and Responsibilities of Co-Chairs -

   The Co-Chairs are expected to:

   - Actively serve their appointed term.
   - Make a commitment to this process and its results.
   - Participate in all decision-making and problem solving.
   - Undertake special tasks, as requested by the Advisory Committee.
   - Participate in a timely manner in the development of meeting agendas, based on input from the LIEED Advisory Committee, for each meeting.
   - Conduct each meeting to maximize the participation of each member and allow for satisfactory discussion through division of responsibilities of Co-Chairs.
   - Participate in debriefings after meetings with members of the Advisory Committee and HHS staff when necessary.
   - Be diligent regarding Co-Chair/Co-Chair-elect roles and responsibilities, duties, and tasks. Co-Chairs will refer to the Robert Rules of Orders.
   - Review the minutes from each meeting and ensure that proceedings of the advisory committee meetings are accurately represented.
   - Responsible for determining meeting dates after consultation with members on the Committee.

- The Co-Chairs will be empowered to act accordingly on all meeting matters including cases in which replacement of community members may be warranted. Co-Chairs will reach out to the pertinent community entity to come to some resolution. Co-Chairs will come to a resolution with Community Entities input.

D. Roles and Responsibilities

1. Role of an Advisory Community Member. Primary function is to provide expert guidance and support to the Institute in carrying out the recommendations set forth by the Minority Health Initiatives/Program Advisory Committee in its 2013 report.

   a) Responsibilities and Expectations:
   - Understand and support the overall LIEED goals.
   - Attend and participate in at least 50% of the quarterly meetings scheduled for the year.
   - Offer guidance to LIEED management and staff on critical strategies and steps aimed at implementing the recommendations of the 2013 MHI/P Report.
   - Assist in the establishment of collaborative relationships between the LIEED and other public and private entities as appropriate.
   - Inform DHHS leadership about the needs of racial/ethnic minority populations, including emerging populations and put forward recommendations to address problems and needs.
   - Inform the community through their respective community entities about the LIEED activities, programs, and services.
   - Serve as liaison between HHS and communities-in-need.
   - Advocate, identify and garner support and resources for the LIEED activities.
   - Come prepared for active participation.
   - Provide progress reports to County Council and County Executive and other key stakeholders as appropriate.
   - Report quarterly to their respective community entities/steering committees regarding the work with the LIEED Advisory Committee.

   b) Orientation - All new LIEED Advisory Committee members are required to attend an orientation session. The orientation session will place emphasis on the roles and responsibilities of members, the LIEED structure, functions, and key activities. Each new member will be given an Advisory Committee notebook which includes:
   - Current LIEED Advisory Committee Agenda and Meeting Schedule
   - Member Contact List
   - LIEED Advisory Committee Framework document
   - 2013 Minority Health Initiatives/Program Advisory Committee Report: Eliminating Disparities and Providing Equitable and Quality Services to Racial/Ethnic Communities in Montgomery County
   - Roles and Responsibilities of Workgroups
   - Conflict of Interest Issues

2. Role of the Montgomery County Department of Health and Human Services. HHS will report on status of recommendations to the Advisory Committee and will ensure transparency in decision making process.

   a) LIEED staff -
   - Develop work plans and carry out LIEED activities and operations to ensure that priority areas and recommendations outlined in the MHI/P Report are implemented.
   - Provide relevant data and analyses to assist in activities of the LIEED Advisory Committee.
   - Provide updates on LIEED activities
   - Staff and support the LIEED Advisory Committee.

   b) Content Area Advisors - Advisors include the DHHS Director and Service Chiefs.
   - Provide the Advisory Committee input from their areas of expertise and help foster communication between DHHS and Community perspectives.
   - Share expertise with the Advisory Committee and participate on specific workgroups and projects, as needed.
   - Liaise with staff and constituents of their respective service areas on Advisory Committee recommendations as appropriate.
   - Attend Advisory Committee quarterly meetings and participate in discussions.

3. Shared Responsibility - Both the MCDHHS and the LIEED Advisory Committee will jointly agree to:
   - Select Co-Chairs - The Director of the DHHS appoints the DHHS Co-Chair. The community Advisory Committee members elect the Community Co-Chair and Co-chair-elect.
   - Approve policies that address LIEED Advisory Committee composition, selection, appointment, and terms of office on a two year basis.
   - Ensure that the Advisory Committee membership reflects the population characteristics of the Montgomery County's racial/ethnic and minority communities, including emerging populations.
   - Promote linkages between HHS and the Community.
   - Track the progress of the development of the LIEED and the implementation of the recommendations in the MHI/P Advisory 2013 Committee Report.

E. Meetings and Co-Chairs Election Procedures

1. Attendance. The LIEED Advisory Committee shall convene quarterly with additional meetings scheduled as necessary. Represented community members are expected to attend all meetings of the Advisory Committee. If unable to attend, it will be the responsibility of the represented entity to call on his/her designated alternate. The alternate is responsible for updating the represented member regarding the meeting discussion to ensure that any action or follow-up items are carried out in a timely

manner. Voting is limited to primary representative unless alternate is sitting in for the primary representative. If represented community entity fails to designate an appropriate alternate, co-chairs can request assistance from the leader of the community entities to identify and recommend a suitable replacement. Additionally, failure of the represented community advisory member or his/her alternate to attend fewer than 50% of meetings in one year shall result in termination of the individual as a member of the LIEED Advisory Committee.

2. Agenda. The agenda will be prepared by the two Co-Chairs of the Advisory Committee in consultation with other committee members and LIEED staff, as necessary.

3. Conducting Meetings.

   a) Procedure.
   The LIEED Advisory Committee will function under Robert Rules of Orders in conducting its meetings. This will be used to facilitate workgroup meetings, agenda-setting and/or any other decision making matters where warranted. The Co-Chairs are empowered to act accordingly on all meeting matters. Decisions will be made by consensus of all voting members present. When group vote is deemed necessary, Roberts Rules of Order will be followed. In the event there is not a consensus, majority and minority opinions will be recorded.

   b) Voting. A simple majority of the voting members of the Advisory Committee shall constitute a quorum for the transaction of business. The action of a majority (more than 50% plus one) of the members present at a meeting at which a quorum is present is sufficient to approve any matter that properly comes before the meeting. On all matters before the Advisory Committee, at the determination of the Co-chairs, members may vote in person, via e-mail, conference calls, postal service or other appropriate communications mechanisms.

4. Election of Community Co-Chair and Co-Chair-Elect Procedure. The election will take place by written ballot at the start of the term or when a vacancy occurs. In the case of a vacancy, the elected member shall serve the remaining term of office. Each Co-Chair's and co-Chair-Elect election will begin a new term.

5. Alternates. Community entity must designate an alternate to attend a meeting in the absence of the primary appointed community member. Alternates shall participate on behalf of the primary community representative and will have full voting authority. The alternate shall be empowered to act on behalf of the primary community member to ensure that any action/follow- up items are executed in a timely manner. They are also responsible for communicating and updating the community entity and the primary community representative serving on the Advisory Committee.

F. Conflict of Interest

The role of the LIEED Advisory Committee is to provide expert guidance and support to the Institute in its efforts to implement the recommendations set forth by the 2013 Minority Health Initiatives/Program Advisory Committee Report. The Committee is not involved in financial decisions.

This policy is intended to supplement, but not replace, any applicable state and federal laws governing conflicts of interest for advisory groups.

The purpose of this policy is to protect the interests of the LIEED Advisory Committee and provide advisory members guidelines for handling perceived, potential or actual conflicts of interest. A conflict of interest may occur if an outside interest or activity influences or appears to influence the ability of an individual to exercise objectivity or impairs the individual's ability to perform his or her responsibilities in the best interests of the LIEED Advisory Committee. An individual is considered to have a potential conflict of interest when:

- He or she may have direct financial interest or duality of interest (defined below) as a result of the individual's advisory position with the LIEED; or
- When a community member uses LIEED information gained through participating in the LIEED Advisory committee for personal or professional gain.

1. Duality of Interest.
   A duality of interest may exist when an Advisory Committee member of LIEED is affiliated with an organization seeking to request a grant from MCDHHS. Such affiliation exists if the person is a director, trustee, officer or employee of the organization, or has an unofficial role such as significant donor, volunteer, advocate or adviser.

2. Disclosure, Recusal, Abstention and Removal for Cause.

   a) Duty to Disclose - In connection with any perceived, actual or potential conflict of interest or duality of interest, an interested person must disclose the existence of his or her financial interest or affiliation and all material facts to the LIEED's Co-Chairs. All covered people will be asked to complete a disclosure form prior to serving on LIEED and update appropriately as soon as a new affiliation begins and before it becomes a matter of committee action.

   Covered Individuals - Any member of the LIEED Advisory Committee who has a direct or indirect financial interest or duality of interest is a covered person. MCDHHS staff and consultants are covered by a separate conflict-of-interest County policy.

   b) Recusal - When an Advisory Committee member has a financial interest or duality of interest in a proposed transaction, he/she shall provide information as requested and then shall be recused (leave the room), and shall not participate in the deliberation on the merits of the proposal or the vote.

c) Abstention - When an Advisory Committee member does not have a financial interest or duality of interest in a grant proposal but decides not to vote on a particular matter, the Advisory Committee member may voluntarily abstain (shall not vote), but may remain in the room during the discussion, deliberation and vote.

d) Removal for Cause - Members will be removed for inappropriate or abusive behavior while conducting LIEED Advisory Committee business, including but not limited to falsification and/or failure to disclose any conflict of interest. In these instances, the Director of DHHS, the Co-Chairs and the leader of the community entity will review all pertinent information; and reasonable notice and opportunity to be heard will take place before determining what course of action will be required. Their determination is deemed final.

G. Sub Committees and Workgroups

As needed, sub committees and workgroups shall be convened by the LIEED Advisory Committee and may include subject matter experts outside of the Advisory Committee to address specific tasks which are then brought back to the entire Advisory Committee for action. The DHHS shall ensure that the sub committees and workgroups members have the resources, including the core administrative support needed for successful completion of their work. Any workgroups formed must be chaired by a member of the Advisory Committee.

Additionally, Advisory Committee members will comply with authorized release time of confidential information and/or documents in the course of official LIEED Advisory Committee.

H. Books and Records

The LIEED staff will ensure that they shall keep minutes of all proceedings of the Advisory Committee, a summary of major decisions and such other books and records as may be required for proper conduct of its business and affairs.

I. Amendments to the LIEED Advisory Committee Framework

Any proposals for revision to this document shall be presented to the Co-Chairs and Advisory Committee for discussion. Approval of two-thirds (2/3) of the membership is required for ratification

Montgomery County Department of Health and Human Services

Minority Health Initiatives/Program Advisory Committee Report:

Eliminating Disparities and Providing Equitable and Quality Services to Racial/Ethnic Communities in Montgomery County

February 2013

Contents

MHI/P Advisory Group Members

- **Uma Ahluwalia**: Director, DHHS
- **Fernanda Bianchi**: Latino Health Steering Committee
- **Sara Black**: Acting Chief, Special Needs Housing, DHHS
- **Perry Chan**: Acting Program Manager, Asian American Health Initiative
- **Raymond Crowel**: Chief, Behavioral Health & Crisis Services, DHHS
- **Wilbur Friedman**: Steering Committee, Asian American Health Initiative
- **Dr. Marilyn Gaston:** Executive Committee, African American Health Program
- **Kate Garvey**: Chief & Social Service Officer, Children, Youth & Family Services, DHHS
- **Pat Grant**: Executive Committee, African American Health Program
- **Arva Jackson**: Executive Committee, African American Health Program
- **Jay Kenney**: Chief, Aging & Disability Services, DHHS
- **Nadim Khan**: Chief, Special Needs Housing, DHHS
- **Betty Lam**: Chief, Office of Community Affairs, DHHS
- **Helen Lettlow**: Deputy Health Officer, Public Health Services, DHHS
- **Rose Martinez**: Latino Health Steering Committee
- **Henry Montes**: Latino Health Steering Committee
- **Sonia Mora**: Program Manager, Latino Health Initiative
- **Sam Mukherjee**: Steering Committee, Asian American Health Initiative
- **Grace Rivera**-Oven: Latino Health Steering Committee
- **Dourakine Rosarion**: Special Assistant to the Director, DHHS
- **Wendy Shiau**: Steering Committee, Asian American Health Initiative
- **Ulder Tillman, MD**: Chief & Health Officer, Public Health Services, DHHS
- **Diego Uriburu**: Latino Health Steering Committee
- **Robert Walker**: Executive Committee, African American Health Program

Background

In the late 1990s/early 2000s, the Department of Health and Human Services(DHHS) established The African-American Health Program, the Asian American Health Initiative and the Latino Health Initiative, collectively the Minority Health Initiatives/Program (MHI/P) to better meet the health needs of minorities in Montgomery County. Guided by respective Executive/Steering Committees comprised of community leaders and volunteers, the MHI/P have been highly effective at building and leveraging community relationships to address issues of health disparities, access, and quality of care.

Significant changes have occurred in Montgomery County since the MHI/P were established at the turn of the century, including rapid growth of these and other racial/ethnic minority populations including communities of African, Caribbean and Middle Eastern heritage. Recognition and understanding of the impact of social determinants of health have also continued to influence service delivery and the design of programs to serve racial/ethnic minority communities. Additionally, the County has felt the pressures of a challenging national economy. These factors, among others, led DHHS to re-examine its efforts to serve racially, ethnically and linguistically diverse communities in order to best leverage its resources and achieve maximum impact.

In the summer of 2011, DHHS created a framework to guide an assessment of the MHI/P. The Department's vision was to "implement an inclusive and comprehensive assessment process where all possibilities and options for the (possible) reorganization of the MHI/P are identified, explored, discussed and agreed upon by various key internal and external stakeholders."

To accomplish the assessment, an Advisory Group composed of community representatives from each of the MHI/P Executive/Steering Committees, HHS Service Chiefs, Managers of the MHI/P and the Director of DHHS was established under the auspices of the Office of Community Affairs (which manages the MHI/P). The mission of the MHI/P Advisory Group was to create a road map for DHHS to guide the future functioning of the MHI/P with a focus on health equity, social determinants of health, and the elimination of racial and ethnic health disparities while building on the value, purpose and effectiveness of the initiatives/program.

The MHI/P Assessment Process

The Advisory Group met for three hours once or twice a month over a 20- month period to accomplish their task. The work was undertaken in two phases. Phase One – Discovery and Learning – provided an opportunity for the Advisory Group members to gain a deeper understanding of community needs, programs and services provided by DHHS, and opportunities for collaboration across DHHS. Phase Two was devoted to identifying priority areas and developing specific recommendations that needed to be addressed in order to better serve racial/ethnic minority populations, including the emerging communities previously mentioned.

As a result of these activities, the Advisory Group formulated an outcome goal for the process, which would guide their work:

> ***To enhance HHS practice, policy and infrastructure to best serve racially, linguistically and ethnically diverse communities, including emerging populations, and explore and recommend the roles of the MHI/P as integral to the department.***

While the process began with a focus on the MHI/P, this goal statement recognized that the effort should be an integrated, department-wide focus on equity and elimination of disparities. As such, it was determined that attention should be given to how to promote and encourage collaboration and coordination across the DHHS with a focus on leveraging the knowledge, expertise, and community relationships of the MHI/P to inform and support the elimination of racial/ethnic disparities and promote equity goals across the DHHS.

The Group agreed on a very inclusive decision-making protocol for all key issues, including priority areas and recommendations. The process employed for this effort not only resulted in recommendations to strengthen the department's ability to better serve racial/ethnic minority, including emerging populations but, equally important, helped to build broader relationships among and across key stakeholders in the community and DHHS.

Priority Areas and Recommendations

The priorities and recommendations unanimously approved by the Advisory Group evolved from detailed discussions of key themes and opportunities identified during the Learning and Discovery Phase. It was determined that they offered the best short to midterm (2-5 years) opportunities to leverage the MHI/P's capacity, experiences and expertise, and to strengthen collaborations and enhance the efforts of DHHS and outside entities to properly serve racial/ethnic minority populations, eliminate disparities and promote/achieve equity.

Below are the priority areas and their respective recommendations. It should be noted that, in order to allow maximum flexibility for addressing the issues as most appropriate with time and resources available and, in recognition that there may be opportunities to simultaneously address multiple issues, the Priority Areas are not in any particular order of importance.

Priority Area	Recommendation
Systemic and Systematic Approach *Use systemic and systematic approaches to develop, implement, review and adjust/improve practices, policies and infrastructure of the department and its contractors to better serve racial/ ethnic minorities and emerging populations with the goal of eliminating disparities.*	Ensure that HHS and its contractors focus on the delivery of culturally and linguistically competent services for racial ethnic minorities and emerging populations with the goal of eliminating disparities. Ensure that service areas and other HHS offices, including administrative units, work collaboratively with MHI/P to systematically plan and consistently provide culturally and linguistically competent services. Standardize and embed the collection, analysis and reporting (internal and external) of racial and ethnic data with an intent to improve the development of policy, prioritization of HHS investment and delivery of services. Ensure ongoing engagement with the community to assess the cultural and linguistic competency of existing systems and services, and to gather information and knowledge necessary to develop culturally appropriate practices and services.

Priority Area	Recommendation
Access to and Delivery of Quality and Equitable Services *Ensure equitable access to and delivery of quality services and programs provided by HHS and its contractors to serve racial/ ethnic minorities and emerging populations.*	Increase utilization of HHS services and programs serving racial ethnic minorities and emerging populations with the goal of eliminating disparities by enhancing cultural and linguistic competencies especially at points of entry to services. Identify and eliminate unnecessary HHS policies, processes and systems that pose barriers to utilization and/or decrease quality of services. Strengthen programmatic monitoring and oversight of all HHS contractors to ensure timely and quality services for racial/ethnic minorities and emerging populations with the goal of eliminating disparities. Ensure racial/ethnic and emerging populations are knowledgeable of HHS services and resources and how to access them by developing and implementing comprehensive, culturally and linguistically competent communication and outreach strategies. Operationalize a "no wrong door" model to HHS services and resources by simplifying access at all points of entry and by increasing coordination and integration throughout the health and human service continuum, using such approaches as one-stop shops and the Tess Center model. Evaluate and improve cultural competence of services and programs, as necessary to meet cultural, linguistic, health literacy needs to increase utilization of service.
HHS Workforce *Ensure that the diversity of the DHHS workforce at all levels of staff, from leadership to program delivery, is proportional to the County's demographics. In addition, ensure that staff has the skills, experience, and capacity to effectively serve racial/ ethnic minorities and emerging populations with the goal of eliminating disparities.*	Examine current DHHS workforce to identify gaps in representation that will lead to the establishment of a comprehensive and systematic strategy to recruit, select, develop, promote, and retain a workforce that is culturally and linguistically competent and representative of the racial/ethnic minorities and emerging populations benefiting from or in greatest need of HHS services with the goal of eliminating disparities. Actively involve MHI/P in the: • Development of future workforce, based on cultural diversity and programmatic needs; and • Recruitment process along with MHI/P Advisory Group and community partners to increase the diversity and chances for success

Priority Area	Recommendation
Accountability *Identify accountability processes to monitor progress of the implementation of the final recommendations*	Establish an MHI/P Advisory Committee comprised of HHS staff, MHI/P Steering/Executive Committee representatives, as well as representatives from emerging populations, to monitor and assess the progress of the implementation of final priority areas and recommendations.

The Future of the MHI/P

The Advisory Group recognized that the MHI/P do not currently have the breadth and depth of resources required to affect health disparities at a large scale or to fully address the needs of other emerging racial and ethnic groups. Perhaps more importantly, the Group recognized that eliminating health disparities and ensuring equitable treatment of all consumers could not be the responsibility of any one program within DHHS. To be successful, responsibility would have to be embedded across all aspects of the department's operations including programs and services, technology, and administrative functions. As such, the critical need to institutionalize department-wide policies and practices to better serve racial and ethnic groups became paramount.

While the approach to eliminating disparities and ensuring equity must be a department-wide strategy, the MHI/P have vast knowledge, expertise and experiences that provide a solid foundation upon which to build and support an integrated, department-wide effort to better meet the needs of racially/ethnically diverse communities. Hence, the Advisory Group's recommendations for operational and structural changes leverage the considerable strengths of the MHI/P while also enhancing the department's capacity and capability to eliminate disparities and inequities and provide quality service to the County's racial/ethnic minority communities.

The Advisory Group recommends that the roles of the MHI/P be expanded to encompass activities that support department-wide efforts to eliminate health and other disparities and achieve equity while continuing their population-targeted programs and services. The Group further recommends that a Leadership Institute for Equity and Elimination of Disparities (LIEED) be established under the auspices of the Office of Community Affairs (OCA). The LIEED would bring together the MHI/P, the Equity Work Group and related outreach functions of the OCA in order to provide greater collaboration and coordination among these closely-related key activities. With the breadth, depth and scope of experiences working with the racial/ethnic minority populations of Montgomery County, an Institute which brings the functions together would serve as a bridge to the underserved communities.

The mission of the LIEED within HHS is:

To address social determinants of health with the goal of contributing to eliminating disparities and achieving equity among racial/ethnic minorities and other under-served groups of Montgomery County.

Function and Roles of the LIEED

The LIEED will support the DHHS commitment to create a coordinated and integrated department-wide focus on equity and the elimination of health and other disparities by facilitating internal and external collaborations and partnerships that emphasize holistic, integrated and sustainable strategies and approaches.

The table that follows provides an overview of the proposed functions of the LIEED. The proposed functions will include population-specific and cross-cutting activities, as appropriate.

Strategic Leader and Coordinator   *Serve as the coordinating entity pertaining to eliminating disparities and promoting equity in HHS and outside the Department, as appropriate.*
Capacity Builder   *Provide technical assistance, guidance, and support to public and private entities interested in enhancing services to racial and ethnic minorities, and emerging populations, with the goal of eliminating disparities.*
Resource Partner and Collaborator   *Collaborate with internal and external partners on specific projects related to eliminating disparities and achieving equity. Serve as a resource to others.*
Liaison/Broker in Effective Community Engagement   *Assist with the flow of communication and establishment of relationships among DHHS programs and members of racial and ethnic communities, as well as emerging population groups.*
Opportunity Seeker, Incubator and Innovator   *Develop models of programs and services to adequately serve racial and ethnic minorities, as well as emerging populations*
Community Advocate   *Advocate internally and externally for policies and services to eliminate disparities and achieve equity among racial/ethnic minorities and other emerging groups.*

The LIEED will support DHHS efforts and respond to community needs by:

- Leveraging the capacity, experience and expertise of the MHI/P staff and Steering/Executive Committees.
- Promoting equity principles throughout the DHHS
- Coordinating efforts pertaining to racially/ethnic diverse populations and equity across the Department.
- Facilitating systematic integration i.e., (program planning, outreach, communications, policy development, resource allocation, etc.) among the MHI/P and the rest of the Department.
- Linking key programmatic and administrative activities within the Office of Community Affairs
- Maximizing resources to create efficiencies of scale
- Increasing potential for sustainability

Structure of the LIEED

As mentioned earlier, the LIEED will be formed by combining the work of the existing MHI/P, Equity Work Group, and OCA outreach efforts. Under the general supervision of the Chief of the OCA and with support and guidance from the Advisory Group, the LIEED will have two major components:

1. MHI/P Community Programs and Activities:

As currently established, MHI/P will continue to provide direct population-specific interventions to the African American, Asian, and Latino populations in addition to two community programs serving emerging populations (African Immigrants, Caribbean, and other new American groups).

2. Systems Enhancement:

This component will focus on holistic and integrated interventions aimed at institutionalizing culturally and linguistically appropriate and equitable policies, guidelines, infrastructure and practices within DHHS. In addition, this component will lead the process of increasing visibility and building capacity for sustainability with community/public/private-sector partners at the local, state and national levels, as appropriate.

Next Steps

The establishment of the LIEED will be incrementally phased-in over a two to three year period, beginning in July 2013, contingent on the availability of appropriate resources.

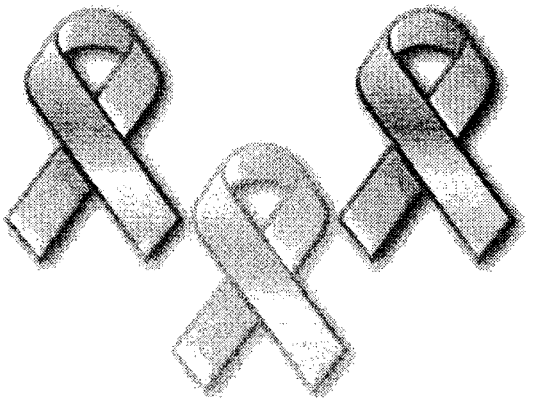
DHHS will develop a specific work plan to guide the implementation of the Advisory Group's recommendations. In addition, the Advisory Group will remain active to support and monitor the work; it will also be expanded to include representatives from emerging populations.

To fully implement the recommendations of the Advisory Group, there is an understanding that there will be a need to increase staffing and other support to effectively and efficiently carry out LIEED operations and activities. In terms of staffing, the Advisory Group recommends the reclassification of key current positions to perform higher level work of the Institute, requests the creation new positions and evaluation of the feasibility of converting contracted positions to County positions. It will also be essential to allocate operating funding for additional technical assistance as well as to co-locate program staff of OCA to maximize coordination.

African American Health Program

ANNUAL REPORT

The Power and Promise of Prevention



FISCAL YEAR 2013
JULY 1, 2012 – JUNE 30, 2013

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AAHP HISTORY AND OVERVIEW

The African American Health Program (AAHP) was created and funded in 1999 by the Montgomery County Department of Health and Human Services (DHHS).

VISION

African Americans and people of African descent in Montgomery County will be as healthy and safe as the rest of the population.

MISSION

Eliminate health disparities and improve the number and quality of years of life for African Americans and people of African descent in Montgomery County, MD.

GOALS

1. Raise awareness in the Montgomery County community about key health disparities.
2. Integrate African American health concerns into existing services and programs.
3. Monitor health status data for African Americans in Montgomery County.
4. Implement and evaluate strategies to achieve specific health objectives.

STRATEGY

Bring together community partners and resources in a collaborative and effective manner to support AAHP goals.

AAHP focuses on six major health areas: infant mortality, HIV/AIDS, diabetes, oral health, cardiovascular disease, and cancer. Services provided include outreach, health education, counseling, support groups, and nurse case management. The program is staffed by registered nurses, health educators, and community outreach personnel.

AAHP operates in conjunction with a volunteer executive committee that provides advisory and strategic planning and advocates for the program. In addition to the committee, there are two community-based coalitions focused on infant mortality and HIV/AIDS. The coalitions provide support and advocacy for AAHP initiatives as well as feedback on AAHP activities. In addition, the Diabetes Unit is guided by an advisory group, which is required for accreditation by the American Association of Diabetes Educators.

FUNDING

AAHP is funded by the Montgomery County DHHS and administered by BETAH Associates, Inc. The program receives additional funding from Holy Cross Hospital through the Minority Outreach and Technical Assistance (MOTA) award, provides funding for AAHP health promoters in their efforts to encourage improvement of the health care status of African Americans and individuals of African descent by facilitating health education, disease prevention and screening, and other outreach activities. AAHP also participated in the ABCS (Aspirin, Blood Pressure control, Cholesterol control and Smoking cessation counseling) or One Million Hearts program. The project was a DHHS project for reducing cardiovascular risk factors, morbidity and mortality among low-income, uninsured county residents.

A YEAR IN REVIEW

FOCUS ON PREVENTION

During fiscal year 2013, AAHP continued to address health disparities in Montgomery County through outreach, education, referrals, and events. Looking back at this year, we are reminded of the importance of prevention. Improving quality of life for African Americans and people of African descent hinges upon the education of individuals, communities, and organizations. AAHP aims to empower and partner with others to prevent not only health disparities but also specific health conditions.

Without question, prevention is the core around which all AAHP activities are based. This year, the program's prevention-related activities were abundant in each of the six focus areas. Detailed information about such activities is provided through this annual report. The following synopsis outlines the primary services offered in support of each focus area's prevention-driven goal.

	Infant Mortality	Diabetes	HIV/AIDS
GOALS	*Reduce pre-term deliveries and low birth weights, primary causes of infant mortality*	*Consumer prevention and management of diabetes and pre-diabetes as well as associated health conditions*	*Prevent the spread of infection and, for those who have HIV, circumvent the onset of AIDS and complications*
ACTIVITIES	– Nurse Case Management – Home Visits – Childbirth Education – Lactation Education – Breast Pump Program	– Blood Glucose Testing – Education Classes – Dining Clubs (includes educational and physical activities) – Individualized Counseling	– Regular HIV Testing Events and Campaigns – Teen Summits – Counseling and Referral – Preventive Health Education for Inmates
	Cardiovascular	**Cancer**	**Oral Health**
GOALS	*Reduce or eliminate risk factors that predispose African Americans to cardiovascular diseases*	*Reduce controllable risks that increase the likelihood of cancer diagnoses and related health issues*	*Promote healthy oral care and reduce oral diseases and conditions that can lead to more serious conditions*
ACTIVITIES	– Heart Health Screening (can include assessment of blood pressure, body mass index, glucose, and oral health) – Wellness Walks and Events	– Distribution of resources around health and hygiene – Referrals for screening (e.g., mammograms) – Education designed for French-speaking African Immigrants	– Oral Health presentations during outreach – Distribution of oral health kits (include toothpaste, toothbrush, and floss)

The AAHP team will continue to place great emphasis on prevention in the year to come. Ongoing efforts around health screening and preventive education will be strengthened and expanded. In large part, it is through prevention that AAHP will achieve its goal to eliminate health disparities and improve the number and quality of years of life for African Americans and people of African descent in Montgomery County.

SUCCESS: BY THE NUMBERS

388 Montgomery County residents tested for HIV (all with negative results)

82 Circle of Friends walking group members

6,077 Montgomery County residents who received support from AAHP

364 French-speaking day-laborers reached by Projet Santé Pour Tous (Health for All Project)

1,980 Oral health kits distributed

199 Women referred to S.M.I.L.E. by other County agencies and programs

127 Heart Health Screening Day Attendees

94 Percent of full-term deliveries by S.M.I.L.E. participants

714 Hours of diabetes class instruction administered

African American Health Program

70 Teen participants in the *MoCo Getting Real and Going In* Teen Summits

876 Hours of instruction administered through Diabetes Dining Clubs

20 One-on-one counseling sessions conducted by a Certified Diabetes Nurse Educator

2,183 Community members reached by health promoters

27 Pregnant women who attended the Childbirth and Breastfeeding Education Series

49 Inmate participants in the WIGO program

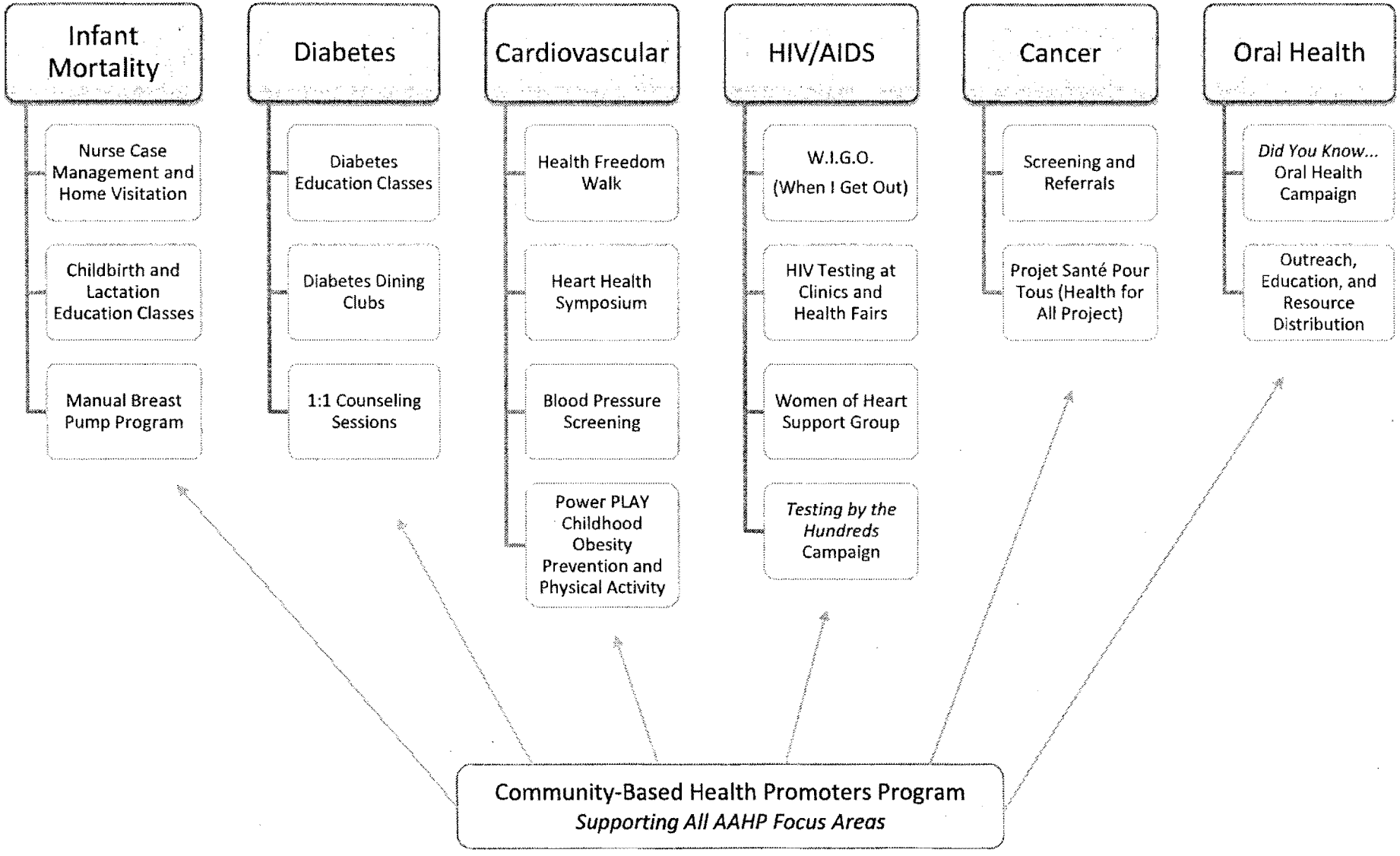
216 Recipients of S.M.I.L.E. nurse case management services

202 Outreach events conducted by health promoters

44 Crib and car seat vouchers distributed to participants who completed childbirth and lactation classes

1,477 Home visits conducted by nurse case managers

PROGRAM FOCUS AREAS AND INITIATIVES



ACCOMPLISHMENTS BY FOCUS AREA

INFANT MORTALITY

A disproportionately high infant mortality rate exists in the African American population. Black women are more likely than White and Hispanic women to experience infant mortality in the first year of their child's life. They are also more likely to experience infant mortality as a result of low birth weight, Sudden Infant Death Syndrome (SIDS), and maternal complications during pregnancy. According to the Maryland Department of Health and Mental Hygiene, in Montgomery County in 2010, the rate of infant deaths per 1000 live births was 4.3. The mortality rate for White infants was 3.3 and the rate for Latino infants was 3.7, but for African Americans, it was 7 – roughly double the rate of other groups. *Source: Healthy Montgomery, www.healthymontgomery.org.*

Start More Infants Living Equally healthy (S.M.I.L.E.) Program

S.M.I.L.E. is a health program that focuses on the development and maintenance of a healthy lifestyle for pregnant and postpartum women. Registered nurses conduct home visits to high-risk prenatal women as well as new mothers and their infants. Among the various factors that ensure the success of S.M.I.L.E. is the staff's commitment to building strong relationships with community partners. During this fiscal year, 497 referrals were made to other support programs in the community. In addition, 199 individuals were referred to S.M.I.L.E. by other County agencies and programs.

Nurse Case Management

Case management services are provided to women before and after they give birth until their infants' first birthdays. During this fiscal year, AAHP provided case management services to 216 families and conducted 1,477 home visits. Of the 216 clients served, 118 were prenatal women and 98 post-partum women with their infants. Home visits helped AAHP nurse case managers to achieve their goal of reducing pre-term deliveries and low birth weights.

Breast Pump Loan Program/Manual Breast Pump Program

It is important for women to understand the benefits of breastfeeding and be comfortable when nursing their babies. All S.M.I.L.E. participants are encouraged to breastfeed. On average, 66% of participants breastfed their infants for at least three months. This is significantly greater than the national average of 40%, as reported by the Centers for Disease Control and Prevention in 2010. The breast pump loan program provides qualifying mothers with breast pumps, breast-pump kits, and breastfeeding training with a certified lactation consultant. To qualify, a mother must be a resident of Montgomery County, have proof of a negative HIV test, and be simultaneously breastfeeding and returning to the workplace or school. During the fiscal year, the decision was made that the program would be more effective if mothers were given manual breast pumps to keep.

Childbirth and Lactation Education Series

Free childbirth and lactation classes are offered twice a year to Montgomery County residents. The series consists of six hours of interactive instruction time, which is divided across two or three days.

Among the many topics addressed by the series, the curriculum includes information on the anatomy of pregnancy and fetal development, special pregnancy circumstances, the childbirth process, what to expect at the hospital, breastfeeding, newborn care, and car seat safety.

Childbirth and Lactation Education Series Statistics: Fiscal Year Totals							
Pregnant Women Present	Race of Pregnant Women Present				Fathers Present	Car Seat Vouchers	Crib Vouchers
	African American or African Descent	Latina	Asian	Caucasian			
27	26	0	0	1	17	26	18

All participants who completed the six-hour class were offered a hygiene kit, a Pack 'n Play crib or car seat voucher, and an AAHP tote bag containing pregnancy-related materials.

Data Collection

Consistent with the Montgomery County DHHS focus on tracking performance and outcomes for all programs supported by the agency, the AAHP team continued to focus on measurable outcomes. Working with the S.M.I.L.E. nurses, nurse supervisor, and others within DHHS, the AAHP Executive Committee's Data Subcommittee streamlined the enhanced data system to include records and data sets that resulted in key indicators that may show correlations with birth outcomes. Records and fields within the data system continued to be revised and enhanced based on the input of the Subcommittee throughout the fiscal year.

Of the 71 deliveries during the fiscal year, 66 were full-term and 94% of the infants were born with healthy weights.

Quarter	Prenatal client referrals to SMILE	Home visits	Term deliveries	Pre-term deliveries	Low-birth-weight infants	Very-low-birth-weight infants
First	47	425	12	2*	2[+]	0
Second	58	268	11	2**	2[++]	0
Third	61	393	18	1***	0	0
Fourth	33	391	25	0	0	0
Total	199	1,477	66	5	4	0

** One induced due to maternal hypertension, and the second due to the mother's history of pre-term labor.*

*** Delivered at 36 weeks gestation (no weight recorded)*

****Delivered at 36 weeks (5lbs, 12oz)*

[+]Set of twins (4lbs, 7oz and 5lbs, 2oz)

[++]No additional information available

DIABETES

Diabetes is a lifelong disease marked by high levels of glucose in the bloodstream. People with diabetes cannot properly convert food into energy due to their inability to make or use insulin. According to the Maryland Behavioral Risk Factor Surveillance System, an estimated 25.8 million people, or 8.3% of the U.S. population, had diabetes in 2010. The disease disproportionately affects minority populations. In 2011 in Montgomery County, 5.1% of the adult population had diabetes, but the rate for Black adults was 7.8%, indicating a significant disparity. *Source: Healthy Montgomery, www.healthymontgomery.org.*

AAHP provides free self-management classes and education activities to residents of Montgomery County who desire to prevent or manage diabetes. During this fiscal year, AAHP offered one-on-one self-management counseling and coordinated education classes and dining clubs. These activities are intended to equip individuals with the knowledge to make positive changes in their management of nutrition, exercise, and medication to improve blood-glucose control and reduce the risk of complications associated with diabetes.

Diabetes Education Classes

Classes are accredited by the American Association of Diabetes Educators (AADE). AAHP was approved for continued endorsement this year. During fiscal year 2013, four-class series were held at various community centers and churches. Cumulative statistics follow.

Class Statistics: Fiscal Year Totals	
Hours of Class Instruction	714
Participants	76
Participants who completed all four classes	33
African American(AA)/African Immigrant (AI) Participants	62
Participants with Diabetes	52
African American Participants with Diabetes	40
African Immigrant Participants with Diabetes	3
Participants with Pre-Diabetes	6
AA/AI with Diabetes who have seen a dietitian	13

The positive impact of the classes on the participants is evident to the facilitators. In general, positive outcomes are lifestyle changes made by participants, and often involve weight loss, lower A1C test results, improved fruit and vegetable consumption, and increased physical activity.

Class Outcomes: Fiscal Year Totals	
Self-reported improvement in reading food labels	53%
Self-reported improvement of portion control	36%
Decline in A1C*	33%
Emergency room referrals due to in-class monitoring	2
Admissions to hospital resulting from referral	1

**Follow-up data available for 9 participants.*

Nightly class evaluation scores were consistently positive, with 85-100% of participants "satisfied" or "very satisfied" with the series.

Diabetes Dining Clubs

AAHP hosts three dining clubs to provide monthly support and education to people with diabetes or those working to prevent it. Events include educational presentations, 30 minutes of physical activity, discussion time, and meals chosen by a registered dietitian. During the fiscal year, a total of 876 hours of instruction were administered during dining clubs. Events were held at Goshen United Methodist Church, Mt. Calvary Baptist Church, and Indian Springs Park. Dining clubs do not meet during the winter.

African American Dining Clubs

The main objectives of the clubs this year were to address increased participation in physical activities at club meetings, and to improve diabetes knowledge. Through pre- and post-class evaluation, the majority of participants reported improved knowledge and increased consumption of fruits and vegetables with minimal increase reported in physical activity.

African American Dining Club: Fiscal Year Statistics			
Month	Topic	Activity	Attendees
July	Diabetes Jeopardy with Shop Rite RD	Dancing with Inger	23
Aug	A1C Champ Program	N/A	45
Sept	Food Labels	Square Dancing	40
Oct	What's next for club?	Hoops with Vera	36
Nov	Holiday Gathering (Healthy Eating)	Dancing	N/A
Mar	Diabetes Tidbits	Chair Dancing	39
Apr	Wise Weight Watchers	Exercising at Home	33
May	Monitoring and Medications	Chair Volleyball	23
Jun	Physical Activity and Summer Drinks	Indoor/Outdoor Play	10

African Healthy Living Dining Club

Established in March 2013, this club is designed to support African immigrants, an emerging population in the County. It aims to teach about nutritional content of foods from Africa and the United States, and to support engagement in healthy eating habits, especially for those with diabetes. As the club is new, AAHP's primary objectives this year were to increase outreach and attendance. The team rescheduled gatherings from weekdays to Saturday mornings, moved meetings from a park building to the Silver Spring Civic Center, and reduced the cost of catered meals by partnering with local restaurants.

African Healthy Living Dining Club: Fiscal Year Statistics			
Month	Topic	Activity	Attendees
July	Know Your Numbers and Food Labels	Exercise	7
Aug	A1C Champ Program	N/A	5
Sept	Foot Care	Chair Exercise	7
Oct	What's Next for Club?	(none)	8
Nov	Holiday Gathering (Healthy Eating)	Dancing	N/A
Mar	*Cancelled Due to Inclement Weather*	N/A	N/A
Apr	Diabetes 101	Weight and Scarves	9
May	Blood Glucose Monitoring/Reducing Complications/ Healthy Cooking Oils	Chair Volleyball	10
Jun	Medication: Culture, Access, What They Do	Indoor and Outdoor Play	7

Behavior Changes

Data to assess changes in fruit and vegetable consumption, knowledge scores, number of days of physical activity, and weight change were collected in May and June for all club members. The following chart compares those figures to that of the club members when they entered the club.

Dining Club Member Behavior Changes						
Measure	Members Assessed	Improved	No Change	Regressed	Pre-Club Average	Post-Club Average
Fruit/Vegetable Consumption	33	19 (58%)	7 (21%)	7 (21%)	3.3	4.2
Knowledge Score	32	25 (78%)	4 (13%)	3 (9%)	3.5	6.4
Physical Activity (in days per week)	30	13 (43%)	5 (17%)	12 (40%)	3.2	3.1
Weight Change*	38	19 (50%)	4 (11%)	15 (39%)	194.9	192.6

**A change in weight that is less than or equal to one pound is reported as no change.*

1:1 Diabetes Counseling

The AAHP Certified Diabetes Nurse Educator (CDNE) provides one-on-one self-management counseling sessions with clients referred from the diabetes education classes and dining clubs. During an initial consultation, a client's diabetes knowledge and current treatment plan are reviewed. The client and educator then develop, implement, and evaluate an individualized plan of care. During each visit, glucose levels and vital signs are collected and any abnormal data are communicated to the client's primary care provider.

A new AAHP CDNE was hired in May 2013. Her work began immediately, scheduling counseling appointments and networking with other community organizations and professionals.

This fiscal year, AAHP facilitated 20 individual counseling sessions. Each of the 20 clients received instruction on glucose meters and/or insulin administration.

CARDIOVASCULAR HEALTH

Cardiovascular disease, also called heart disease, is a term that encompasses a variety of different diseases affecting the heart and is the leading cause of death in the United States, accounting for 25.4% of total deaths. According to the Maryland Department of Health and Mental Hygiene, between 2009 and 2011 in Montgomery County, heart disease was responsible for 124.7 deaths per 100,000 population. *Source: Healthy Montgomery, www.healthymontgomery.org.*

African Americans are more likely to die from heart disease than non-Hispanic Whites. Major risk factors for cardiovascular disease include hypertension, obesity, smoking, high salt intake, stress, and sedentary lifestyle. AAHP facilitates events and education opportunities designed to help eliminate risk factors that predispose African Americans to cardiovascular disease.

During this fiscal year, 2,183 community members were reached by AAHP health promoters. Each contact was offered screening for pre-hypertension and hypertension. Twenty-three of the individuals tested were hypertensive or pre-hypertensive and counseled to meet with their health care providers. These screenings proved essential to AAHP's efforts to engage community members in individualized education.

ABCS Program

Under a grant to the County from the Centers for Disease Control and Prevention, AAHP participated in CDC's Million Hearts initiative designed to improve the management of ABCS (Aspirin for high risk patients, Blood pressure control, Cholesterol management, and Smoking cessation). AAHP's health educator and health promoters specially trained to identify persons at possible risk participated in health fairs and other community outreach activities. Blood pressure screening was provided and those identified to be at risk were referred to partner clinics in the community.

Heart Health Screening Day

On February 16, 2013, AAHP and Holy Cross Hospital jointly sponsored the sixth annual Heart Health Day. The fair included screenings for oral health, blood pressure, body mass index, glucose, and cholesterol. There were 127 community members present at the event.

Health Freedom: A Path to Wellness Program

The Health Freedom Walk, a 3.75-mile adventure, is an innovative event that promotes increased physical activity while making creative use of Maryland's integral role in the Underground Railroad. For six weeks prior to the walk, 82 Health Freedom Walk Circle of Friends members met weekly to exercise and discuss how they will adopt healthier eating habits. The ninth annual walk, scheduled for June 8, 2013, was cancelled due to inclement weather. In place of the walk, and in partnership with White Oak Recreation Center, AAHP introduced Power PLAY!, a fitness and nutrition program for children between the ages of 7 and 12. Approximately 40 children enrolled in activities of the three-day, camp-style program. On each day, trainers emphasized the importance of healthy eating habits and exercise through experiential activities geared toward the children.

HIV/AIDS

HIV/AIDS is a significant cause of illness, disability, and death. According to the Centers for Disease Control and Prevention, as of 2007, more than 576,000 Americans with AIDS have died since the start of the epidemic. African Americans are disproportionately affected by HIV/AIDS and the prevalence rates for HIV and AIDS diagnoses in Montgomery County are high compared with other counties in Maryland. In fact, according to the 2009 Maryland HIV/AIDS Epidemiological Profile, Montgomery County has the third highest rate of HIV/AIDS diagnosis in the state. The report showed that 1 in every 316 people is HIV-positive and that African Americans represent 71% of these cases. *Source: Healthy Montgomery, www.healthymontgomery.org.*

Individuals who are HIV-positive can manage the disease to stay healthy, delay the onset of AIDS, and circumvent some life-threatening conditions. From prevention to treatment, AAHP actively addresses

HIV/AIDS by providing education and facilitating counseling, testing, and referral. Robust community partnerships are vital to AAHP's success in establishing and sustaining HIV/AIDS education and wellness at the County level.

Testing, Counseling, and Referral Services

Throughout the fiscal year, testing services were provided at scheduled times at the Dennis Avenue STD Clinic. Testing was also conducted during various community outreach events.

HIV Testing Statistics	
Total Montgomery County Residents Tested	388
Males Tested	189
Females Tested	199
Negative Test Results	388
Positive Test Results	0

MoCo *Getting Real and Going In* Teen Summit

In observance of National Black HIV/AIDS Awareness Day, AAHP developed and conducted its second annual *Getting Real and Going In* summit for teens between the ages of 13 and 17. To make the event more accessible, summits were held in two locations – Silver Spring and Gaithersburg. Health promoters provided information on obesity, cardiovascular health, smoking cessation, cancer, infant mortality, and sexually transmitted diseases to a total of 70 teenaged participants. The Summit provided an opportunity for youth to openly discuss high-risk behaviors and their consequences.

The event, hosted by Angie Ange of WKYS 93.9 FM, and local celebrity Tray "Poot" Chaney, was made possible by the collaborative efforts of community partners. Most notably, the Montgomery County Department of Recreation provided avenues through which AAHP reached high schools to promote the event and encourage participation. The Department also organized transportation to the summits.

When I Get Out (WIGO) Program

Developed in 2007, WIGO is a four- to six-week (depending on unit requests), five-hour program to provide preventive health information to Montgomery County Detention Center inmates to prepare them for good health upon release. The program aims to motivate inmates to set goals and gain skills that will support healthy and safe lifestyles when they re-enter the community.

The WIGO curriculum addresses the topics of oral health, nutrition, mental health, HIV/AIDS, and other sexually transmitted diseases. In-class demonstrations include reading food labels, food portion modeling, proper condom use, and the effective use of a toothbrush and floss.

During this fiscal year, 49 inmates participated in the WIGO program. Feedback received from correctional officers demonstrates the program's impact.

> *"There has been a great change in most of the participants that have attended the health class. They have taken a much more positive role in their hygiene and the way they keep their cells. Most of these guys didn't have anyone to guide them or teach them what they are learning now. Most of them only had their mistakes to learn from."*
>
> *-Correctional Officer, Juvenile Boys Unit*

Women of Heart – HIV Support Group

The Centers for Disease Control and Prevention recommend various strategies to address the HIV epidemic. One approach is to encourage the inclusion of people living with HIV in prevention activities, such as support groups. This fiscal year, AAHP's Women of Heart support group for HIV-positive women met one weekend afternoon per month. The groups were not very well attended, but the team is working on new and innovative outreach methods around this delicate subject.

Journeys Substance Abuse Program – Rehabilitation Center

The AAHP HIV Unit provided monthly prevention STD & HIV education classes and HIV testing at Journeys, a substance abuse rehabilitation center for women, men, and teens. Approximately 70 residents were reached through activities at this site.

Testing by the Hundreds

This campaign started in FY2012 but the concept of working with other county agencies on HIV/AIDS awareness and reduction continued in FY2013. As a result of this engagement strategy, the team submitted a poster presentation abstract to the National Institutes of Health highlighting the campaign as an effective community engagement HIV testing model. The abstract was selected for a poster session during the day-long NIH Science of Eliminating Health Disparities Summit held at the Gaylord Hotel at the National Harbor on December 17, 2012. The poster session was well attended by the summit participants and the discussion generated great interest and positive feedback from the attendees.

CANCER

Cancer is the second leading cause of death in the United States–exceeded only by heart disease. Every year, more than one million people are diagnosed with cancer, an uncontrolled growth and spread of abnormal cells in the body. It is not one disease, but a group of more than 200 diseases. Some factors that lead to cancer can be controlled and others cannot. AAHP provides important health education resources to help community members understand the disease, reduce risk, and cope with diagnosis. For example, the health educator and health promoters demonstrate breast self-examination techniques to mobile medical van clients as well as to visitors to community health clinics and health fairs, and educational materials are distributed on prostrate and oral cancers

Projet Santé Pour Tous (Health for All Project)

Established in 2008, Projet Santé Pour Tous is a culturally-competent education program specifically designed to provide health education, screening, and health care access to French-speaking African immigrant laborers at the CASA de Maryland labor center. Health education sessions are led by the AAHP health educator and health promoters. In addition to cancer prevention and education, the project focuses on health topics such as oral and cardiovascular health, hygiene, healthy eating habits, and HIV. Approximately 364 laborers were reached through Projet Santé Pour Tous during this fiscal year.

ORAL HEALTH

Good oral health plays a major role in overall wellness. Daily brushing and flossing is important because oral health affects the entire body. Plaque can build up along the gum line when teeth and gums are not kept clean through daily brushing and flossing. This creates an environment where additional bacteria can accumulate in the space between the gums and teeth, leading to more serious problems. It is also important that good oral health for children begins at infancy.

The *"Did you know...?"* Campaign

AAHP's ongoing *"Did you know...?"* oral health campaign which started in 2011 educates Montgomery County residents on the importance of good oral health and how it relates to overall health. This fiscal year, AAHP distributed 1,980 oral health kits, which include a toothbrush, toothpaste, and floss. Oral health education is also provided during events such as childbirth and breastfeeding education classes, WIGO sessions, and Projet Santé Pour Tous activities.

COMMUNITY-BASED HEALTH PROMOTERS

The African American Health Promoters Program is an innovative approach to multiplying AAHP community outreach efforts. It uses a network of grassroots individuals (health promoters) who are trained to identify Montgomery County residents who have risk factors for various health disorders, including diabetes, HIV, high blood pressure, infant mortality, and cancer. Those at risk are referred to resources within the County providing health care services. Health promoters also educate the community about the need for early detection and screenings for various forms of cancer through partnership with the mobile medical van, the East County Community Men's Clinic, and health fairs.

All health promoters receive free training on various health topics from AAHP staff and partners. They also meet monthly to discuss strategies for communicating vital information to the community and attend conferences, health fairs, summits, and workshops. In addition, select health promoters attend additional meetings and training, as appropriate.

During this fiscal year, AAHP had 22 health promoters on staff. Six of these were men thus helping to expand outreach to the County's male population. Throughout the year, health promoters participated in 202 outreach events, reaching an estimated 2,183 community members.

AAHP TEAM

AAHP STAFF

Abimbola Idowu, MPA, DrPH
Project Director

Xerxeser Kayode, BSN
Deputy Project Director
Health Freedom Walk Chair

Denise Dixon, MS
HIV Unit Coordinator/Outreach Specialist

Msache Mwaluko, BS
Outreach Coordinator/Health Educator
Screening and Education Committee Chair

Nia M.J. Williams-Myles, RN, MSN-Edu., MPH
S.M.I.L.E. Senior Nurse Case Manager

Saundra Jackson, RN, BSN, CBE
S.M.I.L.E. Nurse Case Manager

Tannyka Coleman, RN, BSN, CM/DN
S.M.I.L.E. Nurse Case Manager

Diane Herron
Diabetes Community Outreach Specialist

Elna S. Narula, RN, BSN, CDE
Certified Diabetes Nurse Educator

HHS STAFF

Heather Ross, MS, CHES
HHS Program Manager

Linda Goldsholl, MS, RD
HHS Diabetes Program Manager

EXECUTIVE COMMITTEE

Pat Grant, BS
Co-Chair

Robert Walker, PhD
Co-Chair

Arva Jackson, MSW
Infant Mortality Coalition Chair
Liaison, Commission on Aging

Beatrice Miller, RN, MS
HIV/AIDS/STI Coalition Chair
Liaison, Healthy Montgomery

Jacquelyn Williams, MPH
Data Subcommittee Chair

Marilyn Gaston, MD, MPH
Data Subcommittee Co-Chair

Michelle Hawkins, DNP, MSN, MBA, RN, CCM
Liaison, Commission on Health

Patricia Horton, RN, MBA
Founding Member

Lizzie James, CRNP, MNSc
Founding Member

Art Williams, BA
Founding Member

HEALTH PROMOTERS (additional languages spoken)

Tirsit Adnew (Amharic)
Tammie Archie
Seid Ahmed (Amharic)
Karen Blanton
Seid Beshir (Amharic)
Ardandia Campbell
Divine Chiangeh
Abraham Desalegn (Amharic)
Viviane Makou (French)
Nancy Margai
Nana Martinson
Patricia Morris
Anita Mwalui (Kiswahili)
Enyerike P. Nwokekeh (Igbo)
Almaz Negresh (Amharic)
Jolene Ogunjirin (ASL)
Melanie Reynolds
Tamari Shunda (Kiswahili)
Evelyn Tandau (Kiswahili)
Rose Tchameni (French)
Eric Serge Toure (French, Russian)
Juliette Traore (French)

In addition to its staff and the Executive Committee, AAHP receives support from a host of individual community members and representatives from local community organizations.

COMMUNITY PARTNERS

- Alpha Kappa Alpha Sorority, Inc. (Gaithersburg-Xi Sigma Omega Chapter)
- Alpha Phi Alpha Fraternity, Inc.
- Boy and Girl Scouts of Troops 96 and 6260
- CASA of Maryland
- CHEER
- Cribs for Kids
- DC Family Alliance, Inc.
- Delta Sigma Theta Sorority, Inc. (Montgomery Alumnae Chapter)
- GapBuster Learning Center, Inc.
- GOALS, Inc.
- Good Hope Union United Methodist Church
- Goshen United Methodist Church
- Gwendolyn E. Coffield Community Center
- Health Freedom, Inc.
- HealthBeam Outreach, Inc.
- Heart to Hand, Inc.
- Holy Cross Hospital
- Journeys Treatment Center
- Lincoln Park Community Center
- Lincoln Park Historical Society
- Marilyn J. Praisner Community Center
- Medical Nutrition Consultant, LLC
- Mid-County Community Center
- Montgomery College (MC)–Takoma Park (TP) AIDS Resource Center
- MC-TP Nursing Department
- MC-TP Student Life Department
- MC Department of Health and Human Services STD Clinic
- MC Department of Parks
- MC Department of Recreation
- MC Minority Infant Mortality Reduction Pilot Project
- MC Office of Minority Health Resource Center
- Mt. Calvary Baptist Church
- RaC3, Inc.
- Radio One, Inc.
- Rockville Pregnancy Center
- Safe Kids Car Seat Program
- Sasha Bruce Youthwork, Inc.
- Shady Grove Fertility Center
- Southern Christian Leadership Conference
- Street Wize Foundation
- Sudden Infant Death Syndrome Mid-Atlantic
- Teen and Young Adult (TAYA) Health Connection
- Victory Christian Church
- Walgreens
- Walter Reed Army Medical Center
- Wheaton Public Library

In addition to collaborating with community partners, AAHP refers clients to other community supports. The following resources are those to which S.M.I.L.E. participants were referred for further assistance.

- Birthright
- Caring Connection
- Catholic Charities
- Child Care Connection
- Community Clinic, Inc.
- Depression Services
- Families Foremost
- Food and Friends
- Gaithersburg HELP
- Health Insurance
- Healthy Mothers Healthy Babies
- Healthy Start
- Holiday Giving Project
- Housing Opportunities Commission
- Infants at Risk
- Interfaith Works
- Job Training
- Manna Food
- Mission of Luv
- MHIP
- MOMS
- Rockville Pregnancy Center
- Services Eligibility Unit
- Shady Grove Pregnancy Center
- TAYA Clinic
- WIC Services
- Wider Circle Furniture

Asian American Health Initiative

Montgomery County, Maryland

Department of Health and Human Services

Annual Report FY 2013

Together to Build a Healthy Community

Message from Leadership

The Montgomery County Department of Health and Human Services' (MCDHHS) Asian American Health Initiative (AAHI) is proud to release its Fiscal Year 2013 (FY13) Annual Report to highlight its systematic efforts to eliminate health disparities affecting the Asian American community in Montgomery County. As the nation's fastest-growing racial or ethnic group in 2012, it is critical to understand and address the unique health needs of this diverse population. In FY13, AAHI implemented programs to improve access to culturally and linguistically competent care, and promoted health equity through community empowerment. AAHI also continued its efforts to enhance data collection and strengthen partnerships with key stakeholders within the County.

Together with the strong leadership and support of MCDHHS, the AAHI Steering Committee, community partners, and multilingual Health Promoters, AAHI completed yet another successful year. AAHI continued its commitment to reach the isolated and medically underserved Asian American community, from offering free hepatitis B screenings and vaccinations to conducting on-site health education and referrals to care for local small business employees.

In FY13, the MCDHHS Minority Health Initiatives/Program (MHI/P) continued to evolve. Leadership of MCDHHS, AAHI, the African American Health Program, and the Latino Health Initiative formed an advisory group to address equity and elimination of disparities. In FY14, the Leadership Institute for Equity and Elimination of Disparities (LIEED) will be established to enhance HHS practice, policy, and infrastructure to better serve racially, linguistically, and ethnically diverse communities, including emerging populations.

On behalf of AAHI leadership, we hope that you recognize our progress and take pride in our achievements of the past year. While much work remains to be done, we are dedicated to working alongside our committed partners and community members to achieve our vision *to build a healthy community.*

Sam Mukherjee, PhD, LCTC
AAHI Steering Committee Chair

Chun Man (Perry) Chan, MS, CHES
AAHI Program Manager

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About AAHI

BACKGROUND

AAHI was established in FY05 under MCDHHS with the support of the Montgomery County Executive, the County Council, and community leaders. Since its inception, AAHI has worked to address the unique health needs of the County's Asian American residents and eliminate the health disparities between them and their non-Asian counterparts. To do this, AAHI partners with various community- and faith-based organizations to collaboratively identify health care needs of the Asian American community and implement culturally competent and linguistically appropriate programs.

MISSION

To identify the health care needs of Asian American communities, develop culturally competent health care services, and implement health education programs that are accessible and available to all Asian Americans in Montgomery County.

COMMUNITY PROFILE

According to the 2010 U.S. Census, Asian Americans are the fastest growing racial population in the nation. Montgomery County's Asian American population reflects this rapid growth, increasing 37.3 percent between 2000 and 2010, making it the second fastest growing minority group in the County. The County's Asian American residents represent 13.9 percent (135,451) of the County's total population and 42.5 percent of Maryland's total Asian American population. Asian Americans are a linguistically and culturally diverse group with unique needs within each subgroup. The 2010 American Community Survey data shows that almost 75 percent of Montgomery County's Asian population are foreign born and 33 percent are linguistically isolated.

Fiscal Year 2013 at a Glance

Community Outreach Events

Health Promoters Program

Hepatitis B Prevention Services Project

Health Education Workshops

Empowering Community Health Organizations Project

Small Business Outreach

Fiscal Year 2013 Accomplishments at a Glance

Please see the respective sections for details.

Enhancing Access to Culturally and Linguistically Competent Care

- **Patient Navigator Program**
  - 5,798 client encounters
    - 4,225 calls received
    - 1,149 on-site medical interpreting sessions
    - 424 medical interpreting sessions by phone
  - 95% of clients linked to County services
  - 72% of callers reported not having insurance
- **ABCS Project**
  - 85 small businesses reached
  - 834 educational encounters
  - 792 pieces of literature distributed
  - 31 referrals
  - 84% of referrals resulted in appointments
- **Smoking Cessation Services**
  - 579 pieces of literature distributed
  - 520 educational encounters
  - 218 carbon monoxide screenings
- **Health Education in Ethnic Media**
  - 8 articles published
  - 5 media sources
  - 5 topics covered

Strengthening Partnerships and Collaborations

- **Komen Community-Assisted Mammogram Program**
  - 461 breast self-exam demonstrations
  - 360 referrals
- **Social Media: Facebook, Twitter, Blogger**
  - 6 AAHI e-newsletters sent
  - 189 social media posts
  - 3,333 views of AAHI's Facebook and Blogger posts

Promoting Community Mobilization and Empowerment

- **Health Promoters Program**
  - 35 Health Promoters
  - 15 languages and dialects spoken
  - 15 ethnic communities represented
  - 4 trainings offered
  - 12 new Health Promoters in FY13
  - 16 Health Promoters with 1-2 years of experience in the program
  - 19 Health Promoters with 3+ years of experience in the program
- **Community Outreach Events***
  - 54 outreach events
  - 20 ethnic communities reached
  - 9,167 pieces of literature distributed
  - 6,118 educational encounters
  - 854 health screenings/vaccinations
  - 758 health service referrals
- **Empowering Community Health Organizations Project**
  - 2 workshops
  - 84 individuals attended
  - 41 organizations represented

Connecting Communities to Services
- *294 small businesses and communities reached*
- *11 clinic outreach events*
- *4 resource information tables*
- *3,257 pieces of literature distributed*
- *1,566 educational encounters*
- *198 health service referrals*

Hepatitis B Prevention Services Project
- *38 participants*
- *100% of at-risk participants referred to vaccinations, of whom 85% completed the three-shot vaccination series*
- *50% of participants were not planning to get screened prior to participating in the project*
- *96% of participants reported they would urge family and friends to be screened and/or vaccinated*
- *96% of participants reported overall satisfaction with program*

Health Education Workshops
- *9 workshops conducted*
- *6 topics covered*
- *1,709 pieces of literature distributed*
- *1,314 educational encounters*
- *361 health service referrals*

**Cumulative total from ABCS project, smoking cessation services, Connecting Communities to Services, Hepatitis B Prevention Services Project, health education workshops, and Komen Community-Assisted Mammogram Program.*

Enhancing Data Collection and Reporting

- 2 hepatitis B evaluation reports published electronically
- 1 annual report published electronically

(9)

Enhancing Access to Culturally and Linguistically Competent Care

Montgomery County's Asian American community is tremendously diverse, encompassing over a dozen countries as well as speaking more than two dozen languages and dialects. Given the diversity and growth of the population, health care systems must implement culturally and linguistically tailored services in order to respond effectively to the community's health and social needs.

According to the Asian American Health Initiative's (AAHI) 2008 County-wide health needs assessment, Asian Americans experience challenges to accessing quality health care due to lack of health insurance, inadequate coverage, financial difficulties, transportation (particularly for seniors), language barriers, and limited access to Asian language health care providers.

In Fiscal Year 2013 (FY13), AAHI continued its longstanding initiatives— the Health Promoters and Patient Navigator Programs, in addition to the Health Education in Ethnic Media campaign— to eliminate such barriers as well as link County residents with essential primary and specialized health care services. AAHI also initiated efforts to provide information on health resources including smoking cessation services and the "ABCS" heart disease and stroke prevention project.

Through these efforts, AAHI continued its goal to reach the most underserved and vulnerable communities in the County, in particular, Asian Americans who experience limited English proficiency as well as social and cultural isolation. Moreover, AAHI continues to work with existing partners to forge new collaborations in order to increase access to free or low-cost preventative health services and treatment.

(68)

Highlights: Patient Navigator Program

The 2011 American Community Survey reported that 76.7% of Asian Americans spoke a language other than English at home. Of those individuals, 47% spoke English less than "very well."

- 2011 American Community Survey

Limited English proficiency (LEP) is a barrier to quality health care for many Asian Americans. When patients have difficulty communicating in a language comfortable to them, they may not successfully express their needs to providers. This may lead to inaccurate assessments, lower adherence to medication or follow-up care, decreased patient satisfaction, and ultimately poor health outcomes.

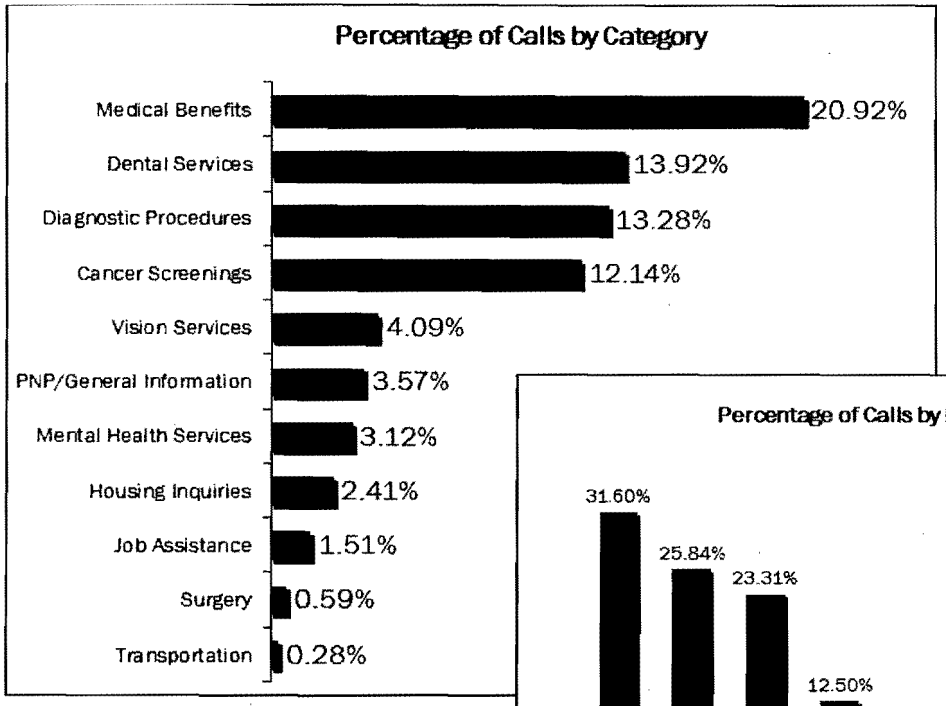
Providing LEP patients access to medical interpreters helps to overcome communication barriers. In partnership with Cross Cultural InfoTech, AAHI established the Patient Navigator Program in 2008. AAHI Patient Navigators go through rigorous training and certification in order to help community members navigate through the wide network of health and social services in Montgomery County.

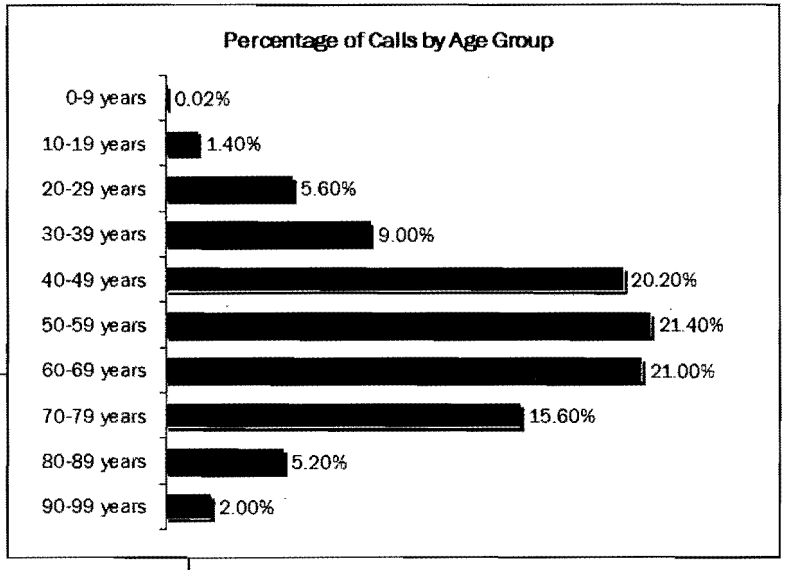
The program is comprised of two components: (1) the Multilingual Health Information and Referral Telephone Line which provides general health information and navigates callers to health care services and (2) Trained Multilingual Medical Interpreters who accompany clients to medical appointments providing face-to-face interpretation and translation of medical forms. Interpretation is available in four Asian languages: Chinese, Hindi, Korean, and Vietnamese.

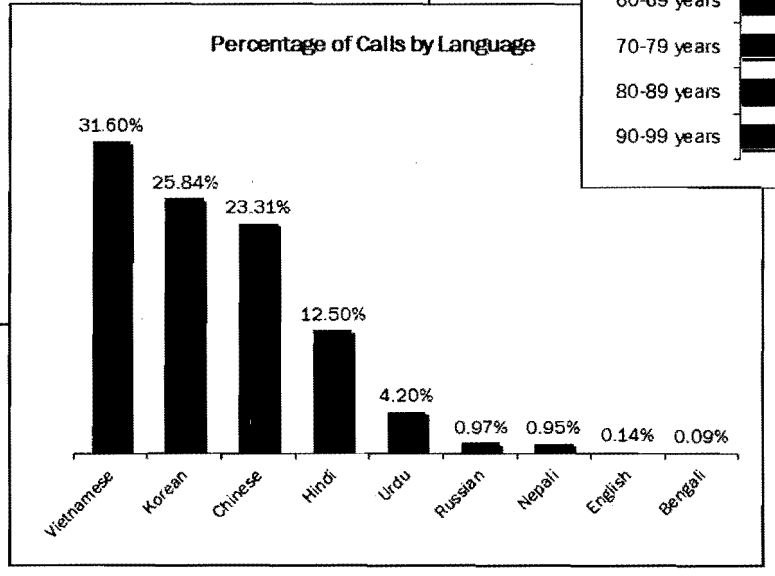
- **5,798 client encounters**
  - **4,225 calls received**
  - **1,149 on-site medical interpreting sessions**
  - **424 medical interpreting sessions by phone**
- **95% of clients linked to County services**
- **72% of callers reported not having insurance**

(8)

Highlights: Patient Navigator Program







Highlights: ABCS Project

Heart disease is the second leading cause of death for Asian Americans.

- *Centers for Disease Control and Prevention*

Be One in a Million Hearts℠

About Heart Disease & Stroke

Risk Factors

We're all at risk for heart disease and stroke. However, certain groups—including African Americans, older individuals, and women—are at higher risk than others. With more than 2 million heart attacks and strokes happening every year in the United States, it's important to know the risks.

Heart Disease and Age

Many people mistakenly think of heart disease and stroke as conditions that only affect older adults. However, a large number of younger people suffer heart attacks and strokes. More than 150,000 heart disease and stroke deaths every year are among people younger than 65.

Heart Disease and Race

Heart disease remains the leading cause of death in the United States for adults of all races. However, there are big differences in the rates of heart disease and stroke between different racial and ethnic groups. Some minority groups are more likely to be affected by heart disease and stroke than others—which contributes to lower life expectancy found among minorities.
As of 2007, African American men were 30% more likely to die from heart disease than were non-Hispanic white men. African American adults of both genders are 40% more likely to have high blood pressure and 10% less likely than their white counterparts to have their blood pressure under control. African Americans also have the highest rate of high blood pressure of all population groups, and they tend to develop it earlier in life than others.

The ABCS project is part of the Million Hearts initiative, a national effort launched by the U.S. Department of Health and Human Services with the goal to prevent 1 million heart attacks and strokes by 2017. Maryland's Million Hearts campaign plans to achieve this goal by improving the quality of care for heart disease and stroke prevention through the following ABCS approach:

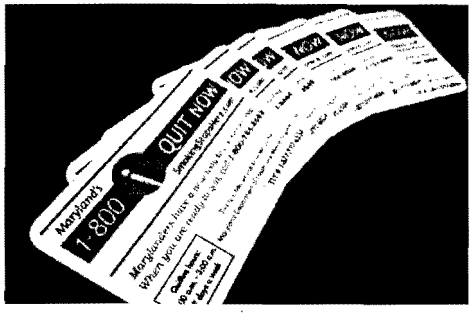
- Appropriate Aspirin Therapy
- Blood Pressure Control
- Cholesterol Management
- Smoking Cessation

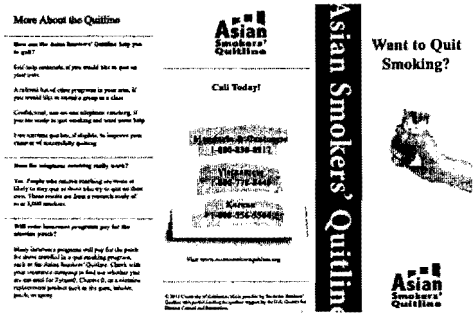
Through ABCS, AAHI works to increase awareness of the risk factors associated with heart disease and connect high-risk Montgomery County residents to preventative health services at local participating community clinics. AAHI's aim is to ensure that the Asian American community is well-informed about how to maintain heart health and the importance of getting screened for heart disease.

AAHI Health Promoters outreach to local small businesses as well as community- and faith-based organizations where most residents they encounter do not have time to obtain information about heart health nor visit a clinic for preventative checkups. Health Promoters conduct brief health education sessions on ABCS and work closely with community members to schedule appointments on their behalf. This interaction creates trusting bonds between Health Promoters and the community members they serve.

- **85 small businesses reached**
- **834 educational encounters**
- **792 pieces of literature distributed**
- **31 referrals**
- **84% of referrals resulted in appointments**

Highlights: Smoking Cessation Services





AAHI has engaged in tobacco use prevention and smoking cessation outreach since its inception. In addition to outreach and education, AAHI recognized that telephone quitline services have been proven to double a smoker's chance of quitting. In past years, AAHI promoted the statewide Maryland Quitline service to County residents. In FY13, AAHI expanded its efforts to increase Asian Americans' access to linguistically competent smoking cessation services through a partnership with the nationwide Asian Smokers' Quitline program.

The Maryland Quitline is a free service that offers one-on-one telephone counseling 24 hours a day, 7 days a week. Eligible callers can also receive a free supply of nicotine patches or gum. Asian Americans comfortable with English are referred to the Maryland Quitline.

The Asian Smokers' Quitline is a free nationwide program that offers self-help materials, one-on-one telephone counseling, and a free two-week starter kit of nicotine patches. Services are available in four languages: Cantonese, Mandarin, Korean, and Vietnamese. In FY13, AAHI received a mini-grant from the Asian Pacific Partners for Empowerment, Advocacy and Leadership (APPEAL) to promote the use of the Asian Smokers' Quitline. For further details, please see to the "Financials" section of this report.

- **579 pieces of literature distributed**
- **520 educational encounters**
- **218 carbon monoxide screenings**

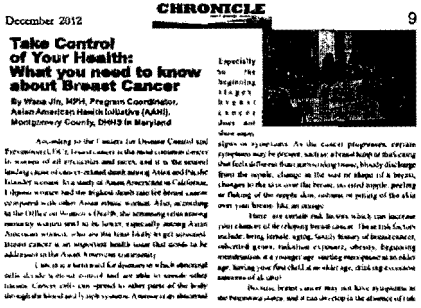
22

Highlights: Health Education in Ethnic Media


社區風采

掌握自己的健康

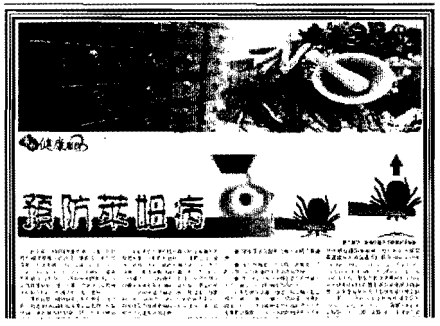
您需要了解的乳癌常識


CHRONICLE

December 2012 9

Take Control of Your Health: What you need to know about Breast Cancer

By Wana Jin, MPH, Program Coordinator, Asian American Health Initiative (AAHI), Montgomery County, DHHS in Maryland


預防華媽病

Three years ago, AAHI initiated the Health Education in Ethnic Media campaign as a means to reach even further into the County's Asian American community. Throughout the year, AAHI develops educational articles on various health topics affecting Asian Americans. AAHI also works with experts in the health care field to review the content. The culturally and linguistically tailored articles are published in a number of print and online ethnic media news sources, in both English and Asian languages.

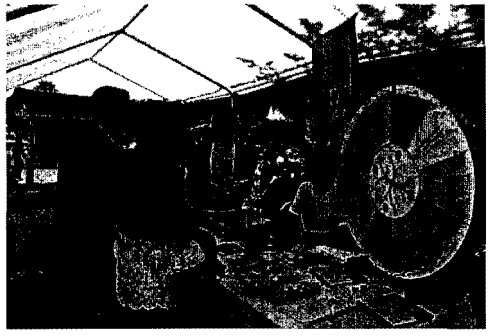
Many Asian Americans look to local ethnic media as a reliable source of news and information. By translating health education articles into multiple Asian languages, AAHI is able to reach a larger portion of Asian Americans and inform them of free or low-cost health services in the area.

- 8 articles published
- 5 media sources:
  - Asian Fortune
  - Epoch Times
  - India This Week
  - Migrant Heritage Chronicle
  - World Journal
- 5 topics covered:
  - Barriers to Health Among Asian Americans
  - Breast Cancer
  - ECHO Project
  - Hepatitis B
  - Lyme Disease

13

Promoting Community Mobilization and Empowerment

Promoting community mobilization and empowerment is a fundamental principle of the Asian American Health Initiative (AAHI). Empowering communities to define and address their own health priorities leads to more sustainable and favorable outcomes. Community involvement also promotes empowered decision making, reduction in service redundancy, and the creation of a unified effort and voice, according to the Centers for Disease Control and Prevention's *Community Mobilization Guide*.



In Fiscal Year 2013 (FY13), AAHI continued to actively engage the County's Asian American community in health promotion and wellness initiatives. Insight gained through the Health Promoters Program, community outreach events, small business outreach, and health education workshops helped inform as well as advise AAHI on the emergent health concerns and issues among the Asian American community.

Additionally, AAHI continued to provide technical assistance to local Asian American leaders and organizations through specific ventures such as the Hepatitis B Prevention Services Project and through capacity-building workshops such as the Empowering Community Health Organizations (E.C.H.O.) Project. The intention of these efforts was also to motivate and mobilize the local community and grassroots organizations to undertake their own self-directed projects that were uniquely tailored to respond to the needs of their respective communities.

Highlights: Health Promoters Program

The purpose of the Health Promoters Program is to help reduce cultural and linguistic barriers to accessing health services for Asian Americans in Montgomery County. As gatekeepers to their respective communities, Health Promoters enable AAHI to better understand and serve a larger network of the County's Asian American population.

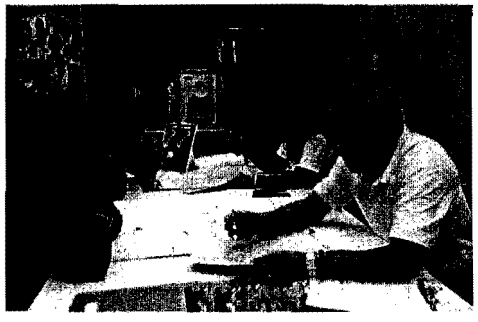
In FY13, six AAHI Health Promoters participated in Holy Cross Hospital's *Ethnic Health Promoter Certification Course* sponsored by the Minority Outreach and Technical Assistance (MOTA) grant. The purpose of the course was to develop a foundation of knowledge and skills surrounding health disparities relevant to Montgomery County's minority populations.

AAHI Health Promoter:

A bilingual and bicultural health advocate who receives training to assist with outreach activities, provide language assistance, conduct health screenings, connect residents to County services, and promote the overall health of their community.

- **35 Health Promoters**
- **15 languages and dialects spoken**
- **15 ethnic communities represented**
- **4 trainings offered**
- **12 new Health Promoters in FY13**
- **16 Health Promoters with 1-2 years of experience in the program**
- **19 Health Promoters with 3+ years of experience in the program**

Highlights: Community Outreach Events



In collaboration with its network of partners, AAHI plans and participates in community outreach events that promote the health and wellbeing of the Asian American community. Emphasizing the importance of prevention, screening, and early detection, AAHI reaches out to individuals, small businesses, and community- and faith-based organizations. As an important part of AAHI's health promotion efforts, outreach events provide AAHI opportunities to relay the latest health information and resources to various Asian American communities. Outreach events also allow AAHI to observe and assess ongoing community needs.

In FY13, AAHI coordinated a range of events, including health fairs and resource information tables, where staff and volunteers disseminated valuable health information as well as referred community members to free or low-cost screenings and health services in the County. AAHI also provided technical assistance to local organizations to build leadership capacity and skills to implement their own health-focused initiatives.

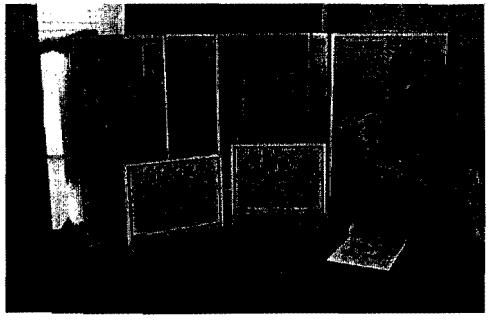
- **54 outreach events**
- **20 ethnic communities reached**
- **9,167 pieces of literature distributed**
- **6,118 educational encounters**
- **854 health screenings/vaccinations**
- **758 health service referrals**

In FY13, AAHI's community outreach events included ABCS project, smoking cessation services, small business outreach (Connect), the Hepatitis B Prevention Services Project, health education workshops, and breast self examination outreach (KCAMP).

Highlights: Connecting Communities to Services

In 2007, 12.1% of the businesses in Montgomery County were owned by Asian Americans.

- *Survey of Business Owners, 2007*



In FY13, Connecting Communities to Services (Connect) encompassed small business outreach, outreach to Montgomery Cares Clinics, and resource information tables. The goal of Connect is to reach out to segments of the Asian American community that are medically underserved and isolated, such as small business owners and their employees.

There is a great need for this type of focused approach given the number of Asian American-owned small businesses in Montgomery County. Through Connect, AAHI provides on-site education and health service referrals to many hard-to-reach community members who otherwise may not have the time nor resources to address their personal health needs.

For clinic outreach, bilingual Health Promoters provide one-on-one health education to patients at Montgomery Cares Clinics and inform them of local health services.

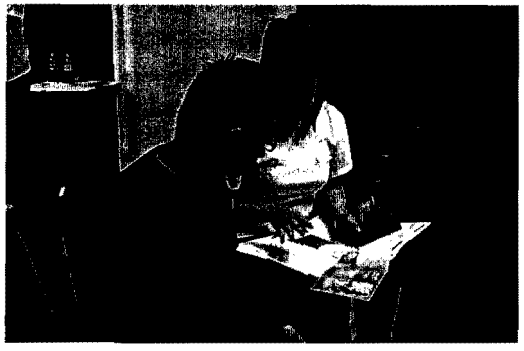
- **294 small businesses and communities reached**
- **11 clinic outreach events**
- **4 resource information tables**
- **3,257 pieces of literature distributed**
- **1,566 educational encounters**
- **198 health service referrals**

(33)

Highlights: Hepatitis B Prevention Services Project

Approximately 1 in 12 Asian Americans and Pacific Islanders is living with hepatitis B.

- *Centers for Disease Control and Prevention*



While Asian Americans and Pacific Islanders make up less than 5 percent of the total U.S. population, they account for more than 50 percent of Americans living with chronic hepatitis B. Acknowledging the need for continued community-driven hepatitis B efforts in the County, AAHI collaborated with the Filipino American (Fil-Am) Ministry of St. Michael the Archangel Catholic Church, a local faith-based organization, on a hepatitis B project for the Filipino American community in Montgomery County. The FY13 Hepatitis B Prevention Services Project provided free hepatitis B education, screenings, vaccinations, and treatment referrals to County residents over the age of 18, regardless of income level or insurance status. Services were provided by the Fil-Am Ministry in cooperation with the Migrant Heritage Commission, Inc. Health Care Resource Program, with support from AAHI.

AAHI provided technical assistance throughout the project as well as shared its experiences and lessons learned from past hepatitis B initiatives. AAHI is committed to empowering organizations with the leadership and technical skills to develop, implement, and evaluate successful health projects for community benefit. For more information, please see the AAHI website.

- **38 participants**
- **100% of at-risk participants referred to vaccinations, of whom 85% completed the three-shot vaccination series**
- **50% of participants were not planning to get screened prior to participating in the project**
- **96% of participants reported they would urge family and friends to be screened and/or vaccinated**
- **96% of participants reported overall satisfaction with program**

Highlights: Empowering Community Health Organizations Project

Since its launch in FY11, AAHI's Empowering Community Health Organizations (E.C.H.O.) Project has been well-received by community leaders and stakeholders. The E.C.H.O. Project is a series of technical assistance and training workshops aimed to build the capacity and sustainability of community organizations that serve Asian Americans in the County. Through the E.C.H.O. Project, AAHI seeks to enhance the ability of community leaders to develop culturally and linguistically competent health programming.

Initially, AAHI performed an informal interest assessment of community leaders to solicit topics that would be appealing and useful to address. Potential training subject areas were then vetted, and AAHI began planning and implementing workshops twice a year.

In FY13, AAHI hosted two workshops. The fall 2012's workshop entitled, "Tackling Grant Budgets," complemented the two previous grant writing workshops, a topic of great interest. Led by Kathleen Sheedy, the Montgomery County Department of Health and Human Services (MCDHHS) Grants Manager, attendees learned how to develop a realistic grant budget and how they can help build trust with a funder. The spring 2013's workshop entitled, "The Affordable Care Act (ACA) in Montgomery County: What You Need to Know," was led by Uma Ahluwalia, MCDHHS Director. She presented an overview of how the ACA will be implemented at the County level. Attendees learned how the new health care law will impact Montgomery County residents.

December 2012:
Tackling Grant Budgets
- 31 attendees
- 14 organizations represented

May 2013:
ACA in Montgomery County
- 53 attendees
- 27 organizations represented

Highlights: Health Education Workshops

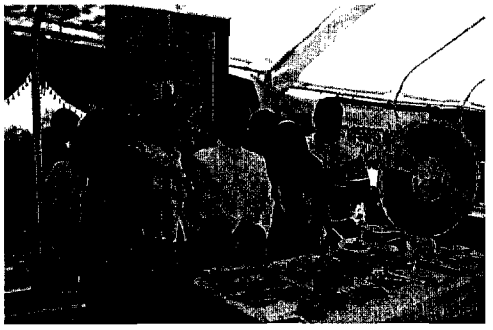
Part of AAHI's health promotion strategy includes health education workshops for the community. The smaller sessions create a more interactive and in-depth learning environment than the traditional large-scale health fair or outreach event. The main goals of the health education workshops are to educate on chronic conditions and health issues pertinent in the Asian American community, to promote the importance of preventative screenings for better health outcomes, and to link the Asian American community to free or low-cost screenings. AAHI engages health experts throughout the planning and implementation of the workshops.

In FY13, AAHI partnered with the Bait-ur-Rahman Mosque, Bethany Church, Burmese American Buddhist Association, Housing Opportunities Commission, International Rescue Committee, Montgomery County Public School's Division of ESOL/Bilingual Programs, and the Muslim Community Center to conduct these workshops. AAHI and community partners worked hand-in-hand to ensure each workshop was tailored to meet the linguistic and cultural needs of the audience.

- **9 workshops conducted**
- **6 topics covered: Breast Cancer, Diabetes, Heart Health, Hepatitis B, Nutrition, Osteoporosis**
- **1,709 pieces of literature distributed**
- **1,314 educational encounters**
- **361 health service referrals**

Strengthening Partnerships and Collaborations

Over the years, the Asian American Health Initiative (AAHI) has forged many mutually beneficial partnerships with stakeholders at the local, state, and national levels. Collaborations are critical for developing comprehensive strategies to address the health needs of underserved and vulnerable communities. Strategic partnerships are also incredibly valuable in maximizing and optimizing resources for community benefit, including reducing the duplication of services and thus supporting a larger scope of service delivery. AAHI continuously looks to connect with organizations with aligned missions in order to collectively better serve the Asian American community.



In Fiscal Year 2013 (FY13), AAHI nurtured existing partnerships as well as fostered new collaborations with entities of similar vision and community dedication. AAHI engaged in a number of public-private partnerships with local hospitals, non-profit organizations, and universities to provide technical assistance on cultural competency and to share the lessons learned in implementing community health projects. One of AAHI's most longstanding collaborations is with Holy Cross Hospital. For eight years, AAHI has partnered with Holy Cross Hospital on the Minority Outreach and Technical Assistance (MOTA) grant that partially supports the AAHI Health Promoters Program and outreach initiatives. The new ABCS project for heart disease and stroke prevention is also part of the MOTA grant. In addition, AAHI continued the Komen Community-Assisted Mammogram Program (KCAMP), in collaboration with Holy Cross Hospital, to provide breast health outreach and community referrals.

Building strong and viable collaborations is a multidimensional process that requires great investments in time and attention. AAHI would like to thank its network of partners for yet another successful year of coming together to build a healthy community.

Highlights: Minority Communities Empowerment Project

Since FY05, AAHI has been a part of the Minority Communities Empowerment Project (MCEP), a program funded by the Maryland Department of Health and Mental Hygiene's Minority Outreach Technical Assistance (MOTA) grant. In collaboration with the Community Health Division at Holy Cross Hospital, the Community Ministries of Rockville, the African American Health Program, and the Maryland Commission on Indian Affairs, AAHI conducts educational outreach and trainings to minority communities on topics such as cancer prevention and tobacco cessation.

On March 23, 2013, MCEP/MOTA hosted the 6th annual *Diversity in Action Conference* at Holy Cross Hospital. The purpose was to explore the adverse effects of diseases and the barriers within health care, as well as to discuss solutions to reduce health disparities facing racial or ethnic communities. Along with representatives of other MOTA partners, two AAHI Health Promoters participated in a segment of the conference by providing accounts in the *A Day in the Life of a Health Promoter* panel.

AAHI has been a recipient of this grant since 2005. Please see the "Financials" section for more information.

Highlights: Komen Community-Assisted Mammogram Program

Since 2009, AAHI has continued its partnership with the Community Health Department at Holy Cross Hospital on the Susan G. Komen Community-Assisted Mammogram Program (KCAMP). Other collaborators included the Community Ministries of Rockville, CASA de Maryland, and the African American Health Program.

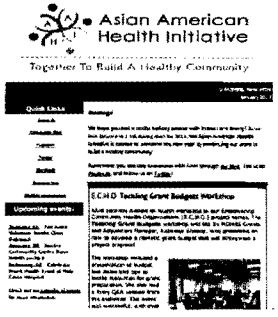
The purpose of KCAMP is to conduct culturally-competent community outreach on breast health and provide referrals to community clinics for clinical breast exams or mammograms. Throughout the year, AAHI Health Promoters provide breast self-exam demonstrations and breast cancer education, as well as refer community members to local clinics for preventative breast cancer screenings. All outreach efforts are linguistically and culturally tailored to the specific Asian American community in order to reduce stigma and fear associated with breast cancer screening and treatment. Through this effort, AAHI aims to reduce the cultural, linguistic, and financial barriers to accessing preventative breast health services.

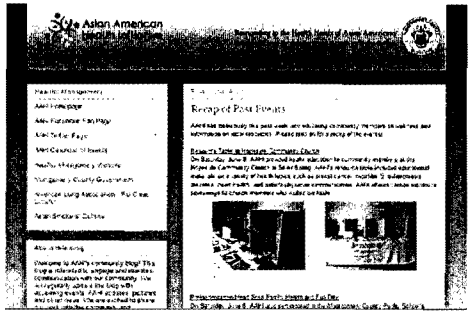
This grant ended in December 2012. Please see the "Financials" section for more information.

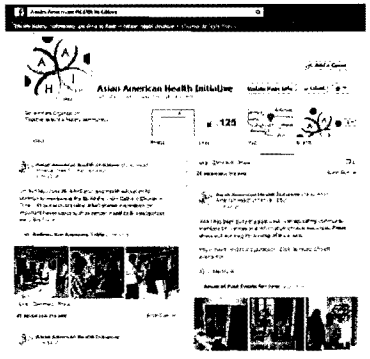
- **461 breast self-exam demonstrations**
- **360 referrals**

In FY13, AAHI's referrals for preventative breast cancer screenings included KCAMP and the Women's Cancer Control Program (WCCP).

Highlights: AAHI in Social Media







As an emerging trend in public health, communication tools such as social media and electronic newsletters are innovative methods for engaging partners, local leaders, and the community. Utilizing social media, AAHI has the ability to promote regional health events, share information on community resources, and increase awareness of local volunteer opportunities in a timely and user-friendly manner.

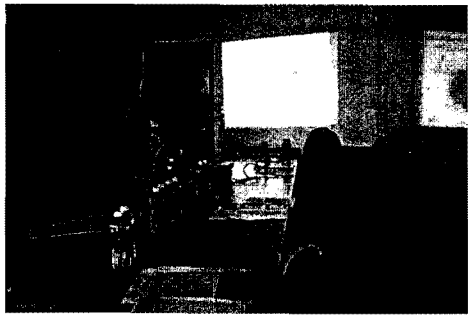
Like AAHI on Facebook

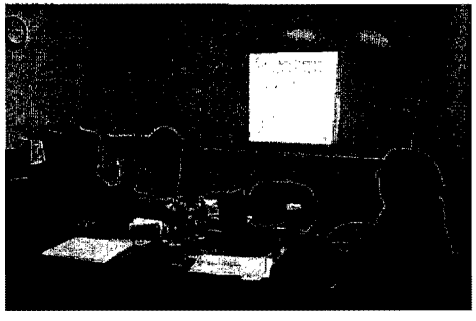
Follow AAHI on Twitter

Read AAHI's community blog

- 6 AAHI e-newsletters sent
- 3 AAHI media sources: Facebook, Twitter, Blogger
- 189 social media posts
- 3,333 views of AAHI's Facebook and Blogger posts

Highlights: AAHI 101 Presentations





In FY13, AAHI continued to provide educational presentations to community partners on the health needs of Asian Americans. Through its *AAHI 101* presentations, AAHI staff shared a comprehensive overview of the diverse health needs and concerns of the Asian American community, both from a local and national perspective. Each presentation included information on demographics, access to care challenges, health disparities, and the importance of cultural and linguistic competency when engaging Asian American populations. Additionally, the *AAHI 101* presentations provided audience members with an overview of AAHI and its programs and services. Presentations were also a valuable opportunity to exchange information as well as explore potential areas of collaboration between traditional and non-traditional partners.

Organizations presented to:

- Bethany Presbyterian Church
- Chinmaya Mission
- Guru Nanak Foundation of America
- Hopeside Community Church
- International Rescue Committee
- Manna Food Center
- New Covenant Fellowship Church
- On Our Own of Montgomery County
- St. Andrew Kim Catholic Church

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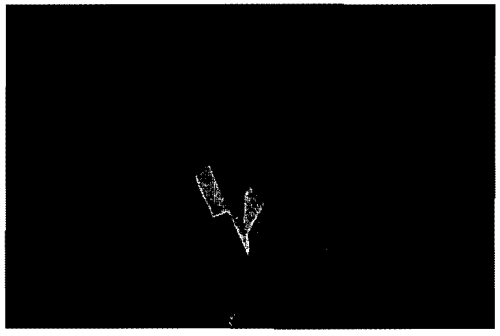
Highlights: Equity and Social Justice Initiative



In FY13, AAHI continued to take part in the Montgomery County Department of Health and Human Service's Equity and Social Justice Initiative. The Initiative is a cross-disciplinary, Department-wide effort that focuses on the use of fair policies, decisions, and actions to positively impact the lives of individuals in Montgomery County. To date, the Initiative has developed a set of equity principles and is currently designing a communication plan and equity tools. Ultimately, the Initiative aims to help the Department integrate a comprehensive equity plan to ensure equitable service delivery in the County.

On October 25, 2013, AAHI and Initiative members participated in a peer learning conference call with colleagues from Seattle's King County Equity and Social Justice Team. King County has worked with Montgomery County to share how they have transformed their work on equity and social justice from a grassroots initiative to an integrated County-wide effort that engages employees and community members to achieve equitable opportunities for all.

Montgomery County Department of Health and Human Services' Definition of Equity:

"Fair policies, decisions, and actions that guides the way that we work with our customers, our colleagues, and our community to promote health, safety, well-being and self-sufficiency."

Highlights: Local, State, & National Collaborators

Please note this is not a comprehensive list of all AAHI partners.

- Adventist HealthCare – Center on Health Disparities
- African American Health Program
- American Diabetes Association
- American Heart Association
- America-Nepal Women's Association of Greater Washington, DC
- Asian American Political Alliance
- Asian Indians for Community Service
- Asian Pacific American Legal Resource Center
- Asian Pacific American Medical Student Association
- Asian Pacific Islander Caucus for Public Health in official relations with the American Public Health Association
- Asian Pacific Islander Domestic Violence Resource Project
- Association of Vietnamese Americans
- Bait-ur-Rahman Mosque
- Bethany Presbyterian Church
- Boat People, SOS
- Burmese American Buddhist Association
- Cambodian Buddhist Society, Inc.
- CCACC Pan Asian Volunteer Health Clinic
- Centers for Medicare & Medicaid Services
- Chinese American Senior Services Association (CCACC)
- Chinese Culture and Community Service Center, Inc.
- Chinmaya Mission
- Community Health and Empowerment through Education and Research
- Community Ministries of Rockville
- Cultural Infotech
- DC Japanese Mental Health Network
- DC Muslim Inter-scholastic Tournament
- Epoch Times Newspaper
- Filipino-American Ministry of Saint Michael the Archangel Catholic Church
- Gaithersburg Chinese Alliance Church
- Global Mission Church
- Guru Nanak Foundation of America
- Hepatitis B Initiative-DC
- Holy Cross Hospital
- Hope Chinese School
- Hopeside Community Church
- Hopewell Health
- Housing Opportunities Commission of Montgomery County
- Idara-e-Jaferia Islamic Center
- Indonesian American Association
- International Buddhist Center
- International Rescue Committee
- Islamic Center of Maryland
- Jain Society of Metropolitan Washington
- Japanese Americans Care Fund
- Japanese Christian Community Center of Washington DC
- Johns Hopkins Bloomberg School of Public Health
- Korean American Association of the Washington Metropolitan Area
- Korean Community Services Center of Greater Washington
- Latino Health Initiative
- Manila Mail
- Manna Food Center
- Maryland Commission on Indian Affairs
- Maryland Department of Health and Mental Hygiene, Office of Minority Health and Health Disparities
- Maryland Insurance Administration
- Maryland Women's Coalition for Health Care Reform
- Mary's Center
- MedStar Montgomery Medical Center
- Migrant Heritage Commission
- Mobile Medical Clinic
- Montgomery College
- Montgomery County Cancer Coalition
- Montgomery County Commission on Aging
- Montgomery County Department of Health and Human Services
- Montgomery County Mental Health Advisory Committee
- Montgomery County Office of Community Partnerships
- Montgomery County Public Schools, Division of Family and Community Partnerships
- Muslim Community Center (MCC)
- MCC Medical Clinic
- National Council of Asian Indian Associations
- New Covenant Fellowship Church
- National Institutes of Health
- On Our Own Montgomery
- Organization of Chinese Americans- DC Chapter
- Organization of Chinese American Women
- Our Lady of Vietnam Church
- Philippine Nurses Association of Maryland
- Primary Care Coalition of Montgomery County
- Recovery Partners Montgomery
- Shady Grove Adventist Hospital
- South Asian Public Health Association
- Southern Asian Seventh Day Adventist Church
- St. Andrew Kim Catholic Church
- St. Rose of Lima Church
- Substance Abuse and Mental Health Services Administration
- Suburban Hospital
- Thai Alliance of America
- University of Maryland College Park, School of Public Health
- U.S. Department of Agriculture, Office of Public Affairs and Consumer Education
- U.S. Department of Health and Human Services, Health Resources and Services Administration
- U.S. Public Health Service-Asian Pacific American Officers Committee
- Vietnamese American Senior Association
- Viet Nam Medical Assistance Program
- Washington Adventist Hospital
- Wat Thai Washington, DC
- White House Initiative on Asian Americans and Pacific Islanders
- Woman's Cancer Control Program
- Women, Infants & Children
- World Journal Newspaper

Highlights: Work Group Participation

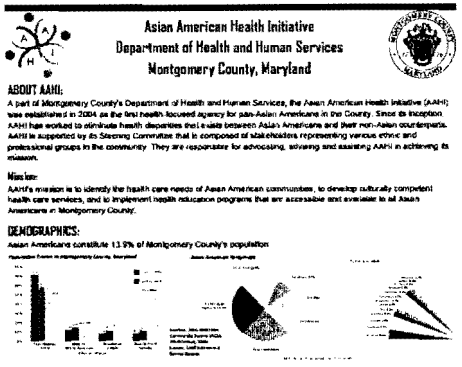
- Asian Pacific Islander Caucus for Public Health in official relations with the American Public Health Association– Executive Committee
- Adventist HealthCare Center on Health Disparities – Advisory Group
- Minority Communities Empowerment Project (MCEP) sponsored Local Health Disparities Committee
- Minority Communities Empowerment Project (MCEP)/Minority Outreach Technical Assistance (MOTA)
- Montgomery County DHHS Equity & Social Justice Initiative
- Montgomery County DHHS Cancer Coalition
- Montgomery County DHHS Tobacco Free Coalition
- Montgomery County DHHS Quality Service Review
- National Institutes of Health, National Institute of Arthritis and Musculoskeletal and Skin Disease – Multicultural Outreach Workgroup

Enhancing Data Collection and Reporting

Data can be a powerful tool for helping organizations understand the health needs of the community and to develop and evaluate programs to better meet such needs. Because Asian Americans are a heterogeneous population, collecting disaggregated data is essential to accurately capture and measure the health status of each unique subgroup. Aggregated data can inaccurately portray the disparities in health care access and coverage of Asian Americans. As a result, the health needs of the population remain unrecognized or inadequately understood. Moreover, without accurate data, the provision of health care resources, programs, research, and policy initiatives may not reflect the needs of the community.

In Fiscal Year (FY13), the Asian American Health Initiative (AAHI) continued to collect both qualitative and quantitative data to monitor the health status of Asian Americans in Montgomery County. Recognizing the importance of program evaluation, AAHI employed various tools, such as the Hepatitis B Project Evaluation Reports, to assess immediate and long-term outcomes of its projects as well as to indicate areas of improvement. AAHI developed these evaluation reports to not only disseminate results to its project partners, but also to provide other organizations with a working framework of how to implement similar hepatitis B outreach efforts in their communities.

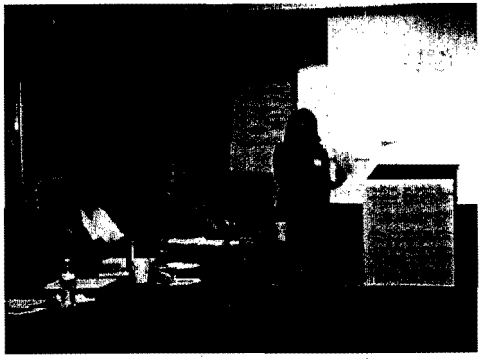
The AAHI Steering Committee also maintained its involvement in the Healthy Montgomery community health improvement process, a collaborative, local data surveillance project. AAHI recognizes that the availability of accurate data is important to community leaders, government officials, and policymakers, and thus continues to enhance the breadth and depth of Asian American health data in Montgomery County.



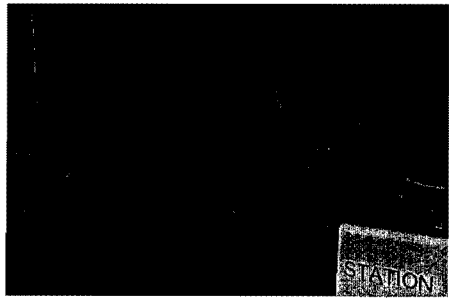
Asian American Health Initiative
Department of Health and Human Services
Montgomery County, Maryland

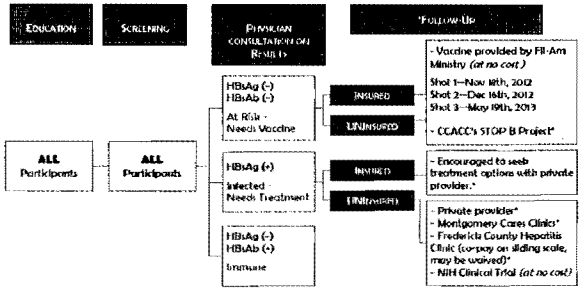
ABOUT AAHI:

DEMOGRAPHICS:



Highlights: Hepatitis B Project Evaluation Reports





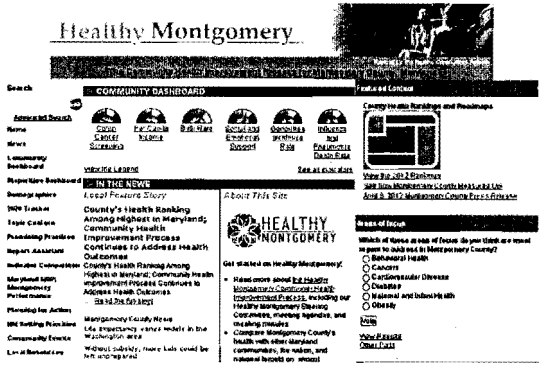
Hepatitis B has been a priority area for AAHI since its inception. Through each of its hepatitis B outreach projects, AAHI incorporated data collection tools and evaluation measures into the program planning.

Last year, AAHI partnered with the Korean Community Service Center of Greater Washington (KCSC) and the Viet Nam Medical Assistance Program (VNMAP) to produce evaluation reports on their respective hepatitis B programs held in FY12. Reports on the Active Care & Treatment of Hepatitis B (ACT Hep B) Program with KCSC and the Screening, Management, Awareness, and Solutions for Hepatitis B (SMASH B) Program with VNMAP are now available on AAHI's website.

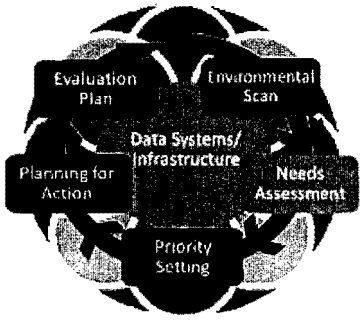
In FY13, AAHI collaborated with the Filipino American (Fil-Am) Ministry of St. Michael the Archangel Catholic Church, a local faith-based organization, on a hepatitis B outreach project for the Filipino American community in Montgomery County. The FY13 Hepatitis B Prevention Services Project provided free hepatitis B education, screenings, vaccinations, and treatment referrals to County residents over the age of 18, regardless of income level or insurance status. Data from the FY13 Hepatitis B Prevention Services Project will be published in an evaluation report outlining program implementation steps, outcome data, recommendations, and lessons learned by AAHI and the Fil-Am Ministry. Please look for the evaluation report on the FY13 Hepatitis B Prevention Services Project in the future.

The evaluation reports of AAHI's hepatitis B projects can be viewed on AAHI's website.

Highlights: Healthy Montgomery



The Healthy Montgomery website is a one-stop, online resource for population-based data and information about the County's health.



In FY13, AAHI's Steering Committee continued to participate in the Healthy Montgomery community health improvement process. Launched in June 2009, Healthy Montgomery brings together individuals from the public and private sectors to identify and address key priority areas that will improve the health status and well-being of the County.

The Healthy Montgomery team compiled quantitative and qualitative health data across various sectors, populations, and communities to help inform the priority-setting process initiated in October 2011. Through the process, the Healthy Montgomery Steering Committee (HMSC) identified six priority areas for action:

- Behavioral Health
- Cancers
- Cardiovascular Health
- Diabetes
- Maternal and Infant Health
- Obesity

The HMSC also selected three overarching lenses through which the action plans for each of the six priority areas should consider:

- Lack of access
- Health inequities
- Unhealthy behaviors

In May 2012, the HMSC established workgroups of experts in the respective priority areas with the responsibility to develop, execute, and evaluate specific action plans. The first two focus areas to complete action planning were Behavioral Health and Obesity. Please visit the Obesity Work Group web page or Behavioral Health Work Group web page for more information on each group's respective action planning activities.

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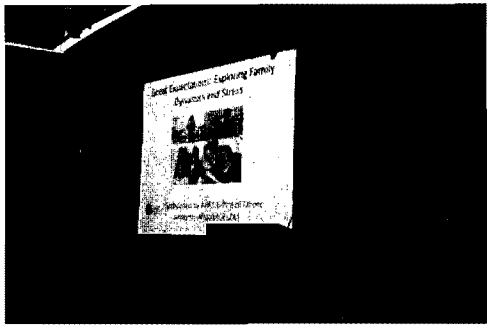
Professional Development

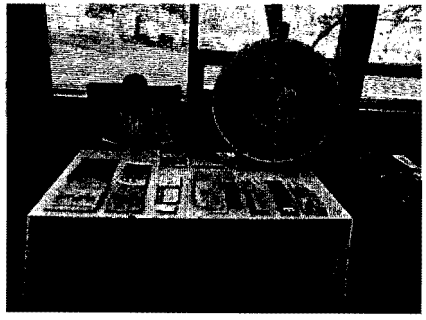
The Asian American Health Initiative (AAHI) is committed to the development and empowerment of the future generation of public health professionals. Through the AAHI Internship Program and its own staff development initiatives, AAHI actively supports continuous learning, mentoring, and skill building for its interns and employees.

Each year, the AAHI Internship Program offers fall, spring, and summer internships for students and recent graduates who are interested in the community health field as well as those who are seeking firsthand experience and practical skills. Through this program, interns are given opportunities to be involved in a variety of AAHI projects ranging from research, to educational material development, to program implementation. For a meaningful experience, AAHI tailors the internships to meet both programmatic needs and the interns' interests. Interns learn about public health in a community setting while also building professional relationships across public and private sectors. AAHI's vision is for interns to expand their field-experience, knowledge, and professional connections for future career development.

In addition to its internship program, AAHI and the Montgomery County Department of Health and Human Services (MCDHHS) support trainings and seminars for its staff. These learning opportunities allow the staff to share their ideas, knowledge, and insight with other professionals as well as to stay up-to-date on new developments in the field. Continual professional development opportunities facilitate staff enrichment and program enhancement.



Highlights: AAHI Internship Program



FALL 2012 INTERN
Jasmine Vinh, *University of Maryland, School of Public Health*

Highlights:

- Provided health education and information on local resources at faith-based organizations, small businesses, and cultural events.
- Supported numerous projects including the E.C.H.O workshops, Health Promoters Program trainings, and the Hepatitis B Prevention Services Project.
- Conducted literature reviews of current diabetes research, mental health in the Asian American community, as well as non-traditional methods of health education and promotion.

Highlights: Staff Development/Trainings

- NIH Health Disparities Seminar: *A Community-Based Participatory Approach to Hepatitis B Intervention for Underserved Korean Americans*
- California Medical Association Foundation Webinar: *Multicultural Communications- Patients & Clinicians Addressing Childhood Obesity within the Asian Pacific Islander Community*
- University of California San Diego's Asian Smokers' Quitline Webinar: *California Smokers' Helpline- Serving the Asian Community*
- Alliance to Reduce Disparities in Diabetes Webinar: *Community Health Workers and Reducing Disparities in Diabetes- Lessons Learned From the Front Lines of Care*

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Financials

The Asian American Health Initiative's (AAHI's) core budget went from $403,209 in FY12 to $413,836 in FY13. FY13 expenses for core appropriated funds were captured in two broad categories:

1. In-House Programs and Administrative: These include program staff, special projects, office equipment, supplies, printing, and mileage. This category accounts for 24.7% of AAHI's core budget expenditures.

2. Contract with Primary Care Coalition: This category accounts for 75.3% of AAHI's core budget expenditures.

Through collaborations with Holy Cross Hospital and other community partners, AAHI also received a $11,600 grant from the Maryland Department of Health and Mental Hygiene's Minority Outreach and Technical Assistance (MOTA) program and a $5,000 grant from the Susan G. Komen Community-Assisted Mammogram Program. In addition, AAHI received a $10,570.69 grant from the Million Hearts initiative and a $642.85 mini-grant from the Asian Pacific Partners for Empowerment, Advocacy and Leadership to promote the use of the Asian Smokers' Quitline.

AAHI Steering Committee

The Asian American Health Initiative Steering Committee consists of 17 professionally diverse individuals from the local community who advocate, advise, and assist AAHI staff in their efforts to achieve health equity in Montgomery County. They represent various ethnic groups and serve as voices for their respective communities. With expertise and intimate knowledge of various communities, the Steering Committee provides invaluable insight and support to the work of AAHI and the Montgomery County Department of Health and Human Services (MCDHHS). In FY13, the Steering Committee members continued to work diligently with their unwavering motivation and efforts to serve the Asian American community. Some of their efforts included:

- Volunteered over 551 hours in support of AAHI's programmatic efforts.
- Advocated in meetings with key leaders in Montgomery County.
- Advised AAHI programmatic efforts throughout the year.
- Heavily involved on the MCDHHS Advisory Board assessing the evolving role of the Minority Health Initiatives/Program in addressing racial and ethnic health disparities and well-being with the leadership of the African American Health Program Executive Committee and the Latino Health Initiative Steering Committee.
- Served as liaisons to external community workgroups including the Asian American Advisory Group to the County Executive, Maryland Governor's Commission on Asian Pacific American Affairs, County Commission on Health, and Healthy Montgomery Steering Committee.
- Assisted AAHI in reviewing ethnic health media for accuracy of content and cultural competency.
- Supported planning of two Empowering Community Health Organizations (E.C.H.O.) workshops, Tackling Grant Budgets and the ACA in Montgomery County.
- Presented with a proclamation by the Montgomery County Council in recognition of National Minority Health Month with other Minority Health Initiatives/Program.

Members
Chair: Sam Mukherjee
Anis Ahmed
Ji-Young Cho
Nerita Estampador-Ulep
Wilbur Friedman
Yan Gu
Harry Kwon
MunSu (Moses) Kwon
Lester (Jao) Lacorte
Meng K. Lee
Sunmin Lee
Michael Lin
Mayur Mody
Nguyen Nguyen
Wendy Shiau
Stan Tsai
Sovan Tun

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How to Get Involved

HEALTH PROMOTERS

Applications for the Health Promoters Program are accepted on a rolling basis. Health Promoters are trained by AAHI in areas of health education, health resources, and County and AAHI services. Health Promoters, in turn, educate and connect their communities to these sources. For more information about the program, or to apply, visit the AAHI website to download an application form.

VOLUNTEERS

Volunteers have the opportunity to assist with health fairs and outreach events. Participation ranges from translation and cultural competency support to event planning and implementation. AAHI is continually searching for dedicated volunteers. Please contact AAHI staff if you are interested.

COMMUNITY PARTNERS

AAHI has long-standing partnerships with many community- and faith-based organizations. With these organizations, AAHI plans health events and participates in cultural festivities. If you are interested in partnering with AAHI or would like AAHI to visit your community, please contact AAHI staff.

INTERNS

AAHI seeks interns during the summer, fall, and spring semesters. Interns have a multifaceted opportunity to assist staff with research, develop educational materials, and implement outreach programs. Interns gain hands-on experience in the areas of public and community health. If you are a current student or recent graduate interested in a meaningful internship at AAHI, visit the AAHI website for details and to download an application form.

STEERING COMMITTEE MEMBERS

The AAHI Steering Committee is comprised of a professionally and ethnically diverse group of stakeholders from the local community who advocate, advise, and assist AAHI with its efforts to attain health parity in Montgomery County. The dedicated members of the Committee provide a wealth of expertise and intimate knowledge of their respective communities. AAHI is currently recruiting additional members who can actively support the organization to achieve its mission and goals. If interested, please download an application form from the AAHI website.

Acknowledgements

AAHI would like to express its deepest appreciation to the County Executive, members of the Montgomery County Council, the Montgomery County Department of Health and Human Services, the AAHI Steering Committee, the AAHI Health Promoters, community partners, staff, and volunteers for their support and dedication during FY13.

AAHI Staff

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Program Manager

Sierra Jue-Leong, MPH
Program Specialist

Sanjana Quasem
Program Coordinator II

Jasmine Vinh
Program Coordinator

Tae Kim
Project Coordinator

Special Thanks

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Montgomery County
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Wana Jin, MPH
Former AAHI Staff

Contributor & Design

Jamie Lok Weng, MPH, CHES
Former AAHI Staff

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Rockville, MD 20850
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Fax: (240) 777-4564
Website: www.AAHIinfo.org
General info: info@aahiinfo.org

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Message

from the Latino Health Steering Committee Co-Chairs and the Latino Health Initiative Manager

Celebrating multiculturalism and multilingualism
Staying true to intended meanings through "transcreation"

Although Saint Jerome was the Patron Saint of Translators, he acknowledged his own fallibility. Perhaps his most famous mistranslation put horns on Moses' head. The original Hebrew scripture stated that when Moses descended from Mount Sinai, he had "rays of light" coming from his head. The Hebrew word can also mean "horns," and Saint Jerome chose the latter meaning. This error has been perpetuated to the present.

There's an Italian saying, "*traduttore, traditore.*" That is, "translator, traitor." This onomatopoeic phrase was first applied to the French by angry Italians who felt that many French-language translations of Dante's works betrayed either the beauty or accuracy of the original writing.

Translation is not a new field, yet it is not an easy task. Over the centuries, professional translators have developed techniques to avoid becoming a translator-traitor. Translation requires research, thorough understanding of both the original and target language, cultural knowledge, and specific training on the topic.

At the Latino Health Initiative, we "transcreate" or adapt language—not literally but by the intended meaning of the language and culture. We know the importance of this translation process or flipped over, the negative repercussions of not engaging in this process. There is no exact translation into English of the Spanish concept, "*sobremesa*," for example. "*Sobremesa*" is the custom of engaging in familial or friendly discussion at the dinner table, long after a meal is completed. While there are innumerable fun examples like that one, "transcreation" becomes particularly critical with respect to health and medical information. Missing an accent in a word can change the meaning of that word and whether to use decimals or commas in numbers may lead to taking incorrect medication doses.

This year's Fiscal Year 2013 Annual Report showcases the many connections the Latino Health Initiative has established and nourished across Montgomery County. We have not let linguistic or cultural differences separate us. We have, rather, built bridges that connect us regardless of language.

Specifically, this Annual Report tracks trends and progress over three years—Fiscal Years 2011, 2012, and 2013. As you will see, Latino Health Initiative project staff have become more efficient at delivering culturally competent services over time. This means engaging in more outreach with fewer resources. Several highlights:

- The 2013 *Ama Tu Vida* event increased the percentage of individuals who obtained care at participating clinics from 53% to 77% in FY12.
- Although the number of System Navigator and Medical Interpreter Program call assessments decreased over the past 3 years, the average number of referrals provided to each caller increased.
- The *Vías de la Salud* Health Promoters Program doubled the number of referrals and the number of persons reached, with an accompanying decrease in labor hours, FY11–FY13.
- The Latino Youth Wellness Program more than tripled its Community Advisory Board group meetings from 4 to 15 meetings FY12–FY13.
- The percent of Smoking Cessation Program participants satisfied with this program was 100% for all 3 years.

We invite you to join us in applauding the resourcefulness of all those who work to promote the County's health.

Grace Rivera-Oven
Rose Marie Martinez, Sc.D.
Co-Chairs, Latino Health Steering Committee, Montgomery County

Sonia E. Mora, M.P.H.
Latino Health Initiative Manager

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Latino Health Steering Committee of Montgomery County

The Latino Health Steering Committee is deeply committed to providing expert consultation and technical assistance to the Latino Health Initiative and the Department of Health and Human Services of Montgomery County. A highly qualified volunteer Latino Health Steering Committee advocates tirelessly and rigorously for policies and practices to improve the health and well-being of Latinos residing in Montgomery County.

Latino Health Steering Committee Annual Retreat

FY13 Accomplishments

During FY13, the Latino Health Steering Committee of Montgomery County:

- Provided comments and suggestions to Dr. Joshua M. Sharfstein, Secretary of the Maryland Department of Health and Mental Hygiene, on Health Enterprise Zones principles in the review of applications and data resources as well as the types of benefits, priorities, and requirements for data at zip code levels. This work was accomplished in conjunction with the Governor's Commission on Hispanic Affairs.
- Supported the proposal to receive funding for a Health Enterprise Zone in the Long Branch area.
- Proposed 3 Latino Health Steering Committee members to the Maryland Health Quality and Cost Council. The Maryland Health Quality and Cost Council accepted the 3 proposed individuals as well as the Latino Health Initiative Manager to its council. Currently, these new members are working in the following workgroups: Cultural Competency, Evidence-Based Medicine, and Wellness and Prevention.
- Assumed responsibility for overseeing recommendations pertaining to the Department of Health and Human Services outlined in the *Report of the Latino Youth Collaborative Steering Committee Montgomery County, Maryland: A Generation of Youth Hanging in the Balance.*
- Volunteered more than 1,800 hours to support the Latino Health Initiative's work and the Department of Health and Human Services Minority Health Initiatives' reorganization process.
- Supported and led the Minority Health Initiatives' reorganization process proposed by the Department of Health and Human Services that yielded the recommendation to establish the Leadership Institute for Equity and the Elimination of Disparities.
- Held the Latino Health Steering Committee annual retreat to strengthen relationships among committee members to work more strategically, promote teamwork, develop consensus on the proposed direction for the Leadership Institute for Equity and the Elimination of Disparities, and establish FY14 priorities.
- Sponsored the following presentations:
  - Dr. Stephen Thomas, Director of the Center for Health Equity, University of Maryland. Dr. Thomas provided an overview of the work of the Center for Health Equity, including its strategic plan and innovative ways the Center for Health Equity has reached out to the community.
  - Dr. Genevieve Martinez, Senior Researcher and Evaluator, Healthy Teen Network. Dr. Martinez presented, "Dreaming the dream: A hurdled journey towards the American Dream," a qualitative research investigation about Latino youth's aspirations in the United States. Dr. Martinez conducted in-depth interviews with Montgomery County direct service providers with an average of 12 years serving Latino youth and their families.

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Latino Data Workgroup

The Latino Data Workgroup was formed in 2001 under the auspices of the Latino Health Steering Committee. This 10-member body provides technical assistance, advice, and advocacy support for the collection, analysis, and reporting of health-related data pertaining to Montgomery County Latino residents.

Latino Data Workgroup members during a group meeting.

FY13 Accomplishments

During FY13, the Latino Data Workgroup:

- Supported the Montgomery County Commission on Health that focuses on 3 areas including the Affordable Care Act, data issues, and the prevention of obesity and cardiovascular diseases.
- Supported 2 priority areas identified in the Healthy Montgomery Action Plan by providing feedback on the goals and objectives developed by the Healthy Montgomery Obesity and Behavioral Health Work Groups.
- Updated the Latino Health Initiative Web portal with tracking software showing 5,567 visitors and 17,214 page views from July 1, 2012 through June 30, 2013. Close to three-quarters (73.22%) were new visitors.
- Produced 3 informational documents on the social determinants of health, with an accompanying PowerPoint presentation: (1) a data-based summary to support the Community Engagement Workgroup's advocacy efforts, (2) a descriptive framework of the social determinants of health, and (3) a fact sheet on the social determinants of health.

Community Engagement Workgroup

The Community Engagement Workgroup was established to boost community participation in decisions that affect the health of Montgomery County Latino residents. To meet this goal, the Community Engagement Workgroup strives to raise the number and capacity of Latino service providers, Latino community leaders, and Latino consumers who lead efforts to ameliorate health.

"Estoy orgullosa de pertenecer al Grupo de Acción Comunitaria. Me siento bien sirviendo a la comunidad brindando mi opinión en una sesión presupuestaria, asistiendo a un foro público o simplemente llamando la atención sobre un asunto de importancia para la comunidad".

—Josefa Salgado
Activista Comunitaria

"I am proud to be part of the Community Engagement Workgroup. I feel good serving the community by providing my opinion at a budget briefing, attending a public forum, or simply bringing attention to a community issue."

—Josefa Salgado
Community Activist

Community Engagement Workgroup members during a group meeting.

FY13 Accomplishments

During FY13, the Community Engagement Workgroup:

- Re-launched and consolidated the Community Engagement Workgroup. New efforts included the confirmation of current members, election of new chairs, recruitment of new members, and consensus on the Community Engagement Workgroup's goals, functions, structures, and roles.
- Attended the Montgomery County's Council FY14 budget hearing and provided testimony highlighting the efforts of the Minority Health Initiatives and offered support for the establishment of the new Leadership Institute for Equity and the Elimination of Disparities in the Department of Health and Human Services.
- Attended the Health and Human Services briefing on the FY14 Recommended Operating Budget, hosted by the Montgomery County Department of Health and Human Services Director.

Community Engagement Workgroup members during a budget briefing with the Montgomery County Department of Health and Human Services Director.

Community Programs and Activities

Ama Tu Vida (Love Your Life) Festival

The *Ama Tu Vida* Health Festival is part of the Latino Health Initiative's ongoing *Ama Tu Vida* Campaign inviting community members to commit to a healthier life. The *Ama Tu Vida* Health Festival seeks to promote health and wellness within the Latino community by facilitating access to preventative health services and offering information and education on key health-related topics.

In FY13, the *Ama Tu Vida Health* Festival was held March 10, 2013 at the Silver Spring Civic Building, in the heart of Silver Spring. Over 30 nonprofit and private agencies partnered with the Latino Health Initiative to provide health and social services to participants at the festival.

For specific information about *Ama Tu Vida* visit http://www.lhinfo.org/en-programs-and-activities/ama-tu-vida-campaign.asp

"'Ama Tu Vida' se ha convertido en una expresión común en las casas de muchas familias, que cada año esperan que se lleve acabo el festival, por los varios y diversos servicios que ofrece al público. Por favor no paren, sigan creciendo".

—Dorita de Lemos Down
Directora, Hispanic Outreach Programs, Circle of Rights, Inc.

"'Ama Tu Vida' has been converted into a household expression among many families, who annually look forward to its festival, because of the many and diverse services it offers the public. Please don't stop, rather continue to grow."

—Dorita de Lemos Down,
Director, Hispanic Outreach Programs, Circle of Rights, Inc.

Blood pressure screening

1,177
FREE MEDICAL SCREENINGS

33
EXHIBITORS

FY13 Accomplishments

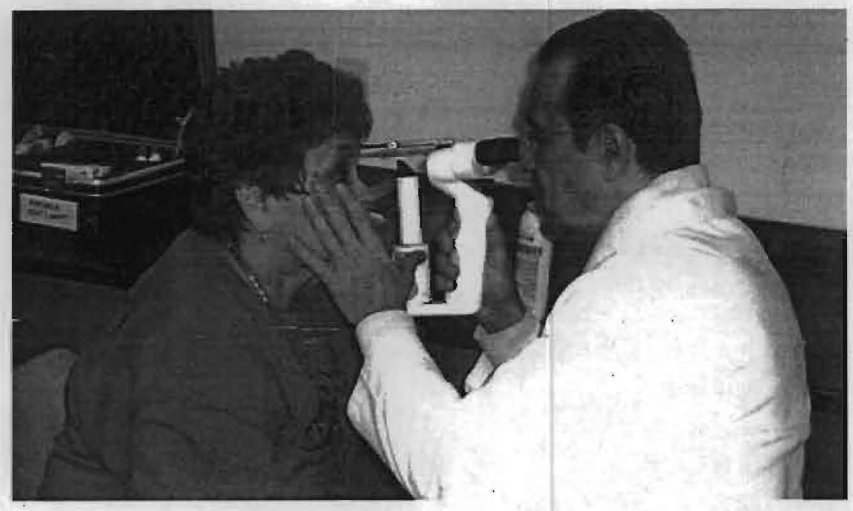
During FY13, the *Ama Tu Vida* Health Festival:

- Coordinated with 33 exhibitors to provide about 1,500 participants with information on disease prevention, health promotion, and ways of accessing services in Montgomery County.
- Provided 1,177 medical screenings free of charge through 9 participating healthcare providers.
- Gave festival participants results of their screenings and assisted uninsured participants in scheduling follow-up appointments at community clinics. Community clinics, including *Proyecto Salud*, Community Clinic, Inc., and Kaseman Clinic, scheduled 27 total follow-up appointments for uninsured Montgomery County residents with abnormal medical screening results.
- Despite a FY12 to FY13 decline in *Ama Tu Vida* Festival's reach (from 3,000 to 1,500 individuals served due to inclement weather), the 2013 event increased the percentage of individuals who obtained care at participating clinics from 53% to 77%. This enhancement was achieved as a result of 4 health promoters who followed up with individuals with appointments made due to abnormal results.
- Follow-up efforts entailed reminder phone calls to individuals before their appointment. Of 27 individuals without insurance that were given appointments, health promoters reached 17 before and after their appointment. Health promoters also provided follow-up calls after the appointments to gauge their experiences.

Ama Tu Vida Health Festival Measures and Results, 2011-2013

OUTPUT MEASURES	Results by Year		
	FY11	**FY12**	**FY13**
# participants	*	3,000	1,500
# medical screenings performed**	*	2,561	1,177
% abnormal results	*	2%	3%
% individuals who attended scheduled appointments	*	53%	77%

*The *Ama Tu Vida* Health Festival was not held FY11 because of budget constraints.

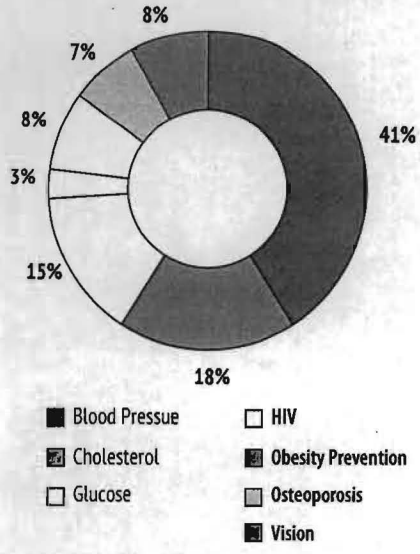


Visual Screening

****Type and Number of Medical Screenings Performed**

Screening Type	Number Performed
Blood pressure	482
Body fat	45
Body Mass Index	45
Cholesterol	209
Glucose	177
HIV	35
Osteoporosis	84
Vision	100
Total	**1,177**

Screenings Performed



CHALLENGES AND LESSONS LEARNED

- Because of inclement weather, we postponed the original date for the *Ama Tu Vida* Health Festival from October 2011 to March 2013. We encountered some unexpected difficulties confirming a new location. Once we secured the new location, a short amount of time remained to promote the event. The health festival was held indoors for the first time in its history. The indoor location was limited in space and thus did not allow for entertainment or extensive physical activity in which youth could engage. We will factor more time in selecting an appropriate venue for next year's health festival and for promoting this event.
- Many *Ama Tu Vida* Health Festival partners continue to face budget constraints. This forced them to reduce the number of people they were able to screen and limit the number of tests they were able to provide at the health festival.
- Culturally and linguistically competent follow-up methods such as the use of trusted community members provide much value such as helping patients to access health services by keeping scheduled appointments.
- Health fairs in which appointments are scheduled for individuals with abnormal results can serve as a valuable mechanism to connect individuals without insurance to critical primary care services.

ASTHMA MANAGEMENT PROGRAM

Asthma is a serious public health problem of childhood in the United States affecting racial/ethnic minority children disproportionately.

Without proper treatment, asthma can interfere with a child's quality of life, making it difficult to engage in daily activities at school and home. While asthma has no cure, it is treatable. An Asthma Action Plan that includes effective medications, paired with environmental modifications to reduce exposure to common triggers, could enable most children with asthma to lead normal and active lives.

The Asthma Management Program offers educational and social support to parents and caregivers of children with asthma. The overall goal of the program is to reduce emergency department visits and hospitalization rates among Latino children by empowering Latino families to appropriately self-manage their children's asthma.

For specific information on the Asthma Management Program visit http://www.lhiinfo.org/downloads/Informational_Resources/Materials_and_Publications/Fact_Sheets/LHI-Asthma-Program-Brochure-03-2012.pdf

"Tengo mi hija de cinco años a quien hace tres años le diagnosticaron asma. A partir de ese momento empecé a interesarme más por su salud. Ahora que he tomado el curso sobre asma en la Escuela Primaria Highland me siento más segura sobre cómo puedo ayudar a mi hija. He aprendido las causas que pueden desencadenar un ataque, cómo prevenir un ataque y a usar mejor los medicamentos. El curso ha sido de gran utilidad para mí y mi familia".

—Abigail, madre de una niña con asma

"I have my five-year-old daughter who was diagnosed with asthma three years ago. Since then, I started to be more interested in her health. Now that I have taken the asthma sessions at Highland Elementary School, I feel more confident in how I can help my daughter. I learned the triggers of an asthma attack, how to prevent an attack, and how to better use medications. The asthma sessions were very useful for me and my family."

—Abigail, mother of a girl with asthma

OVER
69%
OF PARTICIPANTS COMPLETED THE PROGRAM

Asthma program participant

FY13 ACCOMPLISHMENTS

During FY13, the Asthma Management Program:

- Reached 17 parents of children with asthma (88% female, 12% male) who completed intensive education and received support in asthma management.
- Offered basic information on asthma to 678 individuals during outreach through community and school activities.
- Reached 21 children (76% boys, 24% girls) with asthma. Over two-thirds (67%) of the children had public insurance, 19% had private insurance, and 14% did not report having any kind of insurance.
- Offered 16 hours of training on asthma to 12 volunteer asthma coaches ("*consedus*" or counselors/educators). The training enabled "*consedus*" to enhance their ability to provide support to Latino parents of children with asthma.
- "*Consedus*" contributed over 450 hours (representing 56 full-day equivalents) of in-kind social support and counseling to parents participating in the program.
- Was awarded $20,000 after submitting a FY14 grant proposal to the Maryland Department of Health and Mental Hygiene.

Although the number of asthma outreach and community activities implemented decreased over the past 3 years, the number of participants in those activities increased 65.8% from FY11 to FY13. This reflects the efficiency that asthma volunteer coaches ("consedus") have achieved with experience over time. The lower number of education sessions conducted FY13 compared with FY11 and FY12 reflects program staff members' work overloads—program outcomes were not affected, however.

As indicated in the table on page 13, throughout the past 3 years the Asthma Management Program has been greatly appreciated and found very useful by the parents and caregivers of children with asthma who participated in the education sessions. For example, the percentage of participants who were satisfied with the program was 100% in FY11, 95% in FY12, and 95% in FY13. From FY11 through FY13 all program participants (100%) reported that the program helped their child's asthma management over the past 3 years.

Over the past 3 years, over two-thirds (69.4%) of participants, on average, completed the interventions and almost all (95.2%, average) participants reported that they felt their opinions, experiences, and worries were respected in the group.

Steadily, the Asthma Management Program has reached its overall goals as demonstrated by the reported decreases in emergency department visits, hospitalizations, school days missed, and restricted activities due to asthma. Other positive outcomes include increases in reported asthma management knowledge, the development and use of an asthma management plan, and feeling confident in the ability to manage children's asthma.

Asthma Management Program Measures and Results, 2011-2013

OUTPUT MEASURES	Results by Year		
	FY11	FY12	FY13
# asthma outreach and community activities implemented	10	8	6
# participants in outreach and community activities	409	432	678
# education sessions conducted	24	24	16

QUALITY OF SERVICE MEASURES	Results by Year		
	FY11	FY12	FY13
% participants who completed education interventions	70.7%	72%	65.4%
% parents/caregivers satisfied with the program	100%	95%	95%
% participants reporting the program helped their child's asthma management	100%	100%	100%
% participants who feel their opinions, experiences, and worries were respected in the group	96.5%	89%	100%

OUTCOME MEASURES	Percent by Year		
	FY11	FY12	FY13
Increase in asthma management knowledge by parents/caregivers	28.5%	24.5%	24%
Increase in participants who developed an asthma management plan	421.5%	54.5%	240%
Increase in participants reporting use of an asthma management plan	550%	88.8%	150%
Increase in parents feeling fairly or very confident in their ability to manage their children's asthma	95.6%	244%	127%
Decrease in reported emergency department visits due to asthma	50%	59.7%	100%
Decrease in reported hospitalization due to asthma	50.7%	100%	100%
Decrease in reported school days missed due to asthma	20%	42.9%	86%
Decrease in reported restricted activity due to asthma	33.3%	12.6%	50%

Mothers of children with asthma at Highland Elementary School

CHALLENGES AND LESSONS LEARNED

- The economic hardships faced by many Asthma Management Program participants interfered with their full participation in the program, particularly in FY13. Despite education sessions being offered during evening hours, many parents were not able to attend all sessions because they had to work.
- Transportation to and from school and home continues to be a challenge for participants, especially during the winter.
- *Consedus* (counselors/educators) are an important asset to the Asthma Management Program. *Consedus* provide much needed educational follow-up and social support to program participants in a culturally and linguistically competent manner.
- Asthma triggers in the school environment are a major contributor to deficient asthma management. In forthcoming years, the Asthma Management Program will develop a pilot program aimed at empowering parents to work with school authorities to address this issue.

FROM FY11 TO FY13

100%

OF PARTICIPANTS REPORTED THAT THE PROGRAM HELPED THEIR CHILD'S ASTHMA MANAGEMENT OVER THE PAST 3 YEARS.

LATINO YOUTH WELLNESS PROGRAM

The goal of the Latino Youth Wellness Program is to increase protective factors and reduce risk factors among high-risk, low-income Latino youth.

The Latino Youth Wellness Program is based on the Positive Youth Development model and works to increase protective factors (self-esteem, positive expectations for the future, conflict resolution, self-efficacy, knowledge of risky behaviors) while at the same time reduce risk factors (feeling disconnected from school, getting involved in delinquent activities, abusing substances).

The Latino Youth Wellness Program is contracted to Identity, Inc. For specific information on the Latino Youth Wellness Program visit http://www.thiinfo.org/en-programs-and-activities/Latino-Youth-Wellness-Program.asp

"Los muchachos que participaron en el programa aprendieron a sentirse orgullosos de ser latinos y a compartir y aprender con sus padres. Estoy muy contenta con el programa y se lo digo a toda persona que me pregunta. Muchas gracias a todos".
—Neelsville Middle School padre

"The kids who participated in the program learned to be proud of being Latino and shared and learned with their parents. I am very happy with the program and I say that to anyone who asks me about it. Thank you all very much."
—Neelsville Middle School parent

Youth had many opportunities to participate in physical activities.

FY13 ACCOMPLISHMENTS

During the past 3 years, the Latino Youth Wellness Program was implemented at 6 middle schools (Forest Oak, Gaithersburg, Montgomery Village, Neelsville, Redland Middle Schools, and Takoma Park). The Latino Youth Wellness Program also provided case management services to Latino Youth Wellness clients at the Up County Youth Opportunity Center, Gaithersburg.

Due to procurement issues in FY13, Identity, Inc. implemented the Latino Youth Wellness Program through two 6-month contracts.

From July 1, 2012 through December 31, 2012, the Latino Youth Wellness Program:

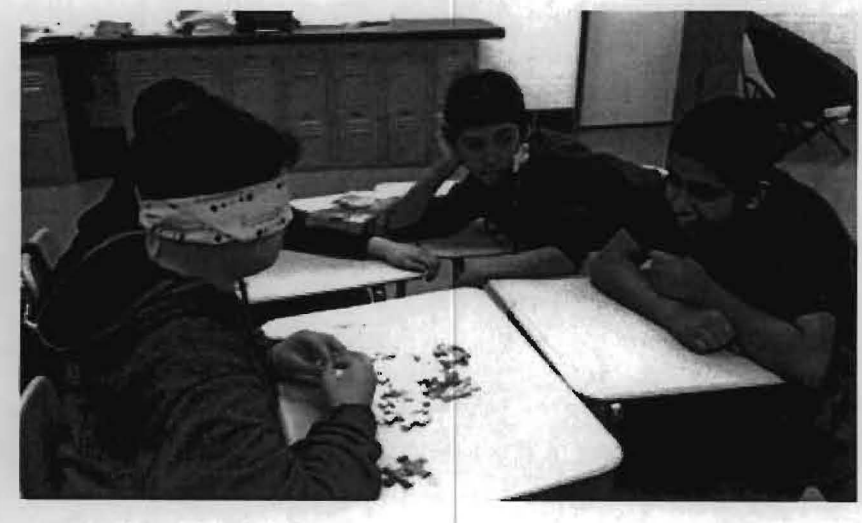
- Prepared 115 wellness plans for 178 families served. These plans were a result of customized assessments conducted with families. Each wellness plan outlined actions to address identified needs (such as access to affordable medical services, assistance finding a job, counseling, emergency food assistance, emergency services, housing, and lack of health insurance).
- Engaged in 93.3 hours of fitness training. Youth enjoyed hikes, outings to sports facilities, and sports tournaments.

From January 1, 2013 through June 30, 2013 (the second 6-month contract), the Latino Youth Wellness Program recruited 79 new vulnerable Latino students who participated in group trainings over 4 months. During this period, the Latino Youth Wellness Program:

- Prepared 88 wellness plans for 71 families served.
- Engaged in 75 hours of fitness training.

As indicated in the output measures table on page 18, during the past 3 years, the Latino Youth Wellness Program increased the number of families served and the quantity of services it provided. For example, the program more than tripled its Community Advisory Board group meetings from 4 meetings in FY12 to 15 meetings in FY13—this is indicative of expanding community involvement in activities. The number of group training hours with parents also increased from 30.5 in FY12 to 40 during the second half of FY13.

At the same time, the levels of satisfaction by program participants remained constant in the 3-year period as evidenced by the percent of youth participants who would recommend the Latino Youth Wellness Program to others (97% in FY11, 96% in FY12, and 99% and 98% during the first and second half of FY13 respectively).



Youth participated in activities to build collaboration.

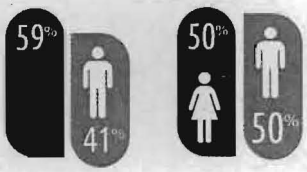
The Latino Youth Wellness Program outcome indicators have demonstrated improvements in each domain assessed over the past 3 years. For example, participants reported improvement in self-efficacy to refuse risky behaviors, such gang involvement. Statistically significant ($p<.05$) improvements were found among youth who reported low levels of emotional wellbeing at baseline.

In response to the high incidence of teen pregnancy among Latino youth, the Latino Youth Wellness Program aims to strengthen protective factors related to reproductive health, including improved attitudes toward healthy behaviors and self-efficacy with respect to sexual decision-making. Participants reported positive improvements in their levels of self-confidence to refuse unsafe sex. During FY13, more than half of youth who initially reported engaging in unsafe sexual behaviors indicated they are now practicing safe sex (always using a condom).

The Latino Youth Wellness Program's positive effect on risky behaviors among participants increased over the 3-year reporting period, reaching maximum

General student profile

GENDER



June–December, 2012 July–December, 2013

AVERAGE AGE

12.6 June–December, 2012

12.7 July–December, 2013

47% 12–14 years old

LIVING IN SINGLE PARENT HOME

33% June–December, 2012

23% July–December, 2013

Diverse levels of cultural integration

IMMIGRANTS

31% June–December, 2012

26% July–December, 2013

BORN IN THE U.S.

69% June–December, 2012

74% July–December, 2013

LIVED IN U.S.

30% **Less than 3 years** June–December, 2012

19% **More than 10 years** July–December, 2013

Poverty indicators

NO HEALTH INSURANCE

10% June–December, 2012

9% July–December, 2013

RECEIVE FREE OR REDUCED LUNCH AT SCHOOL

63% June–December, 2012

59% July–December, 2013

WORK PART-TIME FOR PAY

19% June–December, 2012

6% July–December, 2013

Precarious home situation indicative of poverty or instability

LIVING WITH FAMILY IN SINGLE ROOM OR SHELTER

2% June–December, 2012

6% July–December, 2013

113

Latino Youth Wellness Program Measures and Results, 2011-2013

OUTPUT MEASURES	Results by Year		
	FY11	FY12	FY13*
Families served	206	220	178 / 71
Hours of group training with parents	31	30.5	28 / 40
Counseling sessions with youth, parents, and youth with parents	1,227	1,025	624 / 625
Referrals	236	221	228 / 178
Community Advisory Board group meetings	8	4	15
Wellness plans created	120	156	115 / 88
Retreats	4	7	2
Hours of fitness training sessions	107	107.5	93.3 / 75

QUALITY OF SERVICE MEASURES	Results by Year		
	FY11	FY12	FY13*
% youth who would recommend program to friends	97%	96%	99% / 98%

Group Training Participant Outcome Measures (24+ Hours), 2011-2013

OUTCOME MEASURES	Results by Year		
	FY11	FY12	FY13*
Self-esteem scale	39%	41%	47% / 62%
Depression scale	26%	26%	36% / 88%
Future expectations	43%	39%	39% / 86%
Substance abuse knowledge	37%	28%	54% / 79%
Conflict resolution skills	54%	51%	49% / 50%
Self-efficacy to refuse joining a gang	87%	60%	87% / 100%
Self-efficacy to refuse unsafe sex	36%	21%	65% / 58%
Avoiding teen pregnancy (unsafe sexual behavior)	36%	22%	43% / 100%

QUALITY OF SERVICE MEASURES	Results by Year		
Risk or Protective Factor	FY11	FY12	FY13*
Reproductive and HIV healthy behaviors	36%	22%	43% / 100%
Substance abuse behaviors	17%	40%	80% / 100%
Delinquent behaviors	50%	62%	50% / 100%
Gang-related behaviors	38%	73%	67% / 100%

QUALITY OF SERVICE MEASURES	Results by Year		
Risk or Protective Factor	FY11	FY12	FY13*
School motivation	76%	100%	38% / 100%
Positive school perception	63%	88%	71% / 55%
School support	63%	77%	64% / 80%

*For FY13, the summary report covers two 6-month contracts.

values in FY13. For example, participants who initially reported engaging in risky behaviors reported improvement in these domains at exit. Participants also reported consistently significant increases in their sense of school connectedness over the past 3 years. These outcomes were statistically significant ($p<.05$).

From July 1, 2012 through December 31, 2012, results were more significant among youth who reported higher risks at baseline (lower protective factors and/or higher risk factors) in the following domains:

- Attitudes and behaviors regarding gang-related activities
- Knowledge, attitudes, and behaviors related to substance use
- Mental health
- Parent-child communication

From January 1, 2013 through June 30, 2013, pre-/post- survey changes were statistically significant in the following domains:

- Delinquent activities and gang-related behaviors
- Emotional well-being
- Healthy behaviors
- Parent-youth connectedness
- Self-efficacy to refuse risky behaviors (substance abuse, unsafe sex, gang involvement)
- Sense of school connectedness

Parent sessions strengthened relationships between stakeholders and families

CHALLENGES AND LESSONS LEARNED

- The Latino Youth Wellness Program was able to meet and, in most cases, exceed program output targets required for both 6-month FY13 contracts. Results demonstrated that efforts to individualize the program's approach toward working more with youth and their families paid off. We continue to display our commitment to creating meaningful opportunities for youth to contribute in the community by providing extensive hours of leadership training to young Latinos.
- It is important to collaborate with school partners in the scheduling of Latino Youth Wellness Program afterschool activities and in the recruitment of youth to those activities. Schools seek to provide afterschool programs that offer academic support and they often seek to recruit students similar to those who participate in Latino Youth Wellness Program activities.
- Transportation home from school after group and fitness sessions continued to be a challenge for students. As much as possible, we seek to schedule sessions on days when schools provide bus transportation.
- Partnering with local academic institutions to increase resources for bilingual mental health services has partly alleviated the problem of insufficient bilingual mental health services at the community level.

SMOKING CESSATION PROGRAM

The Smoking Cessation Program is based on a culturally and linguistically appropriate curriculum tailored to Latinos. The program's goal is to decrease the prevalence of tobacco use among Latinos who live or work in Montgomery County by providing culturally and linguistically competent tobacco cessation support.

For 6 weeks, smokers who are ready to quit meet once a week to understand the effects of smoking and the addictive nature of nicotine as well as to learn how to develop a personal quit plan and avoid relapses. Also, smokers receive support from a Tobacco Treatment Specialist and an in-class Tobacco Cessation Coach as well as ongoing support after quitting.

For specific information on the Smoking Cessation Program visit
http://www.lhiinfo.org/en-programsand-activities/Tobacco-Cessation-Program.asp

"Me diagnosticaron cáncer del colon. En mi familia hay un gran historial de cáncer: cáncer del pulmón, colon y mama. Yo sé que fumar es lo peor que puedo hacer, pero ha sido muy difícil dejar por mí misma. El Programa para Dejar de Fumar me ayudó no sólo a entender cómo podía hacerlo sino también me ha apoyado en mi esfuerzo para dejar el tabaco. Pienso que sin su ayuda yo nunca hubiera podido dejar de fumar".

—Carmen, participante del Programa para Dejar de Fumar, sobreviviente de cáncer del colon

"I have been diagnosed with colon cancer. In my family we have a strong history of cancer: cancer of the lung, colon, and breast. I know smoking is the worst thing I can do, but it has been very difficult to quit on my own. The Smoking Cessation Program helped me not only to understand how I could quit but it has been extremely supportive in my efforts to quit tobacco. I think that without its help, I could never have quit smoking."

—Carmen, Smoking Cessation Program participant, colorectal cancer survivor

Smoking Cessation closing class celebration

FY13 ACCOMPLISHMENTS

During FY13, the Smoking Cessation Program:

- Offered 6 classes to a total of 8 smokers.
- Provided support during group classes and individual counseling and coaching to each of the 8 smokers.
- Offered participants nicotine replacement therapy, for free (75% of the participants used some form of nicotine replacement therapy during their attempts to quit).
- Invited family and friends, identified by the participants, to also participate in the classes to learn how to help loved ones quit smoking.

Smoking Cessation Program Measures and Results, 2011-2013

OUTPUT MEASURES	Results by Year		
	FY11	**FY12**	**FY13**
# smokers invited to participate	76	63	84
# persons registered for the group sessions	21	14	21
# smokers who participated in the group sessions	12	12	8
% participants who completed the program	91.6%	83.5%	100%

QUALITY OF SERVICE MEASURES	Results by Year		
	FY11	**FY12**	**FY13**
% participants satisfied with the program	100%	100%	100%

OUTCOMES MEASURES	Results by Year		
	FY11	**FY12**	**FY13***
%* change in knowledge about hazards of tobacco use	14%	45.8%	61%
%* smoke-free participants at the end of the 6-week group intervention	81.8%	90%	75%
%* smoke-free participants 12 months ager the group intervention	N/A	20%	33%

*This pertains to the percentage point difference, not percent change.

Smoking cessation group class

100%
COMPLETION RATE IN FY13

As demonstrated by the numbers on the previous page, one of the major challenges dealing with individuals who smoke is securing their participation in actual cessation activities. Although many smokers understand the risks associated with smoking tobacco, many are not ready to make the commitment to quit. Through outreach efforts, we identified and invited 76, 63, and 84 smokers to participate in the Smoking Cessation Program during FY11, FY12, and FY13, respectively. A small proportion of these invited smokers registered for the program: 28% FY11, 22% FY12, and 25% FY13. A smaller portion of the registered smokers actually participated in the intervention: 12 smokers in FY11, 12 smokers in FY12, and 8 smokers in FY13.

Although recruitment of individuals who smoke into the program is challenging, once individuals entered the program and participated in group sessions, the completion rates were extremely high: 91.6% FY11, 83.5% FY12, and 100% FY13.

The high level of participant satisfaction has been a historical hallmark of the Smoking Cessation Program as indicated by the table on page 21. This is a result of personalized counseling and coaching services, the pleasant environment in which classes are held, the provision of food during the classes, and the availability of free nicotine replacement therapy. Classes are customized to the group's needs, including location and time.

Pre- and post-surveys at the beginning and end of the 6-week group intervention evaluate changes in knowledge of the content delivered during the classes. For the past 3 years, knowledge increased 14%, 45.8% and 61%, pre- to post-survey. The percent of smoke-free participants at the end of the 6-week group intervention has been high across three years: 81.8% FY11, 90% FY12, and 75% FY13. Among participants contacted 12 months after completion of the Smoking Cessation Program, 20% in FY12 and 30% in FY13 were still not smoking.

CHALLENGES AND LESSONS LEARNED

- Because the Smoking Cessation Program does not fund outreach or preparation for smokers to attempt to quit, identifying smokers who are willing to quit has been the program's primary challenge—particularly securing smokers who are ready to participate in the program the moment we offer them the program.
- Participants' main motivation to quit is their health and how negative health outcomes might affect family members. Education continues to be a critical element in motivating smokers to quit. Engaging family members to encourage individuals to quit and provide social support during the process enhances potential success.
- After participating in classes on ways to develop a quit plan, participants are more willing to try nicotine replacement therapy. During the classes, participants learn the mechanisms involved in nicotine addiction and nicotine replacement therapy action.
- Even though funds are continuously being restricted for the Smoking Cessation Program, participants agree the program is needed in the community.

SYSTEM NAVIGATOR AND MEDICAL INTERPRETER PROGRAM

Many of Montgomery County's low-income Limited English Proficient residents continue to face a variety of barriers obtaining equitable access to quality healthcare. Unfamiliarity with the United States healthcare system (including the Affordable Care Act), confusion over eligibility requirements, and the current political environment have converged to create a climate of distrust by the immigrant community toward mainstream and government-related providers and programs. Latino residents of Montgomery County often learn to live without health services altogether because they worry that encounters with the health system might lead to their deportation. Lack of culturally and linguistically competent health services is a major barrier to Latinos' access to healthcare as well. Latinos report not knowing where to go for care when they are sick and not scheduling appointments because of language issues. All of these issues contribute to health disparities endured by the Limited English Proficient immigrant community.

The System Navigator and Medical Interpreter Program seeks to address health disparities and enhance access to culturally and linguistically proficient health and social services among low-income Limited English Proficient Latino immigrants in Montgomery County through a bilingual information and navigation hotline. Navigators assess hotline callers' needs and refer them to appropriate services. The provision of medical interpretation services to assist with language barriers during the patient-provider encounter complements the bilingual information and navigation hotline.

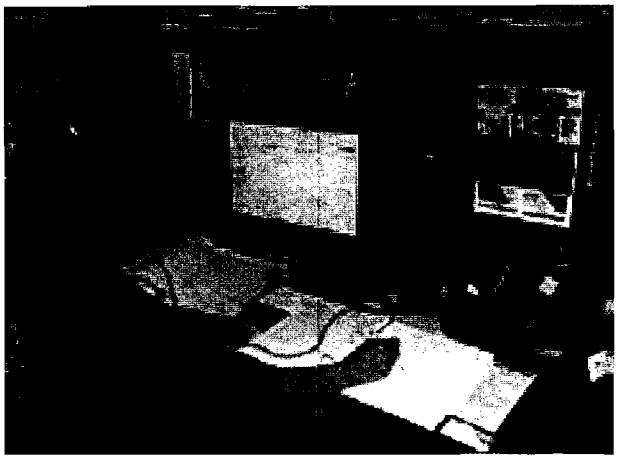
The System Navigator and Medical Interpreter Program is contracted to CASA de Maryland.
For more information about the System Navigator and Medical Interpreter Program visit
http://www.lhiinfo.org/en-programs-and-activities/System-Navigator-and-Interpreter-Program.asp

"Aprecio mucho el hecho de que ofrezcan estos servicios. Es sumamente importante entender lo que el médico le comunica a su paciente. Ya que soy inmigrante en este país y no tengo un gran dominio del idioma, menos sobre la terminología médica, opino que los excelentes servicios brindados por este programa realmente son claves para una vida saludable".

—Elida, cliente del Programa de Interpretación Médica de CASA de Maryland, Silver Spring, MD

"I am grateful for the fact that they offer these services. It is extremely important to understand what the doctor communicates to his or her patient. Since I am an immigrant in this country and I do not have a great command of the language, much less of medical terminology, in my opinion the excellent services offered by this program are really the key to a healthy life."

—Elida, consumer of the Medical Interpretation Program of CASA de Maryland, Silver Spring, MD



Lead Navigator, Irene Jallo, conducting a client assessment on CASA's Bilingual Health Information Hotline.

FY13 ACCOMPLISHMENTS

During FY13, the System Navigator and Medical Interpreter Program:

- Served 4,383 community members with information, referrals, and system navigation and medical interpretation services.
- Provided 3,302 referrals to health and human services for community members seeking assistance through the Bilingual Health Information Hotline.
- Conducted 2,033 medical interpretations at Mercy Health Clinic, Mobile Medical Care, Holy Cross Hospital Health Center, Mansfield Kaseman Health Clinic and other Department of Health and Human Services agencies and specialty care providers in Montgomery County.
- Contracted with 7 certified medical interpreters to provide services in Spanish and French. (Medical interpreters obtain certification after completing 40 hours of training that uses a nationally recognized curriculum designed by Bridging the Gap and offered through the Cross-Cultural Health Care Program.)
- Helped 99% of clients surveyed (3% of total clients served) successfully access health and social services.

System Navigator and Medical Interpreter Program Measures and Results, 2011-2013

OUTPUT MEASURES	Results by Year		
	FY11	**FY12**	**FY13**
# bilingual information line call assessments	2,824	2,689	2,350
# referrals by information specialists	3,840	4,001	3,302
# medical interpreter appointments completed	2,438	2,083	2,033

QUALITY OF SERVICE MEASURES	Results by Year		
	FY11	**FY12**	**FY13**
% clients accessing services	98%	98%	99%

OUTCOMES MEASURES	Results by Year		
	FY11	**FY12**	**FY13***
% satisfaction with bilingual information line[1]	99%	99%	99%
% satisfaction with medical interpreter services[2]	100%	97%	99%

[1] Percentage of clients reporting the most positive responses on a customer satisfaction survey about the Information Line with these response options: Very Helpful, Helpful, Adequate, Not Very Helpful, or Not Helpful At All.

[2] Percentage of clients reporting the most positive responses on a customer satisfaction survey about the Medical Interpreter Program using these response options: Excellent, Good, Adequate, Poor, or Bad.

FROM FY11 TO FY13

99%

OF CLIENTS SURVEY SUCCESSFULLY ACCESSED HEALTH AND SOCIAL SERVICES

Reductions in dedicated funding for the System Navigator and Medical Interpreter Program are the largest contributing factor to the decrease in the number of interpretations and call assessments from Fiscal Years 2011 through 2013 (see above table). Despite the decrease in the number of call assessments, however, the average number of referrals provided to each caller increased through the reporting period from 1.35 in FY11, peaking in FY12 at 1.48 and then leveling off to 1.40 referrals per caller in FY13. These numbers underline the complexity of cases assessed through the hotline program as well as the quality of the assessments themselves. The quality and effectiveness of the services provided are illustrated by the high customer satisfaction marks consistently reported throughout the documentation period.

The table above provides information about the nature of services requested through the bilingual health hotline. As is displayed by the table, the purpose of the calls and the needs of the callers are very diverse. A notable increase in the demand for social services is evident. By FY13, more than one-third of callers received some type of social service referral. Social service referrals encompass a variety of services including legal, financial, education, and employment assistance. As a result of one single assessment, many callers receive social service referrals in addition to a health-related referral.

The table above outlines the distribution of medical interpretations provided by the program to participating clinics. As funding has decreased and the number of overall interpretations fell from 2,438 in FY11 to 2,033 in FY13, the program has increasingly focused on providing support to a smaller core group of recipient clinics.

PURPOSE OF CALLS (%)

	FY11	FY12	FY13
Social services	28%	28.6%	34%
Primary care	21%	22.0%	22%
Cancer prevention	8.5%	5.8%	6.4%
Dental care	6.75%	10.1%	5%
Women's healthcare	5.5%	8.3%	5.9%
Specialty care	5%	3.7%	5.0 %
Physical exams	5%	3.4%	3.2%
Mental health	2%	3.3%	2.5%
HIV testing and STIs	1.5%	1.7%	1.2%

MEDICAL INTERPRETATION LOCATIONS

	FY11	FY12	FY13
Mercy Health Clinic	31.3%	39.7%	22.9%
Holy Cross	30.5%	30.0%	48.4%
Mobile Medical Care	14.7%	20.3%	23.0%
Mansfield Kaseman Health Clinic	6.7%	6.7%	2.5%
Spanish Catholic Center	6.2%	0	0
Mary's Center	7.3%	0	0
Specialty providers	3.3%	3.3%	3.2%

CHALLENGES AND LESSONS LEARNED

- The System Navigator and Medical Interpreter Program has endured a number of challenges over the past 2 years as funding for the program has remained flat while costs continue to rise. Following a major reduction in funding experienced by the program during FY11 in which both staffing and hours of operation were reduced, no additional increases in funding have since been allotted to the program. To account for rising operational costs, services have been slightly reduced over time yielding a decrease in the number of interpretations and net clients served despite growing demand.
- The System Navigator and Medical Interpreter Program has experienced a sharp increase in the number of mid- to aggressive-level case management services generated through the information hotline. These clients require intensive case management services as a result of acute health conditions or extreme socioeconomic obstacles, such as homelessness. Program staff provide these individuals with a comprehensive assessment, typically resulting in multiple referrals and substantial follow-up services. Limited staffing assigned to the program due to funding restrictions affects the number of clients the program is able to serve. However, through partnerships with the University of Maryland as well as with Eastern Mennonite University, the program has recruited Master's in Social Work students with whom to partner in handling the demanding case management load.

VÍAS DE LA SALUD HEALTH PROMOTER PROGRAM

By training and empowering Latino health promoters, the mission of the *Vías de la Salud* Health Promoter Program is to improve the health and well-being of low-income Latinos in Montgomery County. Health promoters encourage healthy behaviors by facilitating access to health services and advocating for health policies that benefit the community.

For more information on the *Vías de la Salud* Health Promoter Program visit http://www.lhiinfo.org/en-programs-and-activities/Vias-de-la-Salud.asp

Health promoters during outreach activity

"Instruir con amor y respeto es nuestro compromiso para ayudar a solucionar las necesidades comunitarias".
—Ana Cáceres, Dina Maravilla, Luz Aleyda Pérez y Ruth Aloras, Retiro de Promotores de Salud

"To teach with love and respect is our commitment to help solve the needs of the community."
—Ana Cáceres, Dina Maravilla, Luz Aleyda Pérez, and Ruth Aloras, Heath Promoters Retreat

FY13 ACCOMPLISHMENTS

- Our cadre of 22 health promoters reached an unprecedented 12,038 individuals through outreach activities conducted in their neighborhoods, community clinics, recreation centers, health fairs, and festivals, among other venues.
- Completed 4 "*caminatas*" (walks) at the Millian Memorial Methodist Church, Wheaton Woods Elementary School, Harmony Hills Elementary School, and Gaithersburg Elementary School with 64 participants. Each session consisted of 8 classes where *caminatas* provide promotores the strength to encourage and incentivize community participants to live a healthier lifestyle through exercise. While waiting for participants to gather for a *caminata*, health promoters engage in healthy fruit and vegetable demonstrations.
- 4 health promoters participated in the Million Hearts Initiative funded by the Maryland Department of Health and Mental Hygiene. The local effort, known as "ABCS" (appropriate aspirin therapy, blood pressure control, cholesterol management, smoking cessation) involved several partners and included the identification and referral of individuals at risk for cardiovascular disease to participating clinic sites. Through this tremendous effort, health promoters reached 1,500 individuals, made 220 referrals to participating clinics, and provided navigation services to 180 individuals at risk for cardiovascular disease. Of those, preliminary data indicate that 69 completed their appointments, 41 have appointments and are still waiting to be seen, and 61 are waiting to receive in appointment from a clinical provider.
- *Vias de la Salud* continued participating with Millian Memorial Methodist Church's Coalition of Community Partners of Aspen Hill and Wheaton. Through this partnership, health promoters continued to conduct health education sessions twice a month with families that use the services of the Church's food pantry program.
- Continued collaboration with Community Health Services of the Department of Health and Human Services to conduct outreach activities aimed at increasing awareness of the Family Planning State Program. Health promoters invested extra effort and time to reach out to the community. As a result, health promoters conducted 137 interventions reaching 2,530 Latino individuals. Health promoters helped community members complete 16 applications for family planning services.
- 18 health promoters received CPR (cardiopulmonary resuscitation) recertification training.
- Provided support to the *Ama Tu Vida* Health Festival, the Salvadorian Health Festival, and the Party in Pink Zumbaton co-sponsored by Susan G. Komen for the Cure. In addition, health promoters conducted weekly activities at Proyecto Salud and the Tess Center.

4 HEALTH PROMOTERS REACHED

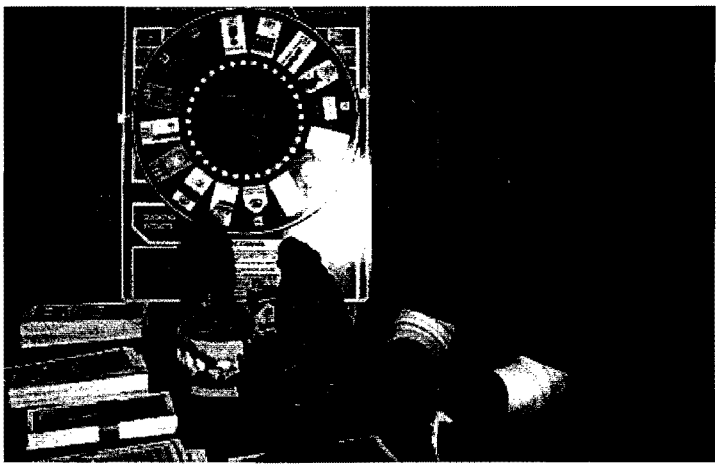
1,500

INDIVIDUALS AT THE MILLION HEARTS INITIATIVE

OUTREACH ACTIVITIES RESULTED IN

137

INTERVENTIONS THAT IMPACTED 2,530 INDIVIDUALS



In memory of Reyna Ochomogo

The fruits from the new skills health promoters acquired during FY11 and FY12 trainings are evident by the doubling of referrals from FY11 (535) to FY13 (1,019). The number of persons reached also doubled over time (from 6,275 in FY11 to 12,038 in FY13). These increases were accompanied by a decrease in labor hours (from 3,592 in FY11 to 2,694 in FY13), demonstrating a growth in efficiency and cost-effectiveness of services over time.

Anecdotally, while we have heard that *caminatas* (walking sessions) are well-liked by the community, the satisfaction of health promoters with the program dropped during the 3-year reporting period. We believe that several factors contributed to this finding. In particular, during FY13 there was much discontent with the way promoters received their monthly incentive (see section on page 31 on Challenges and Lessons Learned). In addition, the unexpected retirement by the Health Promoter Coordinator affected the morale of the group. A few health promoters left the program for various reasons that included enrolling into an academic program and finding permanent work. In addition, Reyna Ochomogo, one of our health promoters, sadly passed away unexpectedly. The drop in health promoter satisfaction (from 100% FY11 to 77% FY13) and a retention rate of 88% FY13 compared with 100% the prior FY12 reflects these sentiments.

From FY11 to FY12, there was a 156% increase in knowledge of physical activity, and a 48% increase in behavior intent related to physical activity, by walking session participants. From FY12 to FY13, however, these changes dropped 8.7% and 79.5%, respectively. The latter may be attributed to many participants being the same over the years at one site and thus, intent would not change dramatically over time.

Vías de la Salud Program Measures and Results, 2011-2013

OUTPUT MEASURES	Results by Year		
	FY11	FY12	FY13
# families referred to programs (Bilingual and Information Line and other county programs, Care for Kids, Holy Cross Maternity Program, MC311, Maryland's Children Health Insurance Program, Mercy Clinic, Mobile Med, Proyecto Salud)	535	609	1,019
# volunteer hours from health promoters	3,592	3,172	2,694
# persons reached by health promoters	6,275	7,898	12,038

QUALITY OF SERVICE MEASURES	Results by Year		
	FY11	FY12	FY13
% health promoter satisfaction with the program	100%	96%	77%
% health promoters retained in the program	90%	100%	88%

OUTCOMES MEASURES	Results by Year		
	FY11	FY12	FY13
% change in physical activity knowledge	9%	23%	21%
% change in behavior intent related to physical activity	56%	83%	17%

CHALLENGES AND LESSONS LEARNED

- As a result of the new protocol on incentives, health promoters had to pay taxes on their 2012 incentives and some health promoters lost 2012 benefits due to increased income. The decision to change the incentive mechanism was put in place to comply with Federal tax regulations. To decrease confusion, new policies outlining the implications (including any possible unintended sequelae) of receiving monetary incentives must be communicated clearly. During FY14, staff will explore alternative mechanisms that do not affect health promoters' livelihoods so drastically yet incentivize them to continue engaging in the important work that they deliver to the community.
- In the middle of the fiscal year, the Health Promoter Coordinator retired unexpectedly. This change in staff altered the program's work plan and negatively affected health promoter morale. Low morale was exacerbated when one of the health promoters suddenly passed away toward the end of the year. By surviving this sad experience, health promoters learned how cohesive and strong they are and the importance of ongoing open communication among each other and the program.

WELCOME BACK CENTER OF SUBURBAN MARYLAND

The Welcome Back Center of Suburban Maryland is an innovative model that builds on the personal and professional assets of internationally-trained health professionals, living or working in Maryland, to facilitate health professions licensure processes and help these professionals re-enter the health workforce in Maryland.

For more information on the Welcome Back Center of Suburban Maryland visit http://www.lhiinfo.org/en-programs-and-activities/Welcome-Back-Center.asp

"Thank you for the opportunity to express my splendid experience about how I changed my life in a short time. As a participant of the Welcome Back Center, I have been motivated and helped by marvelous people who taught me how to start from the beginning to be successful. They opened the doors for the next chapter in my career as a registered nurse in Maryland. I started workingas an RN at Washington Adventist Hospital on May 2013. Once again, I would like to thank the Welcome Back Center staff on behalf of my family and myself."

—Elias Jemal, Registered Nurse,
Welcome Back Center participant

Welcome Back Center staff with foreign medical graduates interested in participating in the Pilot Program for Internationally-Trained Physicians, Application Information Session, September 8, 2012.

FY13 ACCOMPLISHMENTS

During FY13, the Welcome Back Center of Suburban Maryland:

- Provided services to 193 internationally-trained healthcare professionals.
  - 8 participants successfully passed the Registered Nurse licensure exam.
  - 11 participants successfully started working in the healthcare field in Maryland including 5 Registered Nurses, 3 Patient Care Technicians, and 3 Certified Nursing Assistants.
- Maintained a cadre of 9 participants in on-the-job practical exposure to the United States healthcare system working as nurses-in-training at 3 Maryland hospitals.
- Provided intensive services to 105 internationally-trained healthcare professionals (81 nurses, 18 physicians, 6 behavioral health professionals) who are working towards their licensure or certification in the healthcare field to secure a job in Maryland.
- Provided financial assistance to 33 eligible participants (through 73 referrals associated with academic training and licensure or certification expenses).
- Provided guidance to 88 individuals (50 nurses, 25 physicians, 7 psychologists, 2 social workers, 4 individuals in other health professions) inquiring about how to participate in the program and the licensure process in their respective fields.
- Provided a 3-hour training on workplace cultural competency to 17 healthcare provider employee participants through a partnership with the Center on Health Disparities at Adventist HealthCare, Inc.

IN FY13 PROVIDED
GUIDANCES TO

193

INTERNATIONALLY TRAINED
HEALTH CARE PROFESSIONALS

- Provided 29 total hours of group guidance and support focusing on career development, job readiness, and pre-employment services (job search, résumé writing, interviewing skills, job readiness training for nurses).
- Initiated a pilot program with 18 physicians and 6 behavioral health professionals. The purpose of the pilots is to enhance the Welcome Back Center's capacity to serve a more diverse pool of internationally-trained health professionals and to identify specific obstacles in the licensure or certification and workforce reintegration process.
- Held a meeting with the Executive Director of the Reginald S. Lourie Center for Infants and Young Children to explore collaborative opportunities including the possibility of offering employment to internationally-trained behavioral health professionals participating in the pilot.
- Staff received a 3-hour training, conducted by the National Welcome Back Initiative Director, on ways to provide services to foreign-trained physicians based on the experiences of other Welcome Back Centers across the country.
- Conducted meetings at the Montgomery College School of Radiography, Washington Adventist Hospital, and Prince George's Community College on October 2012. Welcome Back Center staff members learned about alternative careers that internationally-trained physicians may be interested in exploring and the procedures for counseling, financial aid, and transcripts.
- Met with the Maryland Board of Physicians to introduce the work of the Welcome Back Center with foreign medical graduates. Center staff members have been gaining a better understanding of the pre-licensing and licensing processes for foreign medical graduates in Maryland.

Welcome Back Center of Suburban Maryland Measures and Results FY11–FY13 and Overall Cumulative Results FY07-FY13

	FY11	FY12	FY13	OVERALL CUMULATIVE RESULTS (FY07–FY13) Number	Percent (n=129)
OUTPUT MEASURES					
Number of participants					
Nurses	81	95	81	129	-
Behavioral Health Professionals	-	-	6	6	-
Physicians	-	-	18	18	-
Hours of individual case management with participants	173	86	109	-	940
Hours of group guidance and support with participants	29	18	27	-	211
OUTCOME					
Completing Credentials Evaluation/Licenses/Certificates:					
Number of participants completing credentials evaluation	8	11	4	72	56%
Number of participants passing English oral proficiency exam	14	12	14	80	62%
Number of participants passing Nursing Licensure Exam as Registered Nurse (RN)	11	8	8	46	36%
Job Placements:					
Number of participants who began working in their profession as RNs in Maryland	9	9	5	36	28%
Number of participants who began working as nurses-in-training in Maryland	6	8	3	48	37%
Number of participants who remained working as nurse-in-training from prior years	10	3	6	36	28%
Number of participants who began working as Patient Care Technicians, Certified Nursing Assistants (CNAs), or other capacity in the health field in Maryland	3	3	6	14	11 %
Career and Economic Development Impact:					
Average time to complete the program from entering program until passing Nursing licensure exam as RN	22 months	25 months	18 months	46 nurses	19 months
Percent average increase in wages from entering program until hired as RN	292%	216%	119%	36 nurses	171%
QUALITY OF SERVICE MEASURES					
Number of nurses retained	81	91	78	119	92%
Percent of nurses satisfied †	98%	93%	91%	-	-

† Levels of satisfaction were measured by participants answering "How would you rate your level of satisfaction with:" (a) the way I am treated by the Center staff; (b) the communication with the person assigned to my case; (c) the experience and capacity of the person assigned to my case; (d) how easy it was to get to the group meetings; (e) the scheduled group meeting times; (f) the quality of information provided in the group meetings; (g) the clarity of the written materials; (h) the explanation of the information received; and (i) the answer to my questions.

129

Welcome Back Center FY11-FY13 Data Trends

- The type of health professions served by the Welcome Back Center of Suburban Maryland increased during the last year as a result of the incorporation of internationally-trained physicians and behavioral health professionals in addition to nurses.
- Even though the number of participants increased from FY11 to FY12, the number of individual case management hours provided to participants decreased. The decision to institutionalize key functions, in FY12, entailed engaging in an analysis of different levels of individual case management needed by participants. Taking into consideration each participant's needs, we reduced the number of face-to-face sessions to 2 times a year, rather than 4 times a year, and maintained additional one-on-one communication via telephone and email as needed. This change helped us use available resources more effectively and efficiently.
- The hours for group guidance and support with participants are less in FY12 than FY11 because most new participants recruited in FY12 had already completed the process for credentials evaluation and the three to five-hour long credentials evaluation workshops were not necessary.
- The availability of nurse-in-training jobs at partner hospitals providing participants on-the-job practical exposure to the United States healthcare system decreased from 16 jobs in FY11, to 11 jobs in FY12, and to 9 jobs in FY13. This reduction took place as a result of the economic recession, obliging employers to delay retirement while at the same time hospitals' high priorities changed to address the transition to using electronic records and monitoring of competencies for quality assurance requirements. This impacted their staff capacity to dedicate time to serve as preceptors and mentors of the nurses-in-training.
- The average time to complete the program varied from year to year. Overall, the cumulative average for all 46 nurses who have already passed the nursing board examination is 19 months. The total time needed to obtain Registered Nurse licensure varies depending on the licensure stage at which a participant enters the program. Those who need to enhance their English skills will take longer than those already at the desirable English fluency. The amount of time needed to complete the credentials evaluation could also vary considerably depending on the country at which the participant obtained their degree—this step can become the bottleneck delaying program completion.
- The average increase in wages also varied from year to year. Overall, the cumulative average increase in wages for all 36 nurses who started working as Registered Nurses in Maryland is 171%. The average increase in wages is higher when participants begin the program unemployed or working at a job with low pay. When participants have a higher paid job at the time they start the program, the average increase in wages is lower. However, the cumulative average increase of 171% indicates the tremendous economic and social impact the program has on those participants who are able to obtain licensure and secure a job.

[illegible]

- The impressive results of quality-of-service indicators (retention and satisfaction of participants) is a reflection of the tremendous commitment and high caliber of the Welcome Back Center staff who work tirelessly to ensure that program participants receive the individual attention and support needed for them to be successful.

Left to right: Maria Ramos, CNA, Nursing Assistant; Yelitze Medina, RN, Clinical Nurse, Emergency Department; Gloria Robles, RN, Clinical Nurse. All former Welcome Back Center participants on-duty at Holy Cross Hospital.

CHALLENGES AND LESSONS LEARNED

- The challenge of securing additional funds to serve a larger number of healthcare professionals including nurses, physicians, and behavioral health professionals still persists.
- The Welcome Back Center still has limited capacity to respond to the demand for its services. Close to 900 internationally-trained healthcare professionals living or working in Maryland have approached the Center seeking guidance and support. Of those, we have only been able to serve 153.
- Establishing linkages with more potential employers with the capacity to hire internationally-trained health professionals is crucial to the success of the participants. Passing the boards is a critical step in the process, but the ultimate goal for reintegration into the healthcare system is the ability to secure a job in the field.
- At the beginning of FY13, funding available to provide financial assistance was limited. To continue to provide this critical resource to program participants in greatest need, with the guidance of the Center Advisory Council, the eligibility guidelines were adjusted. This component of the program is extremely challenging and requires close monitoring by program administrators.

900

WANTED TO PARTICIPATE IN THE PROGRAM

THE PROGRAM HAS ONLY BEEN ABLE TO SERVE

153

Other FY13 Latino Health Initiative and Welcome Back Center Activities

FY13 Accomplishments

In FY13, the Latino Health Initiative showcased its diverse assets and impressive accomplishments through the following activities.

- Latino Health Initiative staff committed a vast amount of time engaging the coordinating team that coalesced senior Department of Health and Human Services staff and African American Executive Committee, Asian American Health Initiative, and Latino Health Steering Committee representatives to work on specific recommendations aimed at improving services for racial/ethnic minorities and emerging Montgomery County populations. This effort, which began in FY12, produced a set of FY13 recommendations to improve the health and wellbeing of racial/ethnic minority populations, including Latinos, African American, Asian American, Continental Africans, Caribbean, and Middle Eastern communities. A major outcome of the process was the recommendation to establish the Leadership Institute for Equity and the Elimination of Disparities (LIEED) in the Department of Health and Human Services. The LIEED will begin operations in FY14.
- The Latino Health Initiative's Asthma Management Program Coordinator served as a member of the Maryland Asthma Control Program Executive Committee. This Committee reviews trends in data and seeks potential avenues for addressing asthma in Maryland.
- The Welcome Back Center of Suburban Maryland delivered a presentation on Center activities during a panel titled, "Economic success: Pathways to meaningful workforce skills and credentials for all types of workers," at the National Immigration Integration Conference in Baltimore, Maryland (September 2012).
- The Latino Health Initiative hosted a session on effective models to improve health outcomes for immigrants at the National Immigration Integration Conference (September 2012).
- The Latino Health Initiative served as a sponsor of the Thirteenth Annual Montgomery County Public Schools Latin Dance Competition held at Strathmore. This event brings together high school students to compete in several categories of Latin dance. Through this mechanism, Latin students learn more about their culture and traditions while engaging in physical activity.
- The Welcome Back Center of Suburban Maryland delivered a presentation on the Center at the Continental African Community Leadership Exchange Meeting with Montgomery County Executive, Isiah Leggett. The meeting promoted the importance of working together and advocating with a common voice on issues related to community development, equity, and quality of life as well as providing opportunities for overcoming challenges faced by immigrants living in Montgomery County (May 2013).
- Welcome Back Center of Suburban Maryland staff members participated as panelists in a seminar at Montgomery College titled, "Pathways to Success," that focused on providing information and resources to help skilled immigrants further pursue education and obtain professional licensure or certification that will secure professional employment in the United States. The Global Talent Bridge, World Education Services in collaboration with the Community College Consortium for Immigrant Education, and Montgomery College hosted the seminar (March 2013).

- The Welcome Back Center of Suburban Maryland presented on the Center's services to faculty and staff from various community colleges in Maryland, including in Montgomery, Howard, and Prince Georges, and Baltimore City Counties (March 2013).
- Welcome Back Center of Suburban Maryland staff delivered presentations to the general public. Center staff conducted one of these sessions, attended by 60 people, at the Takoma Park Campus and a second session, attended by 200 people, at Rockville Campus (April 2013).

In the News

In May 2013, the Migration Policy Institute released a report titled, *"Credential Recognition in the United States for Foreign Professionals,"* that examines the credential-recognition barriers immigrant professionals often face in the United States. The Migration Policy Institute's report acknowledged the Welcome Back Initiative's role in supporting foreign-trained health professionals in the United States, being the only initiative operating on a wide, interstate scale. http://www.migrationpolicy.org/pubs/UScredentialrecognition.pdf

FY13 Funds Received and Invested

During FY13, the Latino Health Initiative received a total of $1,191,663 from Montgomery County general funds.

Expenses for FY13 core appropriated funds were captured in two broad categories:

Contracts and In-House Programs:

These include program staff, contractors, major programs and activities (Latino Youth Wellness Program, Smoking Cessation Program, *Vías de la Salud* Health Promoter Program, Asthma Management Program, and Welcome Back Center of Suburban Maryland). This category accounts for 97% of the Latino Health Initiative's core budget expenditures.

*Funds appropriated to the System Navigator and Medical Interpreter Program were directly handled by the Office of Community Affairs and not included in this allocation.

Administrative:

This includes operational expenses such as for Latino Health Steering Committee support, interpretation services, office equipment, supplies, printing, parking permits for staff, and mileage reimbursement. This category accounts for 3% of the Latino Health Initiative's core budget expenditures.

Despite heavy workloads, Latino Health Initiative staff worked diligently during FY13 to leverage $218,706 in additional funds from public and private sources. These monies helped offset the impact of budget cuts and increased demand for services.

The total budget for the Latino Health Initiative for FY13 was $1,410, 369.

FY13 LEVERAGED FUNDS

Funding Source	Amount
Vías de la Salud Health Promoter Program (Maryland Department of Health and Mental Hygiene via Public Health Services, Department of Health and Human Services)	$32,205
Smoking Cessation Program (Cigarette Restitution Funds)	$10,000
Asthma Management Program (Maryland Department of Health and Mental Hygiene)	$20,000
Welcome Back Center of Suburban Maryland (Maryland Department of Labor, Licensing and Regulation; Annie E. Casey Foundation, and National Kaiser Permanente)	$156,501
TOTAL	**$218,706**

FY13 Partners and Collaborators

Adventist Healthcare

Annie E. Casey Foundation

Asthma Control Program, Maryland Department of Health and Mental Hygiene

Care for Your Health, Inc.

CASA de Maryland

Center for Health Disparities

Community Clinic, Inc.

Community Ministries of Rockville

Frederick County Workforce Services

George Washington University

Governor's Commission on Hispanic Affairs

Holy Cross Hospital

Identity, Inc.

Maryland Department of Labor, Licensing and Regulation

Maryland Office of Minority Health Disparities, Department of Health and Mental Hygiene

Mary's Center for Maternal and Child Care

Mercy Clinic

Millian Memorial Church

Montgomery Cares

Montgomery College

Montgomery County Commission on Health

Montgomery County Department of Health and Human Services

African American Program

Aging and Disability Services

Asian American Health Initiative

Children, Youth, and Family Services

Cigarette Restitution Program

Community Health Services

Healthy Montgomery

Linkages to Learning

School Health Services

TESS Center

Montgomery County Department of Economic Development

Montgomery County Workforce Investment Board

Montgomery Medstar Medical Center

Montgomery Works One-Stop Workforce Center

National Kaiser Foundation (Community Health Initiatives Grants Program)

Primary Care Coalition

Priority Partners MCO

Prince George's County Economic Development Corporation

Proyecto Salud

Shady Grove Adventist Hospital

Spanish Catholic Center

Suburban Hospital

United Healthcare

University of Maryland College Park, School of Public Health

Viers Mill Elementary School

Washington Adventist Hospital

Welcome Back Initiative

Workforce Solutions Group of Montgomery County

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