HHS COMMITTEE #2
May 2, 2014

MEMORANDUM

May 1, 2014

TO: Health and Human Services Committee

FROM: Linda McMillan, Senior Legislative Analyst

SUBJECT: **FY15 Operating Budget: Department of Health and Human Services - Follow-up and Deferred Items**

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
Rachael Silberman, Office of Management and Budget

1. Information – MCPS referrals to Crisis Center

At the April 24 session, the Committee and Dr. Crowel, Chief of Behavioral Health and Crisis Services, discussed several growing pressures on the behavioral health system. Mentioned in this discussion were referrals from Montgomery County Public Schools for crisis services for students. The Committee asked for additional information on the source of these referrals. DHHS will provide this information to the Committee at the Friday session.

2. Mobile Crisis Team for Children

At the April 24 session, the Committee briefly discussed a proposal to create a mobile crisis team specifically for responding to children and adolescents. The Committee asked the Department to provide further information on the composition of such a team and the estimated cost. DHHS will provide the Committee with information on this item at the Friday session.

3. Shared Psychiatrist

At the April 24 session on Behavioral Health and Crisis Services, the Committee discussed the Executive's recommendation for increases in the rates paid for psychiatric services, the difficulty in engaging psychiatric services, and the proposal from Family Services, Inc. that the County and outpatient mental health clinic share the cost of psychiatric services as it is unaffordable for any one clinic (©1-3). The proposal would have the County pay for a portion (about 33%) and the rest of the cost would be covered through billings by the clinic. The Committee asked the Department to provide comments and an estimated cost for this proposal. DHHS will provide the Committee with information on this item at the Friday session.

4. Requests from Minority Health Initiatives

At the April 10 session, the Committee reviewed the County Executive's recommendations for the budgets for the Minority Health Initiatives. The Executive is not recommending any reductions.

	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**

a. African American Health Program

The African American Health Program has written to the Council asking for three additional items (©4-6):

- **Data Analyst $25,000** – The AAHP currently has an epidemiologist consulting on services related to the conditions of high blood pressure and diabetes mellitus. AAHP would like to undertake the additional tasks: (1) conduct correlational analysis to evaluate AAHP services and data collection efforts related to AAHP program measures; (2) participate in data collection analysis for further enhancement of AAHP database capacity building; (3) train AAHP staff for capacity building and infrastructure development for a sustainable data repository, management, analysis and reporting.

- **Continue Community Health Workers $25,000** – AAHP is asking for funding for one Senior Community Health Worker and seven additional Community Health Workers. The memo notes that previously AAHP has received funding for this program through the Minority Outreach and Technical Assistance Grant (from Holy Cross) and the Susan G. Komen Foundation, but these sources have been reduced and are not secure.

- **Behavioral Health Program Area $25,000** – the memo provides information on disparities for African Americans regarding mental health and in the mental health system noting that in

Montgomery County there is disproportionate representation of mental health issues related to Black youth in the child welfare, juvenile justice, and criminal justice systems. It also notes mental health issues faced by the African community regarding war-related, post-traumatic stress disorders. AAHP will use the $25,000 requested to the planning and development of a new Behavioral Health Program.

b. Asian American Health Program

The Council has received a request from the Asian American Health Initiative asking for $300,000 in FY15 funding to focus on behavioral health issues (©7-9). The letter notes suicide rates among Asian American and particularly foreign born Asian Americans, as well as issues regarding depression and stress. Older members of the Asian American community may be isolated due to cultural, language, and transportation barriers. The letter discusses the need to partner with Healthy Montgomery and the need for funds to have education and outreach materials and programs translated into different Asian languages.

c. Latino Health Initiative

After the April 10 session, the Council received a request from the Latino Health Initiative asking for $100,000 in additional funding for the Welcome Back Center (©10-12). The letter includes the following anticipated results for FY15: (1) recruitment of a cohort of 20 or 25 internationally-trained behavioral health professionals; (2) establishments of partnerships for program implementation with 5 to 10 new service providers; (3) development and implementation of individualized plans for each participant; and (4) documentation of system's enhancers and barriers to achieve success.

At the April 10 session, the HHS Committee recommended adding $100,000 to the Reconciliation List.

d. Council staff recommendation

Behavioral health is a common issue across these three requests and the request from the Asian American Health Initiative specifically highlights the work of Healthy Montgomery. As the Committee has previously discussed, Health Montgomery's first two action plans are Behavioral Health and Obesity.

- **Council staff recommends that the HHS Committee add $200,000 to the Reconciliation List (in two $100,000 increments) for data development and analysis for Healthy Montgomery's Behavioral Health initiative.** It is important that the Healthy Montgomery effort be able to look at disparities in order to evaluate progress. This funding would be used to support the data needs identified in the requests from the AAHP and AAHI.

- **Council staff recommends the Committee add $25,000 to the Reconciliation List for Healthy Montgomery to use for targeted outreach and education on Behavioral Health.**

This could be used for translating and printing materials, staffing events, and holding community outreach sessions and could also support issues identified by AAHP, AAHI, and LHI.

- **Council staff recommends that $75,000 be added to the Reconciliation List to provide each of the minority health initiatives $25,000 to work on strategic planning around the issue of behavioral health.** While Council staff is recommending that this funding go to each of the initiatives, the initiatives should also work together with DHHS to determine if there are common approaches to planning that should be undertaken.

- **Council staff recommends adding the $25,000 requested by AAHP for continuation of Community Health Workers to the Reconciliation List;** although it is unclear from the information provided whether all this funding is needed if MOTA funding is available in FY15.

5. IMPACT Silver Spring

On April 25th the PHED Committee recommended adding $127,350 to the Reconciliation List to fund continued work in Bel Pre and Wheaton and to begin community building work in Connecticut Avenue Estates (©13-14). The Committee agreed that Council staff should determine if any of this funding is assumed in the Executive's FY15 budget and whether the contracts are administered by DHCA or DHHS.

The contracts for IMPACT Silver Spring are administered by DHHS. The Executive's Recommended FY15 budget includes the following for the items recommended by Councilmember Navarro and the PHED Committee:

Wheaton	$60,000	No funding is required from the Reconciliation List
Bel Pre	$30,560	$1,790 is needed from the Reconciliation List
Conn Ave Estates	$ 0	$35,000 is needed from the Reconciliation List

For these programs, the amount on the Reconciliation List can be revised to $36,790.

Councilmember Branson has contacted Council staff and requested that the HHS Committee consider two additional items for IMPACT Silver Spring: (1) $35,000 to expand community building activities to the east county; and, (2) $52,135 to provide continued funding for the Long Branch Athletic Association operating support and programming. The expansion of IMPACT's efforts into the east county would be a new program. The Executive has recommended a $60,000 Community Grant for the Long Branch Athletic Association but IMPACT needs a total of $112,135. IMPACT has requested a Council Grant for the remaining $52,135 that would not be needed if the program is funded through the Reconciliation List.

6. Montgomery Cares

At the April 10 session, the Committee considered the requests from the Montgomery Cares Advisory Board and the Primary Care Coalition for additional funding for Montgomery Cares. The

Committee recommended adding $1 million to the Reconciliation List in four $250,000 increments. These increments do not align with the specific items requested. **Council staff is recommending that the Committee show the following four increments of funding on the Reconciliation List.** Council staff consulted with the Montgomery Cares Advisory Board about this recommendation, but this is not a new recommendation from the Advisory Board. In particular, Council staff believes that if only two increments of funding can be provided that the pharmacy assessment should be funded. The Council has also received a letter of support for Montgomery Cares from the Commission on Health (©15).

Increment 1:	
Continued support for Electronic Health Records	$260,000
Increment 2:	
Behavioral Health – annualization of FY14 expansion	$ 81,000
Patient Satisfaction Survey	54,000
Pharmacy Assessment	21,600
Increase for Community Pharmacy	59,400
Increase for Specialty Care	40,500
	$256,500
Increment 3:	
Training for Medicaid Participation	$ 21,600
Increase for Specialty Care	40,500
Increase to Community Pharmacy	102,600
	$164,700
Increment 4:	
Behavioral Health Expansion	$225,000
Population Health Data	54,000
	$279,000
Total	**$960,200**

Funding is no longer recommended for the enrollment design and implementation study because Director Ahluwalia is working with foundations and other funders to complete this work. **If the Committee wants to continue to recommend a total of $1 million, Council staff recommends that $39,800 be added to the specialty care recommendation in Increment 3.**

7. Update/Overview of Dental Services and Grant for Muslim Clinic Dental

The Committee asked for an overview of existing capacity in the County's dental services system. Attached at ©16 is a summary table of the programs, locations, and wait times. The wait times are generally 2 to 3 weeks, although the wait time is 5 to 6 months at the Spanish Catholic Center. It is unclear whether people waiting for services through the Spanish Catholic Center would be eligible to seek services at the other clinics if they wanted to be seen sooner.

The Committee was interested in whether there was facility capacity and more people could be served it additional staff was available. DHHS will be able to discuss this further with the Committee at the Friday session.

The Committee deferred its recommendation on the $100,000 grant requested by the Muslim Community Clinic to help with its first year of operation. Council staff is unsure why the grant indicates that the clinic will treat 700 people in the first year but the table provided at ©16 indicates 3,000.

Name	**The Muslim Community Center (Medical Clinic)**
Amount	$100,000
Purpose	Cover 50% of the cost of a part-time dentist and two dental hygienists. Will treat up to 700 people in the first year of operation. Will reach out to more than 10,000 people to provide education on dental hygiene and prevention of dental disease.
MC Advisory Board Comments	**Recommend Funding**
Council Staff Recommendation	**Recommend Funding.** The application notes the scarcity of free or affordable dental care facilities. Many patients get frustrated and scrap the idea of visiting a dentist altogether. Will accept patients through Project Access and safety net clinics. However, Council staff also notes that this is a substantial investment in dental services for the County. If funding is requested in FY16, there should be a discussion of how patients were referred to make sure it is benefitting the capacity of the system as a whole.

Council staff recommends that $100,000 be added to the Reconciliation List for this grant as it is the clinic's start up year. Again, if the grant is requested in FY16, then information should be provided about the number treated, how it is benefitting the system as a whole, and how it can become more self-supporting for the long-term.

8. Mercy Health Clinic Grant – Diabetes and Health Education

At the April 10 session, the Committee considered Council staff's recommendation not to add $24,900 to the Reconciliation List for Mercy Health Clinic's request for their Health Education Program.

The Committee asked for additional information and deferred a decision on whether to put this on the Reconciliation List. Attached at ©17-18 is a letter providing more detail and outcomes on the three components of this program: Diabetes Education, Lifestyle Education, and Nutrition Education and Counseling.

Name	Mercy Health Clinic
Amount	$24,900
Purpose	Health Education Program. Low income patients will increase their knowledge of diet, exercise, and medication management to improve overall health. Requesting $24,900 of total project cost of $49,203.
MC Advisory Board Comments	**Recommend Funding; however –** No evidence it is sustainable Proposal contained some errors about Diabetic Management Project needs outcome measures
Council Staff Recommendation	**Do not fund.** As with many grants there was concern about sustainability but there was also some concern about the program and how outcomes would be measured. Council staff notes that $20,000 was provided in FY14 for health education and there may be a reduction to the program if this funding is not provided.

The additional information does clarify more about the programs, numbers served and outcomes. **Council staff recommends adding this to the Reconciliation List; however, Council staff suggests that the Committee indicates that Mercy Health Clinic should explore alternate sources of funding so that either a decreased amount or no County funding is expected in FY16.**

9. Adult Foster Care – Maximum Rate

At the April 24 meeting, the Committee approved the County Executive's recommendation to add $105,000 to the FY15 budget to increase the maximum rate a provider may charge for housing and caring for people placed through the County's Adult Foster Care program. The current maximum rates are $1,175 for double room occupancy and $1,375 for single room occupancy. The Executive's recommendation raises the maximums by $120 per month. Generally, individuals contribute about $700 per month, which is all but about $60 of their income. The County subsidy covers the difference and the current average subsidy is $475 per month.

The group home providers have requested that the maximum rates be set at $1,800 for double room occupancy and $2,000 for single room occupancy. This is a $625 increase per month from the current rates; or $505 above the Executive's recommended FY15 rates. The following table shows the current and CE proposed rates and two increments of funding to get to the requested level.

County Adult Foster Care – assumes 73 clients

	Maximum monthly rate – double occupancy	Maximum monthly rate – single occupancy	Additional Funding needed in FY15	Additional Funding needed – Reconciliation List
Current rates	$1,175	$1,375	$ 0	$ 0
CE Recommended	$1,295	$1,495	$105,000	$ 0
Mid point ($250 above Executive)	$1,495	$1,695	$324,000	$219,000
Full Request ($505 above Executive and $625 total increase)	$1,800	$2,000	$547,500	$442,500 if one item or $223,500 if done in two increments

As discussed last year, this particular subsidy has not been increased in at least 20 years. That said, Council staff offers the following comments which refer to the table at ©19:

- Raising the maximum rates to the $1,800 (double occupancy) and $2,000 (single occupancy) would place it above the rate allowed under the State's Project Home ($1,376 monthly double occupancy) but would be similar to the maximum rate allowed under the Senior Assisted Living Group Home program (for Levels 1 and 2 care). DHHS staff has shared that the cost for providing services to the Project Home population is less that the costs incurred by Assisted Living Group Home Providers.

- The maximum County subsidy for the Assisted Living Group Home is $650 per month. This is the only other program with a County subsidy. Under the Executive's proposal for Adult Foster Care, the average County subsidy would be $595 per month. The request from the providers would result in an average County subsidy of $1,100 per month.

- In addition to considering options for funding the full request from the group home providers in one or two increments, Council staff suggests the Committee may want to fund an amount that would provide an average County subsidy of $650 per month. This would require an additional $55 per month over the subsidy recommended by the Executive's ($595). This would require funding $48,180 from the Reconciliation List. The maximum rates allowed would be $1,350 for double occupancy and $1,550 for single occupancy.

10. Resource Coordination/Targeted Case Management

At the April 24 session, the Committee reviewed the Executive's FY15 Recommended Budget for Resource Coordination.

- The Executive's budget assumes DHHS will continue to provide Resource Coordination until January 1, 2015. People may choose the County until December 31, 2014. After that time, the State has said that the County may no longer take referrals (©20). It will probably take until March to transition all cases.

- The County asked the State if the County could continue to provide services to transitioning youth but was told they could not serve only a targeted population. As follow-up to the Committee discussion, the County has asked this question again.

- State regulations (COMAR10.09.48.04(H) require freedom of choice and say: "The provider shall place no restrictions on the qualified participant's freedom of choice among: (1) Providers of resource coordination; (2) Providers of community-based services for which the participant qualifies; and (3) Person directed supports and services." (©21-24 with Section H at ©24).

- During FY15, Resource Coordination services staff will be mostly contractors hired through the broker contract. (Resource Coordinators are currently 6 merit staff and 58 contract brokers.) This is because the County will not be providing services by the end of FY15. Director

Ahluwalia told the Committee that while the County continues to provide the best service it can, there are quality issues because of the turnover of staff and the fact that broker staff has been used for an extended period of time.

- Reimbursement from billings will not cover the full cost of a County program. The Committee asked for information about the General Fund subsidy that would be needed to continue to provide Resource Coordination to either a targeted population or to anyone choosing the County as their provider.

- If the County is to continue providing Resource Coordination beyond January 2015, in addition to the need for funding, there will be significant ramp-up time to refill merit positions needed to provide consistent, long-term service.

- Director Ahluwalia said that the Executive is considering whether there should be some sort of Ombudsman program but there is no proposal at this time.

Council staff comment and recommendation

At this time, the Committee needs to make a budget decision based on the best possible information it has. Unless Director Ahluwalia receives information from the State that they will allow Montgomery County to serve a targeted population, the best information now is that the budget should reflect that the County will not accept new referrals after December 31, 2014 and will completely transition out of Resource Coordination/Targeted Case Management by March 1, 2014. The Committee can either recommend approval of the Executive's budget as submitted, or reduce the appropriation and revenues by $743,430 to reflect this current reality. (The Executive's budget does not eliminate the broker appropriation and revenues from billing for the last quarter of FY15.)

If at a later time, the State approves the County's request to serve a targeted population, the Executive can propose a special or supplemental appropriation that would reflect that staffing, expenses, and revenues that would be associated with this newly structured program.

If the State does not allow the County to serve a targeted population, the Executive should come forward in the fall with any proposed Ombudsman program so that it can be in place by the time the County must stop providing these services.

Council staff understands and agrees with the Committee members' and the Department's deep concern about these clients and their families, the disruption this change has caused, and the uncertainty about whether the private providers will have the capacity to serve all those needing services and provide the level of care and service that the County has provided for many years. However, until there is reconsideration by the State, Council staff recommends the budget clearly reflect the expectation that this transition will finally and fully occur during FY15.

Over 100 Years of Service

Family Services, Inc.

An affiliate of Sheppard & Enoch Pratt Foundation

Montgomery County Council Hearing
April 17, 2014
Thom Harr, CEO

I am very pleased to be here today representing Family Services, the oldest non-profit social services agency in the county, celebrating its 106th anniversary this November. Things have changed a bit over the years, today's Family Services employs 390 people from 50 birth origin countries who speak 42 languages. We are a multi-cultural reflection of the face of the new Montgomery. Last year we touched the lives of 25,000 people and we brought into the community over $15,000,000 of Federal, State, and Foundation funding. And yet, the surge in the population, the growing disparity, and the major shifts in programs including the integration of expensive technologies, places us in a daily struggle for financial survival. Montgomery County currently funds about 15% of our total budget but we ask that you recognize our critically needed services and do a little more to support the work. I would like to first focus on the need of people in our community suffering from the effects of mental illness.

We who work with those who are mentally ill are reluctant to mention Fort Hood, the Navy Yard, Sandy Hook, or even the IBM headquarters in North Bethesda, for we know that it is likely to make things worse for the 96% of people who deal with the devastating impact of mental illness and are more likely to be victims than perpetrators. And yet, today we mention those events because we know they get your attention. Yes, we know that, and yet we wonder why, as perhaps you do as well, that more resources aren't being mobilized to fix a system that is so clearly flawed and so often failing. We must be more aggressive in addressing the loss of productivity at work, the impact on schools, the disruption of families, and the personal struggles of people trying to recover from the impact of this terrible illness. This year's budget doesn't do enough to address this growing problem. Please keep in mind these are the sons and daughters of Montgomery County families and sometimes, parents, colleagues at work, and friends. This illness doesn't discriminate.

Nearly forty years ago Congress passed a Mental Health Systems act. However, the hope for a system died quickly when a new administration failed to fund the work and instead reduced funding and block granted the money to States, essentially creating fragmentation at a national level. Even here in highly motivated Maryland we seem to have missed the concept of system. When we reformed our Medicaid program in 1995 we created a financing approach that allows services to be offered by any willing and qualified provider to any eligible client. We did something our country embraces, we created a marketplace. But a marketplace isn't a system. While we have some idea of the types of services that we need and we do encourage those, we haven't yet made them work together at the level that is needed.

At Family Services we have been committed to the provision of outpatient mental health services in a fully licensed clinic where we see over 1,000 patients. We have successfully integrated primary care with our partner Community Clinic, Inc. We have achieved the highest level of third party certification with CARF accreditation. And, in just a little over 10 years we have recorded losses in

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excess of $2 million dollars while doing so. Our clinic, and others like it operated by similar organizations, should be the backbone of a system. Our leaders should distinguish between a clinic, a group practice, and an individual provider. We need to be clear that people living in low income households, an ever growing number, and most people with severe mental illness will have access only to publicly supported resources. A few years back, the beginning of the "great recession", the County supplement to OMHCs for the administrative burden of offering comprehensive services was reduced by 40%. We need that $400,000 to be restored.

Why is this so important? Let's look at just one simple set of numbers. According to the Academy of Child and Adolescent Psychiatrists, there are about 15 million children in the US in need at any given time and there are just 8,300 psychiatrists to treat them. Treatment availability is poor at best and, while we can't give a number, I can assure you the odds for the children in the public mental health system are even worse.

So what can we do? As stated earlier, build around the core of a system, outpatient mental health centers. Connect them to the resources that are already in the community – hospitals, corrections facilities, and schools are obvious but what about workforce and housing counseling sites where people dealing with job loss or foreclosure are also dealing with the emotional trauma that goes with those life changing events.

A child psychiatrist, with benefits, will easily cost more than $200,000 per year. An OMHC cannot fully recover that cost. For several years, we have suggested shared psychiatry where the County would pick up about 33% of the total and billing would take care of the balance. Add money to make that happen. As a provider we would be happy to send the billings to the County in exchange for a reduction in financial risk.

All that said it isn't just people with mental illness who need a range of support. Those of you who have found time to visit our headquarters in Gaithersburg have probably been surprised to find 90,000 square feet of buildings occupied by non-profits providing early childhood education, housing assistance, primary care, mental health and substance abuse services, WIC, and education services for adolescents with autism in one program and emotionally disturbed children in yet another. Serving as an integrating support for all of this is a Neighborhood Opportunities Network center. The Council has supported case management services in that center for several years but this year there is no funding in the budget. We will not leverage City of Gaithersburg funds without this contribution! We will not provide vital services to 400 to 600 people each month who need more than the NON can offer in a single visit. We can't afford to take a step backwards. I am sure none of us believes that the recession is over for low wage earners and the low income households. Why would we now abandon a successful

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effort? We need $80,000 to continue to excel in this program. Restore at least $40,000, half of what is needed, to keep this program intact.

I started out by noting that we reach many, many people – children, single adults, and families. We provide housing for 160 people, work with 400 families at any given time, screen 5,000 newborns each year through the Baby Steps program, operate the Betty Ann Krahnke center, provide childcare in Clarksburg, medical day services in Rockville, and much more. We need your support to continue our work in building a stronger community. Please preserve the backbone of the system and the legacy of caring that we represent. Thank you for your time and consideration.

Dear Mr. Leventhal:

The AAHP Executive Committee has evaluated our needs this past year and is identifying the following as our additional needs for AAHP for FY15:

Data Analyst	$25,000
Continuation of Community Health Workers	$25,000
Behavioral Health Program Area (planning and development)	$25,000

The justification for the requests is listed below.

If you have questions or need additional information, please contact me on 301.460.7546 or via email (patsygrn@gmail.com).

We thank you in advance for any and all consideration given.

Sincerely,

Pat Grant
Chair
AAHP Executive Committee

JUSTIFICATION for FY15 AAHP Requests

Need for a Data Analyst: $25,000

Currently, an epidemiologist is consulting with the African American Health Program (AAHP) to evaluate the program's services to high risk individuals of Montgomery County suffering from high blood pressure (HBP) and diabetes mellitus (D2m). While the ongoing services have been successfully individualized, the short-and long term impact of these services have not been recognized to date. The epidemiologist has been developing efficient evaluation frameworks for the program measures and services for which the data collection efforts and documentation need restructuring.

Moving forward in FY15, it is necessary for AAHP to have ongoing data analysis support and the epidemiologist is agreeable to continue to consult with the program if funding is available. The epidemiologist will develop specific guidelines and conduct analyses of current data gathering efforts as well as assist in the dissemination of findings to stakeholders. Additional tasks would include the following:

- Conduct correlational analysis to evaluate AAHP services and data collection efforts related to AAHP program measures;
- Participate in data collection analysis for further enhancement of AAHP database capacity building;
- Train AAHP staff for capacity building and infrastructure development for a sustainable data repository, management, analysis, and reporting.

The consulting services by an epidemiologist will provide oversight of overall evaluation efforts of AAHP where demonstrating success has become critical. **Additional funding in the amount of $25,000 would enable AAHP to continue to engage these data management and analysis services.**

Continuation of Community Health Workers: $25,000

During the past decade, private insurers, business enterprises, and the federal government, responding to the high cost of providing adequate health care to employees and the population at large, implemented or proposed changes in health care delivery and financing. Some of the factors contributing to the cost challenges included population changes, provider shortages, accelerating technological progress, and the increasing complexity of the health care system. Population projections have been predicting a large increase in the U.S. elderly population (estimated to be 87 million in 2050) and due to higher fertility among minorities, an increase in population diversity and the size of younger cohorts of individuals from low-income families. These changes in the size, structure, and diversity of the population have been and will be requiring a broader range of health services for entire families and communities. Cultural understanding, community health education, and translation services have been and will be increasingly needed for delivering effective care to families and communities that are often isolated and underserved.

CHW Definition

Community health workers (CHWs) are lay members of communities who work either for pay or as volunteers in association with the local health care system in both urban and rural environments and usually share ethnicity, language, socioeconomic status and life experiences with the community members they serve. They have been identified by many titles; such as community health advisors, lay health advocates, "promotores(as)", outreach educators, community health representatives, peer health promoters, and peer health educators. CHWs offer interpretation and translation services, provide culturally appropriate health education and information, assist people in receiving the care they need, give informal counseling and guidance on health behaviors, advocate for individual and community health needs, and provide some direct services; such as, first aid and blood pressure screening.

Within the AAHP program, many of our activities are dependent on our CHWs who focus on educating the community about AAHP's programs and services, cardiovascular disease, cancer prevention, HIV and STI education and diabetes management. They have received training to conduct on-site blood pressure screening, and to disseminate oral health kits. These CHWs have played a pivotal role in increasing awareness of AAHP among residents and have increased the Program's ability to partner and/or support many local events and health affairs. With the assistance of CHWs, AAHP has been able to support at a minimum 30 local community events or activities during any given month.

In the past, AAHP has received funding for our CHW program principally from Holy Cross Hospital through the Maryland Department of Health and Mental Hygiene's Office of Minority Health, Minority Outreach and Technical Assistance grant (MOTA). Additional funding has also come from Holy Cross through a Susan G. Komen Cancer Foundation grant as well as funding through Ms. Diane Fisher from the Montgomery County Department of Health and Human Services.

Funding for the CHW program is not guaranteed each year through the MOTA grant. The current Fiscal Year funding has been just over $11,000 and was reduced from past years. It is uncertain if Holy Cross will pursue or receive MOTA funds for Fiscal Year 2015. If it does not, the CHW support would be drastically reduced and AAHP's outreach efforts would be impacted significantly. **Funding in the amount of $25,000 would support the cost to engage one (1) senior CHW and seven (7) additional CHWs to continue to sustain the important outreach and education efforts of the program. The funding would also support training materials and activities.**

Behavioral Health Program Area: $25,000

Under the Affordable Care Act, more emphasis will be placed on establishing or expanding behavioral health services for people living with mental illness, and drug and alcohol problems.
According to the U.S. Substance Abuse and Mental Health Services Administration (SAMSHA):

- *"In 2010, 19.7 percent of Black or African Americans aged 18 or older had a mental illness within that year. With regards to serious mental illness, 4.4 percent of Black or African American ages 18 or older suffered from a serious mental illness in 2010.*
- *African Americans of all ages are under-represented in outpatient treatment but over-represented in inpatient treatment. Black or African Americans (Non-Hispanic) persons, aged 12-17, had the highest percentage for receiving mental health services from an inpatient or residential treatment setting compared to their racial/ethnic counterparts at 3.7 percent. However, for outpatient settings they have the second lowest percentage, second to Asians."*

In Montgomery County, there is a disproportionate representation of mental health issues related to Black youth in the child welfare, juvenile justice, and criminal justice systems. Many Black youth in the juvenile justice system may have witnessed a killing or injury, had prior victimization, and/or involved in a gang. Many incarcerated youth have a substance abuse disorder. There has also been a rise in sleep deprivation among youth, which has been attributed to stress due to academic pressures and bullying. Black males continue to experience racial profiling.

According to William Lawson, Chair of the psychiatry department of Howard University's College of Medicine, "there is a huge disparity in access to mental-health treatment and gross under-diagnosis of mental illness for African American males, which is attributed to their more likely to being viewed as having a behavioral problem rather than a mental disorder".

Much have been reported about mental health issues in the African community as it relates to war-related post-traumatic stress disorders amongst combat veterans and those who have sought asylum in the US. In addition, there is a high rate of depression and anxiety.

According to the CDC, an understanding of racial and ethnic groups and their beliefs, traditions and value systems have not been historically factored into mental health research since Caucasian and European based populations have been used as a benchmark. Therefore, as a way to improve utilization of mental health services in the African American and African communities, culturally competent care is essential.

In general, African Americans and people of African descent:

- May feel that seeking therapy could be perceived as a sign of weakness.
- Often seek treatment late
- Typically turn to their family, friends, and church when experiencing stress.

Currently, the African American Health Program does not have a Behavioral Health program area. It is important to provide focus in order to raise awareness about mental health and ensure that prevention and early intervention programs tailored to the targeted community the African American Health Program serves are in place. In addition, having a Behavioral Health program area will help AAHP to help its targeted community to understand the signs and symptoms of specific illnesses like stress, anxiety, depression, schizophrenia, bipolar disorder, eating disorders, and addictions.

Funding of $25,000 for the planning and development of a new Behavioral Health Program area.

Asian American Health Initiative Steering Committee

Asian American Health Initiative Steering Committee
Funding request for FY2015

Dear Montgomery County Council President:

Asian Americans comprise of 13.9% of Montgomery County's population, which is 45% of Maryland's total Asian American population. Of those, 72.1% are foreign born with 81.5% speaking a language other than English at home.[4]

The Asian American population has long been confronted with barriers to access to health care which is even more accentuated when it comes to Mental Health. Among AAHI's programs Mental Health has been a priority and a major health concern during the past few fiscal years but progress on the development of help strategies have been stymied due to logistical and financial reasons and shortage of AAHI staff. A limited health Needs Assessment of 2008 though not a comprehensive survey, revealed the overwhelming concern of the Asian population surveyed across 13 Asian focus groups. The conclusion was that there are several cultural and social stigmas prevalent like the stigma associated with mental illness, lack of awareness, shortage of trained and culturally friendly mental health professionals who could offer linguistically and culturally appropriate, and more. The social stigma creates a taboo and inhibits an open discussion on mental health challenges. Affected people therefore tend to hide, neglect, or deny the symptoms rather than seek help and therefore go untreated compared to their counter parts in the Latino, African American or Caucasian groups.[2]

There is a lack of substantiated, direct or indirect credible data and anecdotal evidence of mental health issues of the Asian population in Montgomery County continues to be a weak determinant factor.

The U.S. Surgeon General's Report on Mental Health and it's relation to Culture, Race and Ethnicity testifies to the low utilization of mental health services among Asian American and Pacific Islander subgroups. It is well recognized in this report that certain cultural values, associated social stigma, lack of ethnically friendly bicultural and bilingual providers are some of the contributing factors.[1]

The available data on suicide rates among the Asian American population, both in the younger and senior age brackets grimly highlight the fact that these figures run to be the highest across any ethnic group in the country. This leads to the recognition of the widespread existence of depression in one or more forms in this population segment and places suicide as the fifth leading cause of death among Asian Americans, compared to the ninth leading cause of death for Caucasian Americans.[3] Females over the age of 65 and young people in the age bracket of 15 - 24 in the Asian American community have the highest suicide mortality rates across all racial/ethnic groups.[3] AAHI's modest Needs Assessment in 2008 did show that older members of the community feel lonely, depressed, isolated due to cultural, language, transportation, hindered social relationships with neighbors, lack of independence as barriers.[2]

According to the National Asian Women's Health Organization, a significant sub-group within the Asian American immigrant population is the refugee population. Economic factors have transcended to a major issue in this sub group obviously leading to enhanced depression, stress and other issues in addition to the language barrier. Suicide rates are higher for foreign-born Asian Americans than those who are American-born.[5]

In context of the above we strongly urge the County Council to take cognizance of the difficult circumstances and the causes for the Asian American Health issues to be treated on a different footing. There is general consensus that credible and substantiated data is lacking about this population compared to others. The mainstream approach has not worked and has not provided any evidence of the magnitude of the issue. There is a lot of good work going on all around involving improved methods of qualitative and quantitative data collection but the reality is that they have not and do not unveil the needs of the Asian American population in the county when it comes to mental health. Can we be passive spectators at the alarming rate of suicides in the Asian American Community?

The question is what do we want to do and how. Obviously we come back to data scarcity but a comprehensive Needs Assessment to collect in depth data is not just expensive but requires some pre ground work. If we may foresee a Needs Assessment proposal for the fiscal year 2016 we definitely require to fulfil certain actions at the ground level in the fiscal year 2015. The AAHI Steering Committee therefore proposes the following and urges the County Council a minimum funding of $ 300,000 for the 2015 fiscal year.

- Help and partner with Healthy Montgomery Behavioral Health Workgroup Action Plan in a more involved way
- Establish community focus groups and hold community outreach sessions throughout the year specifically for mental health
- An enhanced outreach through Faith Based Organizations and Social Organizations to hold community based dialogue on mental health
- Liaise more with the Welcome Back Center
- Develop / translate mental health education material in the different Asian languages
- Recruit and train a larger number of paid volunteers to participate in the plan
- Mental health media campaign in the community TVs and community newspapers and advertise in the brochures at different community events
- Sponsor mental health education and awareness booths at the various ethnic events and celebrations
- Education on how to use Montgomery County behavioral health and crisis services
- Participate and liaise with the Mental Health Advisory Committee
- Special program solely focused on highlighting the social stigma associated with mental health at the appropriate places to try to reduce resistance
- Liaise and partner with some of the existent mental health organizations in Montgomery county and leverage their experience at the same time raise awareness among them to develop bilingual and bicultural volunteer providers
- Recruit a full time staff at AAHI solely dedicated to mental health (already short on staff for current programs)
- Utilize the services of holistic service providers in the county who are currently providing multi lingual and culturally sensitive help

We pray that in the fundamental equal existential and well-being concept the County Council help us and help the Asian under privileged constituents of Montgomery County live a life of Equity.

Sincerely,

Sam Mukherjee, PhD, CLTC
Chairperson
Asian American Health Initiative Steering Committee

Enclosures: AAHI Steering Committee Signatories
CC: George Leventhal, Montgomery Council Vice President, HHS Committee Chair
Nancy Navarro, Montgomery Council HHS Committee
Craig Rice, Montgomery Council HHS Committee
Uma Ahluwalia, HHS Director
Betty Lam, Chief, Office of Community Affairs
Perry Chan, Manager, Asian American Health Initiative

Bibliography:
[1] U.S. Department of Health and Human Services (USDHHS). *Mental Health: Culture, Race, and Ethnicity—A Supplement to Mental Health: A Report of the Surgeon General.* Rockville, MD: USDHHS, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services; 2001.
[2] Asian American Health Initiative (AAHI). *Asian American Health Priorities: A Study of Montgomery County, MD 2008-Strengths, Needs, and Opportunities for Action.* Rockville, MD: Montgomery County Department of Health and Human Services, AAHI; 2008.
[3] National Alliance on Mental Illness (NAMI). *Asian-American and Pacific Islander Mental Health.* Arlington, Virginia: NAMI; 2011.
[4] U.S. Census Bureau, 2010-2012 American Community Survey.
[5] National Asian Women's Health Organization (NAWHO). *Mental Health and Depression in Asian Americans.* San Francisco, California: NAWHO, Empowering Avenues for Community Action: The National Collaborative for Asian American Women's Mental Health.

FY 14 AAHI Steering Committee Members
Sam Mukherjee (Chair)
Anis Ahmed
Ji-Young Cho
Nerita Estampador
Wilbur Friedman
Yan Gu
Meng Lee
Sunmin Lee
Michael Lin
Mayur Mody
Nguyen Nguyen
Wendy Shiau
Stan Tsai
Sovan Tun

Latino Health
STEERING COMMITTEE
MONTGOMERY COUNTY, MD

April 14, 2014

The Honorable Craig Rice
Montgomery County Council President
100 Maryland Avenue
Rockville, MD 20850

Re: FY15 Budget – Request for additional allocation of $100,000 for the Welcome Back Center of Suburban Maryland (WBC)

Dear Council President Rice:

On behalf of the Latino Health Steering Committee (LHSC) of Montgomery County, we thank you for the support that has been provided to the ***Welcome Back Center of Suburban Maryland*** **(WBC)** of the Montgomery County Department of Health and Human Services (HHS) since 2006. Attached please find the roster of the LHSC members.

We respectfully request an additional allocation of $100,000 for FY15 budget for the WBC, in addition to maintaining the funding currently allocated by County Executive ($148,518). These funds will expand services to assist Behavioral Health Professionals to gain licensure/certification to practice in Maryland and to work in Montgomery County.

On June 25, 2013, the Health and Human Services Committee of Montgomery County Council held a first discussion about behavioral health (BH) workforce issues, staffing, recruitment, retention, and training trends with social workers and other BH professions in HHS. Senior staff of the WBC was invited to provide information about WBC and participate in this discussion.

During FY14, the WBC began a collaborative effort with BH Services of HHS to develop a plan of action for the integration of BH professionals into the workforce within and outside the Department. The plan will take into consideration lessons learned from the WBC's experience with nursing professionals with the goal to be executed in FY15.

The WBC serves as a national model for an effective response to health workforce shortages that builds on the personal and professional assets of internationally-trained health professional living and/or working in Maryland, to facilitate the health professions licensure/certification process, and help individuals enhance economic self-sufficiency as they re-enter the health workforce in Maryland. We respectfully request an additional allocation of $100,000 for FY15 budget to expand on the success of WBC.

Latino Health Steering Committee of Montgomery County
8630 Fenton Street, 10th Floor • Silver Spring, Maryland 20910 • 240/777-1779; Fax: 240/777-3501

WBC partners in this effort will include BH Services at HHS, BH service providers who partner with HHS, Montgomery College, and other partners identified in FY14. The anticipated results for FY15 include:

- Recruitment of a cohort of 20 to 25 internationally-trained BH professionals;
- Establishment of partnerships for program implementation with 5 to 10 new service providers;
- Development and implementation of individualized plan for each participant; and
- Documentation of system's enhancers and barriers to achieve success.

Expanding the pool of racial and ethnic minority health professionals will contribute to address the shortage of health professionals. The large number of internationally-trained minority health professionals (not yet licensed to practice) residing or working in the state, is a ready resource to serve the health needs of the County minority community. The WBC will contribute to increase the number of health professionals who provide culturally and linguistically competent services to racial/ethnic minority and other underserved populations in Montgomery County.

We thank you in advance for your support and look forward to working with you in the upcoming years.

Sincerely,

Grace Rivera-Oven
Steering Committee Co-Chair

Rose Marie Martinez, Sc.D.
Steering Committee Co-Chair

Attachment: Roster of the Latino Health Steering Committee Members

cc: Ms. Uma Ahluwalia, Director, Department of Health and Human Services
Welcome Back Center Advisory Council

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LATINO HEALTH STEERING COMMITTEE OF MONTGOMERY COUNTY

Fernanda Bianchi, PhD
Montgomery County Activist
Potomac, MD

Olivia Carter-Pokras, PhD
Dept. of Epidemiology/Biostatistics
University of Maryland College Park
College Park, MD

Norma Colombus
Montgomery County Activist
Silver Spring, MD

George Escobar
Casa de Maryland
Hyattsville, MD

Maria S. Gómez, RN, MPH
Mary's Center for Maternal and Child Care, Inc.
Washington, DC

Rosa Guzman
Montgomery County Activist
Gaithersburg, MD

Anna Maria Izquierdo-Porrera, MD, PhD
Care for Your Health, Inc.
Clarksville, MD

Elva Jaldin
Montgomery County Activist
Silver Spring, MD

Evelyn Kelly, MPH
Institute for Public Health Innovation-IPHI
Washington, DC

Luis Maldonado, MHSA
Montgomery County Activist
Rockville, MD

Rose Marie Martinez, Sc.D. *
Liaison Montgomery County
Commission on Health
Silver Spring, MD

J. Henry Montes, MPH
Montgomery County Activist
Potomac, MD

Cesar Palacios, MD, MPH
Proyecto Salud
Wheaton, MD

Eduardo Pezo, JD, MA, MPH
Montgomery County Activist
Kensington, MD

Patricia Rios
Suburban Hospital
Bethesda, MD

Grace Rivera-Oven *
Montgomery County Latino Lions Club
Germantown, MD

Diego Uriburu, MS
Identity, Inc.
Gaithersburg, MD

*** Steering Committee Co-Chairs** **(March 2014)**

MONTGOMERY COUNTY COUNCIL
ROCKVILLE, MARYLAND

COUNCILMEMBER NANCY NAVARRO
DISTRICT 4

MEMORANDUM

TO: Planning, Housing, and Economic Development Committee
Councilmember Nancy Floreen, Chair
Councilmember Marc Elrich
Councilmember George Leventhal

DATE: April 25, 2014

RE: MHP and IMPACT in the Operating Budget for Department of Housing and Community Affairs

Last year the Council added $100,000 to DHCA's budget for MHP to do community building work in Glenmont and Germantown. This work has been very successful, and I propose adding $100,000 to the FY15 budget to continue it, as well as provide an additional $20,000 to expand their work into the Connecticut Avenue Estates neighborhood, for a total of **$120,000**. MHP did a great deal of work in Connecticut Avenue Estates in the late 1990's, but since then they have had persistent issues with illegal trash dumping, code enforcement, and other public safety issues which the Civic Association does not have the resources to deal with on their own.

Additionally, I would like to propose an additional $127,350 for a contract with Impact Silver Spring. In FY14, the Council added $60,000 to the County Executive's recommendation of $40,000 for Impact. This year, the Executive did not reccomend any funding for this contract. I propose adding:

- **$32,350** to continue work in Bel Pre
- **$60,000** to continue work in Wheaton
- **$35,000** to begin work in Connecticut Avenue Estates in partnership with MHP
- **Total: $127,350**

In Wheaton and Bel Pre, IMPACT reports:

- 400% increase in IMPACT's sports programming (an effective way to engage youth and connect with their families)
- Activated schools in both neighborhoods
- Directly engaged 500 people
- Established an emerging core of 45-50 leaders
- Built leadership capacity
- Built relationships with MCPS/MHP/Linkages to learning
- Established an English learning circle for 150 people- (Every Tuesday)
- Established a Spanish circle for English speakers to learn Spanish
- Established a sewing circle
- Growing the Grandview Opportunity Circle
- These communities are building networks and connecting more to the larger community by engaging with schools, government, other nonprofit organizations, businesses, etc
- Developed a translation unit made up of community members

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Isiah Leggett
County Executive

Uma S. Ahluwalia
Director

April 24, 2014

Craig Rice, President
Montgomery County Council
100 Maryland Avenue
Rockville, Maryland 20850

Dear Council President Rice:

The Commission on Health (COH) thanks you for your ongoing support of the Montgomery Cares program. While many low-income residents are beginning to have access to health insurance coverage through the Affordable Care Act (ACA), many County residents will remain uninsured and dependent on programs such as Montgomery Cares for meeting their health care needs.

The Montgomery Cares Advisory Board is asking for $1.03 million in additional funding for FY15 to help improve quality of care and increase access to needed services such as behavioral health, specialty care, and pharmaceuticals. While the Montgomery Cares program is serving over 30,000 low-income adults in the County, even with full implementation of the ACA the need within the County far exceeds the funding currently provided to the Montgomery Cares program. The increase in funding that is being requested will not cover all of those in need in the County, but will be an important step in the direction of meeting the needs of more County residents who do not have, and are unable to obtain, health insurance. The COH strongly endorses the Montgomery Cares Advisory Board's request.

Sincerely,

Ron Bialek

Ron Bialek, MPP, CQIA
Chair, Commission on Health

RB:jgk

cc: Uma Ahluwalia, Director Montgomery County DHHS
Dr. Ulder J. Tillman, County Health Office

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CURRENT DENTAL CAPACITY

	County dental programs	**Spanish Catholic Center**	**Community Clinic, Inc.**	**Muslim Community Center Medical Clinic**	**Catholic Charities**	**Homeless Health**
Number/ location of operatories	Total of 17 in 6 locations throughout the County	4 operatories in Wheaton	7 operatories in Gaithersburg, 3 in Greenbelt	Under construction – anticipated opening June 30, 2014	Health Care Network	Mobile van at 2 shelter sites
Schedule	Varies across locations, 3-5 days/week	All day, Monday through Friday	All day, Monday through Friday	Yr. 1 20 hrs/week Yr. 2 30 hrs/week Yr. 3 40 hrs/week	Specialty referrals as needed	Fridays
Total number of patients FY 13	**4,694**	**1,299**	**2,848**	Anticipated FY 15 – **3,000**	**77** referrals	**200**
Types of patients served	Uninsured, low-income adults, children, seniors	Low income adults and children	Adults and children, 92% insured (including Medicaid), remainder self-pay	Low income adults	Adults and children	Homeless adult women and men
Wait times for appointments – new patients	2-3 weeks at all locations except Piccard	5-6 months	2 days – 2 weeks			Up to 2 weeks
Wait times for appointments -- emergencies	Same day		24-48 hours			Up to 2 weeks

April 24, 2014

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MercyHealthClinic

Quality Health Care From
the Heart for Those in Need

7 Metropolitan Court, Suite 1
Gaithersburg, MD 20878
mercyhealthclinic.org

MEMO

TO: Linda McMillan, Senior Legislative Analyst, Montgomery County Council
FROM: John Kleiderer, Executive Director
DATE: April 29, 2014
RE: FY15 grant proposal for health education program

At your and the HHS Committee's request, this memo outlines Mercy Health Clinic's health education program in more detail. After reviewing this, please let me know if you would like any further information or have any questions or clarifications: (240-773-0329 or john.kleiderer@mercyhealthclinic.org). Thank you for the opportunity to provide this additional information for the Committee's deliberations.

Mercy Health Clinic's health education program is comprised of 3 components: diabetes, lifestyle and nutrition education. The education is provided in group or individual sessions. Below is additional information on the health education program, including the most recent data from the current FY14 grant period.

The health education program is currently supported by both the County Council's Community Grant as well as the Clinic's general operating budget. The health education program is highly valued by our medical providers, who refer patients to meet with one of our two health educators in a private session or to attend a group class. The County grant funding provides around 50% of the program's cost, with the Clinic raising the remaining funds. Without the County grant funding, we would need to significantly reduce the size of the program or identify other funding sources such as private foundations.

Mercy Health Clinic's FY14 Community Grant for health education began July 1, 2013. From July 1, 2013 through December 31, 2013, 320 patients attended group or individual health education sessions.

DIABETES EDUCATION
Diabetes education was provided to 34 patients in group classes and 19 patients in individual sessions. Mercy offers two group diabetes classes – diabetes basics and diabetes nutrition – in both English and Spanish. Between 7/1/13 – 12/31/13, 16 people attended the basics class and 18 attended the nutrition class. Analysis of pre/post test data from these classes showed that:

- 72% of the attendees in the basics class, and

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MercyHealthClinic

Quality Health Care From
the Heart for Those in Need

7 Metropolitan Court, Suite 1
Gaithersburg, MD 20878
mercyhealthclinic.org

- 69% of the attendees in the nutrition class increased knowledge.

Of those who answered questions about intention to change health related behavior:

- 89% reported the intention to improve their diets with specific changes such as decreasing carbohydrate intake, increasing vegetables, increasing dark green vegetables and increasing fruits.
- 75% reported the intention to increase exercise with specific plans such as add evening exercise, roller skating, and walking.

LIFESTYLE EDUCATION

Thirty-six patients participated in the 8-week lifestyle education program, which focuses on educating patients about a healthy lifestyle and encouraging behavior change to reduce the risk or improve cardiovascular disease. Of the patients who completed the lifestyle program by December 31, 2013:

- 88% increased knowledge of healthy lifestyle based on pre/post test assessment
- 75% decreased waist measurement an average 4.5 inches
- 75% decreased blood pressure
- 63% achieved weight loss of 1-5%
- 38% increased intake of fruits and vegetables and amount of exercise

NUTRITION EDUCATION & COUNSELING

Nutrition education and counseling was provided to 231 patients in individual sessions, in both English and Spanish. The nutrition education and counseling focuses on conditions including cardiovascular disease, elevated blood lipids, fatty liver, hypertension, obesity, overweight and pre-diabetes. Our health educators provide evidence based nutrition recommendations and work collaboratively with the primary care providers.

With our recent switch to electronic health records Mercy Health Clinic hopes to be able to collect outcome data from individual counseling sessions. Our health educators are also planning to include telephone follow-ups with patients.

Diabetes group: 34 patients educated
Diabetes individual: 19 patients educated
Nutrition: 231 patients educated/counseled
Lifestyle: 36 patients enrolled

Mercy Health Clinic and our patients are grateful for the County Council's support for the health education program. Thank you for considering a grant for FY15.

###

Rate Comparisons for Aging and Disability Services Subsidy Program for Frail Elders and Persons with Disabilities			
Program/Services	***Subsidy Rate***	***Notes***	**FY14 funding amount**
Adult Foster Care/Small Group Homes Subsidy Program			
Single Room-24 hour care and supervision	$1,375	Client cost of care is calculated based on client's income. Subsidy Rate does not include cost of medications covered by the program or other ancillary costs (i.e. supplies) Clients receive 24 hour supervision, assistance with daily normal activities, medication management, transportation to medical appts. Monthly allowance is typically $60. Subsidy funds are 100% County dollars. **Subsidy rate set by A&D. Last increase approx 20 years ago.**	715,320
Double Room-24 hour care and supervision	$1,175	same as above	see above
Project Home			
Room and Board-set rate for double occupancy	$1376 ~~$1,340~~	Clients receive 24 hour supervision, room and board, socialization, medication oversight, assistance with ADLS in a family style Project Home certified by DHHS. Each Project Home client and provider is assigned to a case manager. Eligible clients receive Public Assitance to Adults(PAA) benefits. The cost of care is fully subsidized by the State from the PAA grant. The monthly personal allowance is $102. the Project Home is re-certified annually.	State pays directly to client provider. Money doesn't come to DHHS
Senior Assisted Living Group Home Subsidy Program			
Services	***Maximum Cost of Care.***	***Notes***	
Level 1	$1,650	Cost of care limits are established by the program locally, with the approval of the State. Clients reside in many of the same assisted living facilities as AFC clients. Clients receive 24 hour supervision, room and board, transportation and assistance with daily activities. Program does not cover the full cost of care. Personal allowance is $60. Maximum subsidy is $650. Client is responsible for the amount beyond the subsidy payment up to the maximum cost of care. Family, friends and others may help client pay the cost of care. See attached State Level of Care Description.	$90,000 general funds, $209,364 state grant for 3 different levels.
Level 2	$2,050	see above	
Level 3	$2,450	see above	
Waiver Older Adults Program			
Services Provided	***Subsidy Rate***	***Notes***	
Level 2	Monthly range of $1,295.49-1,726.70	Rates are determined by and paid by the State.$55.70/day for the days client does NOT attend Medical Adult Day Care. $41.79 for the days client does attend MADC.	paid directly to providers by the State
Level 3	Monthly range of $1,633.39-$2,178.99	Rates are determined by and paid by the State. $70.29 for the days client does NOT attend Medical Adult Day Care and $52.69 for the days client does attend MADC	paid directly to providers by the State
	*Calculations were based on a 31 day calendar month		

Adult Foster Care

Project Home

Senior Assisted Living Group Home

Waiver Older Adults Program

(6)

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STATE OF MARYLAND

DHMH

Maryland Department of Health and Mental Hygiene
201 W. Preston Street • Baltimore, Maryland 21201
Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor – Joshua M. Sharfstein, M.D., Secretary

Developmental Disabilities Administration
Patrick Dooley, Acting Executive Director

April 3, 2014

Ms. Uma Ahluwalia
Director, Montgomery County Health and Human Services
401 Hungerford Drive
Rockville, Maryland 20850

Dear Ms. Ahluwalia:

Thank you for your efforts and those of your colleagues at the Montgomery County Department of Health and Human Services (DHHS) for continuing to work with the Developmental Disabilities Administration (DDA) during the transition to Targeted Case Management (TCM) for resource coordination services. I am writing to respond to DHHS' request to continue providing resource coordination services for Transitioning Youth (TY) beyond December 31, 2014.

Maryland's TCM Medicaid State Plan and Code of Maryland Regulations 10.09.48.04 require a provider of TCM to provide services to all eligible individuals. The regulation expressly prohibits a provider to serve a specific group of individuals. As Montgomery County has decided to discontinue providing TCM services after December 31, 2014, and therefore will no longer be accepting referrals for all individuals eligible for TCM services, DHHS is unable to solely serve TY after that date.

If the County elects to provide additional resource coordination services beyond those covered under TCM using County funds, this would be permissible.

DDA is committed to working with DHHS to support a successful transition of services for individuals in Montgomery County.

Sincerely,

Patrick Dooley
Acting Executive Director

Targeted Case Management/ Resource Coordination

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10.09.48.04

.04 Conditions for Participation — General.

A. In this chapter, targeted case management services are referred to as resource coordination.

B. Providers shall meet all the conditions for participation as set forth in COMAR 10.09.36.03.

C. Administrative and Professional Requirements. To participate in the Program as a provider of services covered under this chapter, the provider shall:

(1) Be incorporated in the State in good standings with the Maryland Department of Assessments and Taxation unless operating as a local health department;

(2) Have a board of directors or local advisory board in accordance with COMAR 10.22.02;

(3) Be selected by DDA as an approved provider of resource coordination services;

(4) Be selected by DDA as a "most advantageous" provider for the State as a term that is defined in COMAR 21.01.02.01;

(5) Attend a DDA single point of entry session;

(6) Participate in all transition and rollout processes as determined by the DDA;

(7) Serve all individuals in the DDA-defined region referred by the DDA or, if a local health department, serve all individuals in their designated jurisdiction referred by the DDA;

(8) Maintain a standard 8-hour operational day Monday through Friday and have flexible staffing hours that include nights and weekends to accommodate the needs of individuals receiving services;

(9) Maintain a toll free number, unless otherwise authorized by the DDA, and an accessible communication system in accordance with the Americans with Disabilities Act of 1990;

(10) Maintain a communication system that is accessible for individuals with limited English proficiency;

(11) Provide alternative communication methods to serve the needs of individuals receiving services and their family members;

(12) Have a means for individuals, their families, community providers, and DDA staff to contact the resource coordination designated staff directly in the event of an emergency and at times other than standard operating hours;

(13) Annually advise participants of their right to choose among qualified providers of services to include resources coordination;

(14) Comply with all State and federal statutes and regulations;

(15) Maintain a participant's record for a minimum of 6 years after the record is made;

(16) Notify the DDA immediately in writing of any critical incidents that affect the health, safety, and welfare of an individual, as well as administrative and quality of care complaints as required by State and federal law; and

(17) Submit required documents and forms to DDA as requested.

D. Operational Requirements. To participate in the Program as a provider of services covered under this chapter, the provider shall:

(1) Submit a program service plan that includes:

(a) Scope of work; and

(b) Proposed staffing plan, including staff and staff-to-participant ratios;

(2) Complete and submit an initial and annual written quality assurance plan to the DDA which meets the requirements in COMAR 10.22.02.14 and include the following:

(a) Customer service plan that includes strategies and services to meet the needs of participants, their families or caretakers, and providers; and

(b) Self-assessment, remediating, monitoring, reporting, and system improvements strategies, or other quality and compliance actions related to resource coordination;

(3) Submit quarterly updates, as defined by the Department, on progress on quality assurance plans by October 15, January 15, and April 15;

(4) Submit to the Department annually by July 15th the final quality plan summary reports;

(5) Submit monthly service delivery statistical reports as defined by the Department by the 15th of every month;

(6) Maintain a thorough understanding and knowledge of:

(a) Eligibility requirements, application procedures, and scope of services of local, State, and federal resources and programs which are applicable to individuals eligible for DDA services; and

(b) Medicaid, Medicaid waiver programs, and DDA eligibility requirements, application procedures, and service delivery systems;

(7) Coordinate services with multiple long-term service and support systems;

(8) Maximize resources to the greatest possible extent; and

(9) Obtain preauthorization from the DDA for resource coordination services which meet the following conditions:

(a) All individuals referred for resource coordination by the DDA shall be contacted within 3 business days of receipt of referral unless otherwise authorized by the DDA;

(b) A face-to-face meeting, with the referred individual shall be arranged at a time and location convenient for the referred individual during the first contact;

(c) A face-to-face meeting shall occur within 7 business days of the initial contact unless the individual's health or schedule conflicts;

(d) The provider shall document in the case record reasons why face-to-face meetings did not occur within the required timeframe and shared upon request of the DDA or its designee;

(e) Authorization for specific resource coordination services shall be based on referrals from the DDA regional office; and

(f) In the event of emergencies, the individual referred for resource coordination by the DDA shall be contacted by the resource coordinator as circumstances require or as requested by the DDA.

E. Client Record. The provider shall maintain a record on each participant which meets the Program's requirements and which includes:

(1) The name of the participant;

(2) The dates of the resource coordination services;

(3) The name of the provider agency and the name of agency employee providing the resource coordination service;

(4) The name, address, and telephone number of the individual or individuals to be contacted in case of emergency;

(5) A completed individual plan;

(6) The comprehensive assessment as applicable;

(7) Documentation that the resource coordinator provided the participant with a choice among qualified providers of services, including resource coordination;

(8) Documentation that indicates whether the individual has declined services in the individual plan and the reason for the decline;

(9) Documentation that includes:

(a) A schedule for obtaining needed services;

(b) A timeline for re-evaluation of the individual plan not less than annually; and

(c) The name and position of the individual responsible for completing tasks related to the individual plan;

(10) Status of progress on participant-intended outcomes identified in the individual plan;

(11) Documentation of coordination with other service systems, including:

(a) Demonstrated need for other services systems; and

(b) Dates of occurrences of coordination with other service systems; and

(12) Documentation for each contact made by the resource coordinator including:

(a) Date and subject of contact;

(b) Individual contacted;

(c) Individual making the contact;

(d) Contact method;

(e) Nature and extent of resource coordination services provided;

(f) Number of unit or units of service provided;

(g) Place of service; and

(h) Services referred.

F. Technology Requirements. To participate in the Program as a provider of services covered under this chapter, the provider shall:

(1) Manage an electronic information system which, at a minimum:

(a) Maintains confidential individual case and billing records;

(b) Provides documentation of resource coordination services and number of units provided for individuals receiving services;

(c) Maintain a permanent history log of all entries made to the record; and

(d) Adheres to applicable State and federal laws; and

(2) Adhere to the following information technology requirements:

(a) Use the DDA's designated data system to include the provider client information system unless otherwise approved by the DDA;

(b) Ensure that all management information systems:

(i) Are secure from improper use, alteration, or disclosure;

(ii) Utilize industry best practices for secure connection to management information systems;

(iii) Secure network connections with logon only from a secured location;

(iv) Prohibit users from sharing user accounts;

(v) Limit access to the system and related information based on job function; and

(vi) Adhere to DDA information technology data security policies, standards, and procedures when using DDA managed systems;

(c) Report security violations and actual or attempted security breaches affecting the managed systems with participant information within 48 hours of the violation or breach;

(d) Maintain and update as necessary all electronic data systems to be compatible with those of the State and, if required, work with DDA to develop a system for developing protocols for data sharing and read-only access for the DDA and its designees; and

(e) Obtain written approval from the DDA before posting on any public website information that describes DDA services.

G. Billing. To participate in the Program as a provider of services covered under this chapter, the provider shall:

(1) Assist the DDA with billing, processing, and reconciling Medicaid claims as required by the Department;

(2) Be in good standing with the Maryland Department of Assessments and Taxation, and with its equivalent in every state in which the applicant provides services;

(3) Permit the DDA or DHMH or its agent, or any State or federal entity operating within its statutory authority to conduct audits and provide immediate access to all records upon request; and

(4) Comply with audit requirements.

H. Freedom of Choice. The provider shall place no restrictions on the qualified participant's freedom of choice among:

(1) Providers of resource coordination;

(2) Providers of community-based services for which the participant qualifies; and

(3) Person-directed supports and services.

I. Provision of Services. The provider may not exercise the agency's authority to authorize or deny DDA or other State funded services.

HHS COMMITTE #2
May 2, 2014

ADDENDUM

MEMORANDUM

May 1, 2014

TO: Health and Human Services Committee

FROM: Linda McMillan, Senior Legislative Analyst

SUBJECT: **FY15 Operating Budget: Department of Health and Human Services - Follow-up and Deferred Items**
Neighborhood Opportunity Network – Family Services

The Neighborhood Opportunity Network is a partnership of County Government and non-profit agencies that reaches out to neighborhoods through "door-knocking" and other methods and helps people get referred to and provided with services.

The Executive's FY15 Recommended Budget includes $222,640 in the Community Grants NDA for IMPACT Silver Spring to continue its participation in this effort. Unfortunately, continued funding for Family Services was not included in the Executive's budget. Family Services needs $35,000 to continue it partnership in the Neighborhood Opportunity Network. Family Services indicates that the total cost of the program is $92,150.

Family Services' Neighborhood Opportunity Network site operates Monday through Friday from 9:00 a.m. to 5:00 p.m. and assists clients with applying for emergency services including utilities, rent, food, health care, legal matters, eviction/foreclosure prevention, financial literacy, and employment. Case management is provided for more complicated cases.

Council staff recommends the Committee add $35,000 to the Reconciliation List to continue the County contribution toward this effort.

F:mcmillan/FY2015operatingbudget/DHHS Follow-up addendum