HHS COMMITTEE #1 & 2
April 17, 2013

MEMORANDUM

April 15, 2013

TO: Health and Human Services Committee

FROM: Linda McMillan, Senior Legislative Analyst

SUBJECT: **FY14 Operating Budget: Department of Health and Human Services**
Overview
Administration and Support (includes Minority Health Initiatives, does not include Head Start)
Public Health Services (includes Council Grants reviewed by the Montgomery Cares Advisory Board, does not include School Health Services)

Those expected for this worksession:
Uma Ahluwalia, Director, Department of Health and Human Services
Stuart Venzke, DHHS Chief Operating Officer
Dr. Ulder Tillman, County Health Officer and Chief of Public Health Services
Patricia Stromberg, DHHS Management and Budget
Pofen Salem, Office of Management and Budget
Deborah Lambert, Office of Management and Budget

1. DEPARTMENT OVERVIEW

Excerpts from the County Executive's FY14 Recommended Budget are attached at © 1-7 (overview information), © 8-9 (Administration and Support), and © 10-15 (Public Health Services).

EXPENDITURES

For FY14, the County Executive is recommending an appropriation of $253,791,455 for the Department of Health and Human Services. This is an increase of $1,488,293, or 0.6% from the FY13

original approved budget. General Fund expenditures increase by $3,897,059, or 2.1%. Grant Fund expenditures (which include State funded expenditures as authorized through HB669) decrease by -$2,390,766, or -3.4%. There is a net decrease of 17 full-time positions, with all the net decrease occurring in the Grant funded category.

The following table shows the six year trends for the Department. Since FY09, the overall expenditures for DHHS have declined 3.6%, with declines in both the level of General and Grant Funds.

DHHS (in $000s)	FY09 Actual	FY10 Actual	FY11 Actual	FY12 Actual	FY13 Budget	FY14 CE Rec	Change FY13-14	Change 6 Yrs
Expenditures:								
General Fund	190,089	181,834	170,023	170,088	181,733	185,612	2.1%	-2.4%
Grant Fund	73,215	74,908	70,841	75,758	70,570	68,179	-3.4%	-6.9%
Total Expenditures	**263,304**	**256,742**	**240,864**	**245,846**	**252,303**	**253,791**	0.6%	-3.6%
Positions:								
General Fund FT	845	811	784	753	763	770	0.9%	-8.9%
Grant Fund FT	569	561	564	559	558	534	-4.3%	-6.2%
Subtotal FT	**1414**	**1372**	**1348**	**1312**	**1321**	**1304**	-1.3%	-7.8%
General Fund PT	299	303	302	292	288	289	0.3%	-3.3%
Grant Fund PT	49	47	45	45	44	43	-2.3%	-12.2%
Subtotal PT	**348**	**350**	**347**	**337**	**332**	**332**	0.0%	-4.6%
Total Positions	1762	1722	1695	1649	1653	1636	-1.0%	-7.2%

REVENUES

Revenues Credited to the General Fund

For FY14, General Fund revenues that are attributed to DHHS are projected to be $18,789,967, an increase of 3.0% from FY13 budget. These projected revenues offset 10.1% of General Fund expenditures. The following table shows the changes in selected General Fund Revenues.

SELECTED GENERAL FUND REVENUES:	FY13 Budget	FY14 Recommend	$ Change	Change FY13-14
Core Health Services Funding	3,601,470	3,838,256	0	6.6%
Federal Financial Participation	8,163,248	8,237,390	74,142	0.9%
Medicaid/Medicare Reimbursements	1,059,000	1,865,226	806,226	76.1%
Other Intergovernmental Aide	1,345,881	44,077	(1,301,804)	-96.7%
Health and Human Services Fees	1,375,868	1,447,928	72,060	5.2%
Health Inspections: Restaurants	1,580,540	1,580,540	-	0.0%
Health Inspections: Living Facilities	233,200	234,370	1,170	0.5%
Health Inspections: Swimming Pools	260,000	286,100	26,100	10.0%

Revenues Credited to the Grant Fund

The Grant Fund revenues presented in the operating budget book reflect actual amounts received in FY13 and known changes for FY14; but do not include changes from the 2013 General Assembly session. The Recommended Budget estimates $68,179,261 in grants and state revenues for FY14, a decrease of ($2,390,766) or (3.4%) from FY13.

The budget assumes that State reimbursements that are provided because Montgomery County has been authorized to have a unified Department of Health and Human Services will increase by 2.7%.

	FY13	FY14	$	Change
STATE REIMBURSEMENT:	**Budget**	**Budget**	**Change**	**FY13-14**
HB669 Child Welfare	11,859,776	12,129,998	270,222	2.3%
HB669 Adult Services	4,405,077	4,304,356	(100,721)	-2.3%
HB669 Family Investment	13,686,280	14,368,577	682,297	5.0%
HB669 Local Administration	1,617,307	1,715,110	97,803	6.0%
HB669 Flex	550,874	478,070	(72,804)	-13.2%
HB669 Subtotal	**32,119,314**	**32,996,111**	**876,797**	**2.7%**

The following table highlights selected other revenues.

	FY13	FY14	$	Change
SELECTED GRANT REVENUES:	**Budget**	**Recommend**	**Change**	**FY13-14**
ADAA Adult Intensive Outpatient Srvs	518,059	595,502	77,443	14.9%
ADAA Block Grant	2,096,238	2,074,226	(22,012)	-1.1%
ADAA Treatment Grant	645,662	1,244,962	599,300	92.8%
Community Mental Health Grant (all)	785,653	818,616	32,963	4.2%
DD Service Coordination*	3,473,246	-	(3,473,246)	-100.0%
Emergency Preparedness Base	609,862	626,066	16,204	2.7%
Emergency Preparedness City Readiness	196,894	35,854	(161,040)	-81.8%
Emergency Shelters HB1415	211,280	215,340	4,060	1.9%
Fed Block Grant Homelessness	357,878	348,834	(9,044)	-2.5%
Family Planning	459,476	459,073	(403)	-0.1%
Health Ed and Risk Reduction	529,079	-	(529,079)	-100.0%
NSIP Nutrition	234,786	203,070	(31,716)	-13.5%
Older Americans Act (OAA all titles)	2,509,446	2,636,380	126,934	5.1%
Infants and Toddlers State Grant	1,922,590	593,527	(1,329,063)	-69.1%
MD Infants and Toddlers Grant	1,147,030	1,186,040	39,010	3.4%
Oral Health	257,787	308,699	50,912	19.7%
PWC/MD Kids Count Eligibility	1,709,711	1,549,719	(159,992)	-9.4%
Senior Care/Gateway	980,374	978,403	(1,971)	-0.2%
Substance Abuse Prevention and Treatment	365,318	365,318	-	0.0%
Victims of Crime	269,902	229,420	(40,482)	-15.0%

*At the time of the March 15 budget, the State had told DHHS that this program would not be provided by the County in FY14. There have been ongoing discussions with the State and it is now likely that the County will continue some portion of the program. The Executive will send an update in his budget adjustments. This is the most significant programmatic change in the department for FY14

DEPARTMENT WIDE INCREASES

The FY14 budget includes a net increase of $4.6 million from department wide cost changes to General Fund expenditures, 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 "Miscellaneous Adjustments" included for each service area. Compensation changes are reviewed by the GO Committee.

Department wide adjustments (General Fund)	Dollars
FY14 Compensation Adjustments	3,024,104
Retirement Adjustment	610,805
Group Insurance Adjustment	499,821
Annualization of FY13 Lapsed Positions	147,516
Other Labor Contract Costs	136,393
Motorpool Rate Adjustment	174,950
Printing and Mail Adjustment	26,405
Risk Management Adjustment	(5,730)
NET CHANGE	**4,614,264**

Cross Department Issue – Increase to Certain Contracts

In FY13, the Council provided $660,940 in additional funding to increase most contracts with non-profits by 2%. The Council included the following language in the FY13 Appropriation Resolution:

> This resolution appropriates $660,940 for inflation adjustments for tax-supported contractors with the Department of Health and Human Services (DHHS). Any inflation adjustment awarded under this paragraph must not exceed 2% 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, 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 2013 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.
> h. This increase does not apply to contracts covered by the Residential Treatment Provider Supplement.

The Council has received a request from Nonprofit Montgomery (© 16) that contracts to non-profits receive a 9% increase to "help restore recession era reductions." Nonprofit Montgomery estimates that this will cost $5.5 million. Testimony from the Mental Health Administration said that inflation since 2010 has been 6.56%.

As background:

- The FY09 original budget included a 2% ($450,000) increase to eligible contracts. One percent was included in the Executive's recommended budget and an additional 1% was funded by the Council.

- In the FY10 original budget, the Council added $249,530 for a 1% adjustment to eligible contracts. While there were reductions to certain programs and contracts as a part of the FY09 and FY10 savings plans, there was not an across-the-board reduction.

- In FY11, the Council added $489,310 in funds to the budget to reduce the Executive's proposed 7% across-the-board reduction to contracts to a 5% reduction; however, this was action was reversed in the FY11 Savings Plan (December 2010) and a 7% reduction was implemented.

- In FY12, There was a recommended 5% reduction to the DD and Residential Provider supplements which the Council restored. There was no across-the-board reduction or increase to eligible contracts.

Assuming the pool of eligible contracts in FY13 is about $350,000 (slightly higher than FY13), the cost of a 9% increase to eligible contracts would be $3.15 million. This is a different amount than the request and Council staff is working to understand the difference. It would be helpful to have some direction from the Committee about the options they would like to examine regarding this request and whether they would like to generally follow the FY13 policy as outlined in the Budget Resolution.

In addition, the Council has received a request from InterACC (© 17) and other providers of services to the Developmentally Disabled to increase the County's "DD Supplement". The Council appropriated $7,872,486 in FY13 for this supplement. The total request from InterACC is for $665,000 (an 8.4% increase), of which $315,000 would provide a 4% inflationary adjustment and $350,000 would expand the supplement to cover clients that have come on in the last few years when no expansion was provided. The Committee can discuss funding for this supplement as a part of the worksession on the Aging and Disability Services budget.

Previously, when the Council has made adjustments to the "DD Supplement" it has made a similar adjustment to the supplement to residential treatment providers. This supplement is about $850,000. A 4% increase would be about $34,000 and a 9% increase would be $76,500.

Lastly, the Council has also received a request to increase adult foster care rates. The Council has not addressed this issue in many years. Council staff is requesting additional information on this payment to understand how it may be similar to these other supplements.

2. ADMINISTRATION and SUPPORT SERVICES (© 8-9)

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	FY10 Budget	FY 11 Budget	FY12 Budget	FY13 Budget	FY14 Rec	Change FY13-FY14
Office of the Director	3,321	2,630	2,227	2,350	2,187	-6.9%
Office of the Chief Operating Officer	18,560	16,110	15,524	16,197	17,530	8.2%
Office of Disparities Reduction	3,815	NA	NA	NA	NA	NA
Office of Community Affairs	3,458	6,740	6,795	6,839	6,826	-0.2%
TOTAL	**29,154**	**25,480**	**24,546**	**25,386**	**26,543**	4.6%

The Community Head Start Grant will be reviewed by the joint HHS and ED Committee.

A. Office of the Director

The County Executive is recommending a total of $2,187,259 and 18.75 FTEs for the Office of the Director.

1. Charges from PIO to DHHS for MC311
$51,973

DHHS must cover the cost of certain staff serving in the 911 Call Center as they must be authorized and a DHHS employee in order to access HHS information systems. Previously, the Public Information Office had the funding but it has been shifted to DHHS for FY14. **Council staff recommends approval.**

2. Multi-program Adjustments
-$215,066 and -0.25FTEs

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 $17,529,799 and 89.25 FTEs for the Office of the Chief Operating Officer.

1. Add recurring costs for Electronic Health Record System
$433,212

The Department of Health and Human Services is working to acquire and implement an electronic health records system that will be used in DHHS programs and clinics (this is different from the funding to assist with implementing an electronic health records system for Montgomery Cares clinics). The Department needs a system to comply with requirements of the Affordable Care Act and to bill for Medicaid funded services. The system will be procured during FY13 and cost will be covered within the FY13 appropriation. This FY14 funding is the estimated cost of ongoing licensing and maintenance. **Council staff recommends approval.** Council staff has received the following information regarding the timeline for this project and the ongoing costs.

> The Department is working with DGS - Procurement to identify the appropriate procurement vehicle. We expect to have a contract in place before June 30th. Once the contract is in place, the implementation is expected to take 6 to 9 months with rollout in early 2014. We have estimated costs for implementation for the EHR to be between $900k and $1M. The precise software may change as we move forward, and the license renewal costs will hinge in part on the initial purchase price, which have not yet been negotiated. The 433K is the estimated recurring costs based on pricing we received from two vendors last fall (please see below).

	NextGen PCC Clinics and MCDHHS	E-Clinical Works PCC Clinics and MCDHHS
Total UpFront Costs	$ 947,787	$ 786,388
Annual Costs	$ 433,212	$ 426,312
Total Cost	$ 1,380,999	$ 1,212,700

Council staff also asked whether the contract be negotiated by DHHS can be expanded to provide and electronic health records system to the Department of Correction and Rehabilitation. Council staff believes this is important so that DHHS and DOCR can easily share information about clients that are served by both departments and because there is some potential (limited) for billing for services for those in the correctional system. Council staff has received the following response:

> Maybe. We have begun discussion with the Department of Corrections to determine any unique requirements which may be needed for services provided at the correction facility.

2. Server hosting and license renewal for the Enterprise Case Management System
$230,000

The Executive is recommending this funding for the ongoing licensing and maintenance costs associated with the HHS Process Technology and Modernization system that is being funded through the CIP project, Technology Modernization – Montgomery County Government. Capital costs are about $3.2 million. The project will reduce the number of systems in place in DHHS and replace system that have

reached their useful life. The project will help to implement the "no wrong door" approach to providing services. **Council staff recommends approval.**

3. Multi-program Adjustments
+$669,480 and +3FTEs

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.**

The 3.0FTE adjustment is from the creation of a Full-time Term technology position that will assist with the Enterprise Case Management System and the shifting of two positions from other part of the Administrative service section.

C. Office of Community Affairs

Note: Community Action Agency and Head Start are reviewed jointly by HHS and ED Committees

The County Executive is recommending a total of $6,826,388 and 22.5 FTEs for Office of Community Affairs.

1. Multi-program Adjustments
-$7,855 and +0.2FTEs

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. Workers Center Contract Update

The Executive's FY14 Recommended Budget includes two non-competitive contracts with CASA de Maryland, Inc. of $173,420 each for operation of the Crabbs Branch and Wheaton Temporary Worker's Centers. The Council has previously discussed that the Department was going to issue an RFP to have a competitive consolidated contract for all the Temporary Workers Center.

DHHS issued an RFP and held a pre-bid conference in March. The closing date for the RFP was April 5th. It is not certain that the full contracting process will be completed by July 1 and a new contract will be in place or all of FY14. The extension of a non-competitive contract will allow services to continue until a new contact is executed.

Council staff notes that the approval of a non-competitive contract through Section G of the Budget Resolution sets a maximum for the contract but does not guarantee that the entity will have a contract or receive the full amount until the contract is executed. The Council could approve this

non-competitive recommendation acknowledging that it expects that during FY14 the competitive contract will be awarded.

CASA de Maryland has also applied to the Council for Council's grants to operate these centers. CASA is requesting $185,000 for each or $11,580 for each Center than has been included by the Executive.

2. Multilingual Patient Navigation/Medical Interpretation Contract

As a part of the FY11 budget, the Council approved the consolidation of patient navigator and medical interpretation that had previously been provided under separate contracts funded through the Asian American Health Initiative, the Latino Health Initiative, and Montgomery Cares. The Executive proposed this consolidation, expecting that it would result in an overall cost reduction and an alignment of service. The expectation was that the contracting process would allow a new contract to be in place for FY12. A contracting process was undertaken in FY11, but there was a protest and the County has decided to re-bid the contract. An RFP was released in March but it is unlikely that a new contract will be executed by July 1st. FY14 funding is maintained at $450,000. DHHS will ask the Contract Review Committee to continue two non-competitive contracts until a new contract is executed.

3. Minority Health Initiatives – Minority Health Initiatives/Program Advisory Committee Report

Minority Health Initiatives				
	FY11 Approved	**FY12 Approved**	**FY13 Approved**	**FY14 Recommended**
African American Health Program	1,408,171	1,365,877	1,382,076	1,337,578
Asian American Health Initiative	552,822	403,290	413,837	415,125
Latino Health Initiative	1,344,470	1,171,964	1,211,661	1,141,086
Total	**3,305,463**	**2,941,131**	**3,007,574**	**2,893,789**

Note: the FY14 reductions are technical in nature as they are adjustments to personnel and contracting costs, not to program.

Minority Health Initiatives/Program Advisory Group

As the Committee has previously been informed by Director Ahluwalia, the Department convened an Advisory Group in the Summer of 2011 that met for about 20 months to look at how to better serve racial and ethnic minorities in the County. At this session, Director Ahluwalia will provide the Committee with an overview of the effort and representatives from the Minority Health Initiatives/Program have been invited to provide the Committee with additional comments. The Executive Summary of the Committee's report is attached at © 18-30. The Advisory Group formulated an 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 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.

The Group is recommending that a Leadership Institute for Equity and Elimination of Disparities be established in DHHS' Office of Community Affairs. The report says that the LIEED will be established over tow to three years and says that this change will take additional staffing and resources that may include reclassification of current staff, possibly converting contractual staff to County staff, and operating funds for technical assistance and co-location of program staff.

Updates from the Annual Reports from the Minority Health Initiatives.

a) African American Health Program (AAHP)

The FY12 Annual Report of the African American Health Program is attached at © 24-80. The vision of the AAHP is, "African American and people of African descent in Montgomery County will be as healthy and safe as the rest of the population." Its mission is, "To eliminate health disparities and improve the number of years and quality of life for African Americans/Blacks in Montgomery County." The AAHP has four goals: (1) To raise awareness in the Montgomery County community about key health disparities; (2) To integrate African American health concerns into existing services and programs; (3) To monitor the health status data for African Americans in Montgomery County; and, (4) To implement and evaluate strategies to achieve specific health objectives." In addition to the annual report, attached at © 31-33 is the summary information provided to the HHS Committee from Dr. Idowu about AAHP efforts targeted to African and Caribbean immigrants.

The Annual Report notes the following:

- The AAHP provided services and referrals to 6,790 Montgomery County residents.

- AAHP provided HIV/AIDS education and testing to more than 1,000 African Americans and people of African descent on National Aids Days.

- The SMILE (Start More Infants Living Equally Healthy) program provided services to 215 clients during FY12, with an average of 130 clients at any given time. There were 1,666 home visits. There were 63 full-term deliveries and 8 pre-term deliveries. Four of the babies born were low birth weight and 3 were very low birth weight. The program includes a breast pump loan program and lactation education as well as a crib loan program for women who cannot afford a safe crib.

- AAHP continues to have Diabetes Self-Management health education and sponsor Diabetes Dining Clubs at several locations. While there was a decline of 24% in the number of new participants in FY12 in the self management and education program participants did report increasing consumption of fruits and vegetable and in their physical activities. A new dining club targeted to African immigrants was established with a monthly attendance of about 15 people. About 58% of the people entering the Diabetes Self-Management program were also found to have high blood pressure and about 36% of those followed-up up with a doctor.

- The "When I Get Out (WIGO)" program was created by the AAHP to provide health education to inmates in the county jail system who are preparing to re-enter the community. The curriculum includes oral health, nutrition, mental health, sexually transmitted diseases, and HIV and AIDS. Fifty-one inmates participated in FY12.

- HIV testing and education was provided to the women in the Journey's Rehabilitation program.

- AAHP's efforts to improve cardiovascular health included the Annual Heart Health Day that is in partnership with Holy Cross Hospital and the eighth annual "Health Freedom: A Path to Wellness Celebration Walk."

- AAHP had a total of 17 Health Promoters in FY12 who received training through the AAHP. AAHP participated in 58 events that included Health Promoters providing information to 1,529 community members. The report provides a complete listing of the outreach efforts of AAHP and the types of education activities that were provided at different sites.

b) Asian American Health Initiative (AAHI)

The FY12 Annual Report for the Asian American Health Initiative is attached at © 81-116. Its mission is "To identify the health care needs of Asian American communities, develop culturally competent health care services, and implement health programs that are accessible and available to all Asian Americans in Montgomery County."

Highlights from the report include:

- Asian Americans comprise 13.9% of the County's total population and grew 37.3% from 2000 to 2010. The 2010 American Community Survey estimated that almost three quarters of Montgomery County's Asian population is foreign born and one third is linguistically isolated.

- In FY12, the Patient Navigator program had 5,532 total client encounters and received 4,087 calls. It linked 96% of clients to county services. 78% of the callers had no health insurance. The program provided 1,144 on-site medical interpreting sessions and 301 medical interpreting sessions by phone. The top three languages spoken by those accessing the Patient Navigator Program were Chinese (29%), Korean (26%), and Vietnamese (26%). The largest cohorts by ages of callers were aged 40-40 (33%) and 50-59 (27%).

- AAHI had 34 Health Promoters in FY12. The Health Promoters spoke 16 languages and dialects and represented 16 communities. There are 14 Health Promoters with 3 or more years of experience in the program.

- In FY12, there were 41 outreach events and 5,421 educational encounters. Health services referrals were provided to 362 people and 1,412 health screenings were performed.

- In FY11, a Health Education in Ethnic Media campaign began and was continued in FY12. Ten articles were published covering topics that included breast cancer, diabetes, heart health, Hepatitis B, Osteoporosis, and tobacco use prevention. The media sources were the Epoch Times, India this Week, Korea Times, and Washington Chinese News.

- Hepatitis B disproportionately impacts Asian and Pacific Islanders; while they represent under 5% of the country's population they account for more than half of chronic Hepatitis B cases. In FY12, the AAHI conducted three Hepatitis B projects: (1) Screening, Treatment. Outreach, and Prevention (STOP B) with the Chinese Culture and Community Service Center; (2) Screening, Management, Awareness, Solutions (SMASH B) with the Vietnam Medical Assistance Program; and (3) Active care and Treatment of Hepatitis B (ACT Hep B) with the Korean Community Service Center of Greater Washington. There were 540 participants. One hundred percent of at-risk participants were referred for vaccinations and 80% of those completed the three-shot series. One hundred percent of infected participants were referred to follow-up care and 73% of those accessed treatment.

- During FY12 AAHI partnered with the Housing Opportunities Commission to conduct three workshops covering mental health and osteoporosis.

- In FY12, AAHI continued the Independent Outreach Project to connect with hard to reach populations. 106 small businesses and communities were reached. There were 599 educational encounters, 837 pieces of literature were distributed and there were 37 health service referrals.

- In FY12 as a part of the Empowering Community Health Organization (ECHO) Project, the AAHI held a Grants 101 Workshop attended by 56 people and a Grants 102 workshop attended by 52 people.

The report highlights AAHI efforts to collect disaggregated data and disseminate to partners, including Healthy Montgomery. It also continues work to evaluate its Hepatitis B programs.

c) Latino Health Initiative (LHI)

Testimony from the Latino Health Steering Committee is attached at © 117-118.

The Latino Health Initiative's FY12 Annual Report is attached at © 119-156. The LHI is charged with development of a plan of action that would be responsive to the health needs of Latinos in the county. The LHI is committed to improving the quality of life of Latinos living in Montgomery County by: (1) Enhancing coordination among existing health programs and services targeting Latinos; (2) Providing technical assistance to programs and services to effectively serve Latinos; (3) Developing and supporting models of programs and services to effectively serve Latinos; and (4) Advocating for policies and practices that will effectively reach the county's Latino population.

Highlights from the report include:

- The Health Promotion Program, Vias de la Salud, reached 10,673 individuals and Health Promoters provided 3,172 volunteer hours. The report notes that the programs was impacted mid year by changes in the how the incentive could be provided to Health Promoters and a reduction in regular group meetings.

- The Latino Youth Wellness Program was implemented at Forest Oak, Neelsville, Montgomery Village, and Gaithersburg middles schools and Northwood High School. A new curriculum was developed for middle school students that includes 15, 2½ hour sessions and a retreat. The program served 220 low-income families. In addition there were seven weekend retreats for participants. One hundred and thirty-nine youth were served as a part of Identity's after-school program

- In FY12, the Asthma Management Program reached 432 individuals through outreach and community activities. In addition, 36 individuals completed intensive education and support on asthma management at Harmony Hills, Weller Road, and Gaithersburg elementary schools. Participants reported a 60% drop in emergency room visits and a 100% drop in reported hospitalizations. There was a 43% decrease in the number of school days missed.

- The smoking cessation program provides intervention to Latino smokers who need help in ending their dependence on tobacco. In FY12, 63 smokers participated in the program and 83% completed the program. About 90% of the participants used nicotine replacement therapy at some point in the program.

- The System Navigator and Medical Interpreter Program received 2,689 calls and information specialists made 4,001 referrals. There were 2,106 medical interpreter appointments.

- The Suburban Maryland Welcome Back Center (WBC) had 95 nurse participants during FY12. It takes and average of 25 months from entering the program to passing the RN licensure exam. Since FY07, it is estimated that on average a nurses wages increase by 181% once they have completed the program and can he hired as an RN. The WBC was able to get funding from the Annie E. Casey Foundation and Healthcare Initiative Foundation to fill ARRA funding that ended

in FY11. In FY13, a small pilot is being undertaken to behavioral health professionals and physicians.

- The LHI continued the Ama Tu Vida Festival in FY12. There were more than 3,000 participants and over 2,500 medical screenings. Forty people were found to have abnormal results and 53% of them followed through with scheduled appointments. Due to budget constraints some organizations were unable to participate and the location could not accommodate a soccer tournament or other physical activities as occurred before FY11. A new location will be identified for future festivals.

3. PUBLIC HEALTH SERVICES (© 10-15)

Note: School Health Services will be reviewed jointly by the HHS and ED Committees

This service area's programs protect and promote the health and safety of Montgomery County residents. The following table provides an overview of the budget trends for this service section.

Public Health Services Expenditures in $000's	FY10 Budget	FY 11 Budget	FY12 Budget	FY13 Budget	FY14 Rec	Change FY13-14
Health Care For the Uninsured	11,875	13306	12,686	13,073	12,862	-1.6%
Comm Disease and Epidemiology	1,440	1747	1,773	1,909	2,008	5.2%
Community Health Services	12,949	11846	11,637	12,307	11,608	-5.7%
Dental Services	1,977	1919	1,963	2,149	2,268	5.5%
Environ Health and Regulatory Srvs	3,104	2862	2,914	3,085	3,150	2.1%
Health Care and Residential Facilities	1,351	1499	1,498	1,562	1,523	-2.5%
Health Promotion and Prevention	1,265	187	-	-		
Cancer and Tobacco Prevention	1,289	980	1,142	1,150	1,140	-0.9%
STD/HIV Prevention and Treatment	6,257	6726	7,005	7,219	7,306	1.2%
School Health Services	21,255	20922	19,958	22,096	23,192	5.0%
Tuberculosis Services	2,146	1838	1,797	1,762	1,657	-6.0%
Women's Health Services	4,236	2817	2,738	2,794	2,805	0.4%
Public Health Emergency Preparedness	2,050	2052	1,918	1,390	1,173	-15.6%
Service Area Administration	1,293	1429	1,406	1,505	1,708	13.5%
TOTAL	**72,487**	**70,130**	**68,435**	**72,001**	**72,400**	0.6%

To Be Discussed April 22 - Service Eligibility Unit and Income Supports:

Council staff is concerned about the workload in both the Service Eligibility Unit in Public Health Services and the Eligibility Unit in Income Supports in Children, Youth, and Family Services. Council staff is recommending that the HHS Committee discuss this as a cross-section issue. Council staff will address this issue at the April 22nd worksession on Children, Youth and Family Services.

A. Health Care for the Uninsured

The Executive's is recommending a total of $12,862,463 and 6 FTEs in this program area.

1. Kaiser Community Benefit Grant
-$115,384

In April, 2011, DHHS received a $95,000 grant from Kaiser Permanente of the Mid-Atlantic States to support the development of enhanced organizational infrastructure to allow for expanded Medicaid and PAC participation for service providers supported under the County's Montgomery Cares, HIV/AIDS services, and School Based Health Centers programs. Last year, the Department explained that the project was building upon a prior grant awarded to Montgomery County DHHS by Kaiser in July 2010 to create Medicaid and PAC participation capability at several of the Montgomery Cares clinics. The grant funds awarded under this grant will utilize the tools developed under the prior grant, with the following specific objectives: 1) to support further implementation steps toward Medicaid and PAC participation among several of the Montgomery Cares clinics that need additional consulting support, 2) to help create Medicaid and PAC billing capacity in the County's HIV/AIDS program, and 3) to explore the challenges and opportunities for Medicaid participation in the County's School-Based Health programs. Consulting assistance is being provided under a contract with the Primary Care Coalition, which in turn is working in collaboration with SHR Associates, a locally-based consulting firm that specializes in Medicaid billing implementation. It was noted that the grant would end in December 2012. **Council staff recommends approval to reflect the ending of the grant.**

2. Multi-program Adjustments
-$115,384 and 0.0FTEs

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.**

3. Care for Kids

The Executive is not recommending any change to the Care for Kids Program in FY14. Funding to the Primary Care Coalition for this program is recommended to be $933,450. The 2012 Annual Report from the Primary Care Coalition says that that the Care for Kids Program served 2,812 children who are not eligible for the Maryland Children's Health Program or other state of federal medical assistance and provided 4,664 primary care visits. Fifty-eight percent of families had incomes below 100% of the Federal Poverty Level. There were 711 referrals for specialty care and 437 referrals for optometry services.

4. Montgomery Cares

The Montgomery Cares program is the County's primary health care program for low income uninsured adults. While it serves people and families with incomes up to 250% of the Federal Poverty Level, a majority of clients have incomes below the Federal Poverty Level. The Montgomery Cares Program is a partnership with community clinics, county hospitals, and volunteer health care professionals who bring tremendous resources to the program. The Primary Care Coalition is the County contractor for many administrative aspects of this program.

The Executive's budget does not describe any specific changes to the Montgomery Cares Program. The Council has received requests from the Montgomery Cares Advisory Board and the Primary Care Coalition for additional funding for Montgomery Cares.

MONTGOMERY CARES	FY10 Budget	FY11 Budget	FY12 Budget*	FY13 Budget	FY14 Rec	Change 13-14
Enrollment for Patients not served through Healthcare for the Homeless	23,000	28,000	28,000	32,250	32,250	0.0%
Budgeted Number of Primary care Encounters at $62 per visit	62,100	70,000	75,000	85,625	85,625	0.0%
Services Areas:						
Support for Primary Care Visits**	3,682,800	4,340,000	4,725,000	5,308,750	5,308,750	0.0%
Community Pharmacy-MedBank	2,136,590	1,785,590	1,785,590	1,793,490	1,793,490	0.0%
Cultural Competency	75,000	45,000	28,000	22,500	22,500	0.0%
Behavioral Health and Oral Health	950,000	930,000	930,000	1,002,000	1,002,000	0.0%
Specialty Services	660,468	450,468	486,790	730,468	730,468	0.0%
Program Development	343,070	260,960	110,840	110,840	110,840	0.0%
Information and Technology	350,360	320,360	315,360	415,360	415,360	0.0%
PCC-Administration	569,274	529,274	507,621	502,774	502,774	0.0%
HHS - Eligibility Determination***	205,137	-	-			
HHS - Administration	484,030	482,296	478,186	495,608	556,083	12.2%
Facility	311,700	67,040	67,040	67,040	67,040	0.0%
Build-out new Holy Cross Clinic	na	na	75,000	75,000	-	-100.0%
Subtotal	**9,768,429**	**9,210,988**	**9,509,427**	**10,523,830**	**10,509,305**	-0.1%
Healthcare for the Homeless						
Budgeted Enrollment	1,000	800	500	500	500	0.0%
Budgeted Primary Care Encounters	2,700	2,400	1,500	1,500	1,500	0.0%
Direct Healthcare services (visits)	435,000	435,000	217,500	217,500	217,500	0.0%
HHS Administration (includes hospital discharge planning)	303,972	255,158	266,140	262,139	236,280	-9.9%
Subtotal	**738,972**	**690,158**	**483,640**	**479,639**	**453,780**	-5.4%
TOTAL	**10,507,401**	**9,901,146**	**9,993,067**	**11,003,469**	**10,963,085**	-0.4%

*FY12 Budget includes a mid-year reallocation of DHHS funds to Montgomery Cares

**This table does not include $50,000 for primary care visits funded by Carefirst via PCC during FY12

***Eligibility Determination is handled by the Services Eligibility Unit

There are three changes shown in the table: (1) the elimination of funding for renovations for the now-open Holy Cross Hospital, (2) changes to the cost of HHS Administration based on recommended compensation adjustments, and (3) changes to the cost of the HHS Administration in Healthcare for the Homeless based on recommended compensation adjustments and a technical adjustment to benefit costs.

The Montgomery Cares FY13 mid-year report is attached at © 157-181. It shows:

- Through December 2012 the clinics had submitted reimbursement for 40,464 primary care encounters. This is about 47% of the 85,625 primary care visits that are funded in the FY13 budget. Three of the clinics have used over 50% of their expected number of encounters.

- Through December 2012, the clinics have reported seeing 19,597 unduplicated patients. This is about 61% of the expected 32,250 patients that are the basis for the budget.

- The wait times for a new patient continue to vary by clinic. Three clinics can see new patients immediately; 7 clinics can provide an appointment within a week; 2 clinics have a 2 week wait; and 3 clinics have a wait of 3 to 4 weeks.

- At the end of the 2nd quarter about 55% of the funding for the community pharmacy had been spent. Medications received through the Medbank program are valued at $1.47 million. There were 268 new enrollees in the program in the first half of FY13. The average patient volume is 1,593. About 66% of prescriptions requested are filled by the pharmaceutical companies.

- About half the requests for specialty care are being scheduled. In FY12 it is estimated that hospitals provided $863,027 in charitable care and physicians $188,029 in charitable care to Project Access.

- 1,045 patients received services through the Montgomery Cares behavioral health program at the Holy Cross clinics, Mercy Clinic, and Proyecto Salud. Other clinics are serving some Montgomery Cares patients through other clinic based programs. DHHS and Mary's Center are going to pilot psychiatric consultation during 2013.

- The Oral Health program served 1,132 people during the first half of the year; 748 at the Spanish Catholic Center and 384 at the DHHS Clinic. There is a 180 to 210 day wait time at the Spanish Catholic Center and a 21 day wait at the DHHS Clinic.

Request from the Montgomery Cares Advisory Board (© 182-186)

The Montgomery Cares Advisory Board is recommending an addition of $871,875 to the Montgomery Cares FY14 budget. It should be noted that there is not a request for additional primary care visits. FY14 will be a transitional year as it is expected that mid-year some Montgomery Cares patients will be eligible and move to an expanded Medicaid. This should free up space to serve new patients. As it is expected that there will be a substantial number of uninsured in Montgomery County even after the expansion of Medicaid and availability of insurance through the exchanges, there is also not a

recommendation to reduce the expected number served. **Council staff agrees that the expected number served and number of visit does not need to increase in FY14.**

1. Increase the Reimbursement for Primary Care Visits from $62 to $65 $256,875

This is a recommendation of the Advisory Board and the Health Centers Leadership Council. It is noted that this would be the first increase since 2009. A $3 increase would be a 4.8% increase. The Advisory Board estimates that the full cost of a primary care visit is about $100 to $150.

Council staff believes this is a reasonable request but the Committee should wait to make its final decision on this increase until it decides about other inflationary adjustments. While it is accurate that there has been no increase, the Montgomery Cares reimbursement was not subject to the same reduction other DHHS contracts were. While they do not have to be treated exactly the same, Council staff does suggest that this increase only be recommended if there some increase provided to the other eligible non-profit contractors.

2. Performance Improvement Program $140,000 (for ½ year)

The Montgomery Cares Advisory Board is recommending that the Council approve funds which would be used for incentive payments to clinics that show improved outcomes for Montgomery Cares Patients (a brief description is attached at © 187-190. The specific program has not yet been developed. Tasks will include selecting the measures, determining how a provider will qualify to participate, developing a calculation for determining distribution of funds. There is quality information already collected (see © 177-180 and 185 for examples) so quality improvement is not a new goal of the program. The question is whether an incentive program can improve quality faster and consistently.

Council staff agrees with the Advisory Board that there should be a performance based component to Montgomery Cares. This aligns not only with efforts in the Federal government but also with direction from the Council to the County agencies to determine if value based contracting can be a part of employee health plans. Montgomery Cares is not a private insurance plan and so the model will have to be tailored to clinic operations and the types of services that are provided through the Montgomery Cares clinics.

Council staff recommends approval of this funding but cautions that while it is requested for the incentive payment pool, there may be other staff and technical assistance costs that must also be covered to implement this program. If the HHS Committee recommends this funding, it should require a written report on the structure of the program before it is implemented.

3. Preventive Care Services $400,000

The Montgomery Cares Advisory Board is recommending that $179,500 be approved to expand access to mammograms in order to come closer to meeting standards for mammograms for Montgomery Cares patients age 50 and above. The Executive has recommended a FY14 Community Grant for $38,500 for this same purpose. If both amounts are approved, there would be a total of $218,000 in additional funding available.

The second part of the request is $220,500 to expand colorectal screenings for 2,100 patients and 84 colonoscopies for Montgomery Cares patients with positive results.

The Primary Care Coalition's FY12 Montgomery Cares Clinical Performance Measures compares the performance of the clinics (with the exception of Community Clinic, Inc.) again the National Commission for Quality Assurance's Health Effectiveness Data and Information Set (HEDIS). See excerpt from PCC report © 189-190.

- The HEDIS benchmark for percent of patients receiving regular breast cancer screening should be between 50% and 63%. For FY12 the clinic measure is 34%. While this is up significant from the 12% in FY08 it is well below the benchmark.

- There is not a HEDIS benchmark for colorectal cancer screening; however, the clinics report 4% receive recommended screenings.

Council staff believes that an increase in funds for these preventive screening services is justified given the current level of screenings that can be provided. Funding for this type of service, which is not covered through the primary care reimbursement, is also important if a performance improvement program is implemented that expects the clinics to make improvements in meeting HEDIS benchmarks. Council staff recommends approval.

That said, Council staff has asked the Department whether additional funding for cancer screening should be limited to Montgomery Cares' patients or whether it should be available to serve other County program patients that may also require screening.

4. Behavioral Health Services $75,000

The Montgomery Cares Advisory Board is requesting $75,000 to expand the Montgomery Cares Behavioral Health Program. Last year, the Council was able to add funds for a Behavioral Health Care manager but was not able to provide full expansion of behavioral health to another site. The Committee was told that it is estimated that about 30% of Montgomery Cares patients need some level of behavioral health care but that only about 15% are accessing the program. Currently, the Montgomery Cares Behavioral Health Program is offered at the Holy Cross Hospital Clinics, Mercy Clinic, and Proyecto Salud. There are about 14,000 patients at these sites and about 13%, or 1,820 individuals will access behavioral health services.

Council staff understands that the expansion of services might occur at the Muslim Community Clinic and the Spanish Catholic Center. The care team would that would serve the two clinics will consist of a bi-lingual licensed behavioral health professional and a family support worker. As previously noted, the Kaseman Clinic and Mobile Medical have programs that are funded through other sources.

Council staff recommends approval of this funding. The HHS Committee has previously discussed the evaluation that shows that this is an efficient and effective way to serve the population that accesses the Montgomery Cares program.

B. Council Grant requests reviewed by Montgomery Cares Advisory Board (This section is provided by Council Grants Manager Peggy Fitzgerald-Bare)

There are **13 grant applications totaling $717,139** from primary health care providers that are to be reviewed as part of the Committee's discussion of the Montgomery Cares program. One of the purposes of the Montgomery Cares program is to develop a coordinated and more systematic delivery of primary health care to uninsured individuals. In order for the Council and the program itself to be able to assess clinic provider needs, system needs, and set funding priorities, clinic provider funding requests should be considered through the Montgomery Cares program.

As in prior years, staff forwarded the applications to the Department of Health and Human Services for review by the Montgomery Cares Advisory Board. The Board's recommendations are contained on © 191-194.

The Board recommends approval of 11 of the 13 proposals for a total of $635,102. Because the Board "found merit in most all of the proposals," the Board prioritized them for funding to assist in decision making. Staff has listed the proposals in the priority order provided by the Advisory Board.

The clinic requests and Advisory Board recommendations are listed in Table #1. Staff has also provided additional descriptions of the proposals in the subsequent pages of this memo.

Also, the County Executive has recommended full or partial funding for four of the requests as Community Grants and recommends partial funding for one of the requests in the Cost Sharing Capital Budget. The total amount of the Executive's recommended funding for these proposals is $192,300. His recommended proposals and funding are noted in Table #1 and also in the descriptions of the proposals.

Summary of Staff Recommendations:

- **Concur with Advisory Board's recommendations and, add their recommended funding to the Council Reconciliation List, except for the four proposals recommended by the County Executive as Community Grants which will be considered by full Council on 'grants day' and do not need to be added to Reconciliation List at this time. Add $433,602 to Reconciliation List.**
- **Add $50,000 to Cost Sharing CIP project for Muslim Community Center clinic dental facility and also approve County Executive-recommended $50,000 for this project for a total of $100,000.**

Table # 1

Organization	Project Description	Request	MCares Adv. Bd.	CE	Staff
1a.(tied)Mary's Center for Maternal and Child Care	expenses for staff and emergency resources	$100,702	$100,702	NA*	$100,702
1b.(tied) The Muslim Community Center Clinic	funding for a two chair dental care facility	$100,000	$100,000	$50,000 in Cost-Sharing CIP	$100,000 in Cost-Sharing CIP
1c.(tied)Primary Care Coalition	screening mammograms for low income county women	$38,500** see note in memo description	$38,500	$38,500 in Community Grants NDA	$38,500
2. Mobile Medical Care	program support for diabetes care program for low-income uninsured adults	$47,900	$47,900	NA	$47,900
3a.(tied) Mercy Health Clinic #1	health education program	$20,000	$20,000	NA	$20,000
3b.(tied) Mercy Health Clinic #3	funding for clinical director	$75,000	$75,000	NA	$75,000
4a.(tied) Chinese Culture and Community Service Center	Lab, vaccine and staff expenses for Stop B (Hepatitis B) program	$38,000	$38,000	$28,800 in Community Grants NDA	$28,800
4b.(tied) Primary Care Coalition of Montgomery County	technical assistance to clinics in becoming Medicaid providers	$75,000	$75,000	NA	$75,000
5.Muslim Community Center #1	domestic violence prevention and counseling at Clinic & workshops	$25,000	$25,000	$25,000 in Community Grants NDA	$25,000

6. Community Ministries of Rockville #2	Behavioral Health and Podiatry Svcs.at Mansfield Kaseman Health Clinic	$85,000	$85,000	NA	$85,000
7. Mercy Health Clinic #2	support for pharmacy program	$30,000	$30,000	NA	$30,000
Care For Your Health	funding for pilot to test virtual case management	$32,037	Do Not Fund	NA	Do Not Fund
The Muslim Community Center #2	purchase and operate a handicap equipped shuttle van	$50,000	Do Not Fund	$50,000 in Community Grants NDA	See note in memo description

*NA: Either not recommended by the Executive or organization did not submit proposal to CE

1a. (tied) Mary's Center for Maternal and Child Care: $100,702 for a full time Family Support Worker, 2 part time Health Educators, part-time participant Navigator, and emergency resources, at the organization's Silver Spring clinic which currently has 4541 clients, 39% of whom are uninsured. For FY13, the Council approved a Community Grant to the organization for $95,476 for all of the same services, with the exception of the part time Navigator position, which is a new request.

Mary's Center works jointly with the nearby County TESS Center as a Neighborhood Opportunity Network location where families are connected to County and other safety net services. The Family Support Worker ($40,000 plus fringe) who saw 277 participants July-November 2012, assists patients who have a positive screen for depression, alcohol, tobacco, and other drug use, or domestic violence, linking them to appropriate community resources. The Health Educators ($15,670 each plus fringe) address a wide variety of health education and counseling topics, including prenatal care. They also work with patients to reduce risk factors and manage chronic diseases. The Participant/Navigator ($9270 plus fringe) works with patients diagnosed with cancer. Finally, the organization requests $8000 in emergency funds for participants (transportation, emergency rent to prevent eviction, etc.),

The Advisory Board gave the project the highest score (tied for #1 in priority listing), and "found this to be a worthy project that received the maximum number of available points" (in their evaluation)

Staff Recommendation: Add to Council Reconciliation List for potential funding.

1b. (tied) The Muslim Community Center Medical Clinic: $100,000 to establish an in-house two chair dental facility for Montgomery Cares patients. The Muslim Community Center Medical Clinic provided care to over 3500 patients in 2012.

The proposal notes the importance of oral health in maintaining overall health and the scarcity of free or affordable dental care facilities in the County. The Clinic estimates the total cost of the project at $200,000 and requests $100,000 from the County for renovation and purchase of dental clinic equipment. The Clinic will raise the remainder from its own resources. It anticipates that most of the dental professionals and support staff will work as volunteers, patients will pay a small co-pay on a sliding scale, and other Clinic funding will be used to sustain operations. The Clinic anticipates it will enroll 18-20% of its patients (630-700) in first 12 months of operation.

The County Executive has recommended $50,000 for this project in the Cost Sharing CIP project.

The Montgomery Cares Advisory Board also listed this project as #1 in priority order (tied for #1 in priority listing), recommended that the Council approve the full $100,000 request and that the dental clinic should be open to all Montgomery Cares patients.

Staff Recommendation: Approve $50,000 County Executive recommended grant and add an additional $50,000, for a total of $100,000, with funding provided in Cost Sharing CIP project.

1c. (tied) Primary Care Coalition: $38,500 to provide 550 additional screening mammograms for eligible low-income County women. The Primary Care Coalition, working as a systems integrator, has built collaborations for breast health with all Montgomery Cares clinics, all five County hospitals, DHHS, the Women's Cancer Control Project, and private mammography providers. The result has been almost a doubling of mammography capacity since 2008, from 1700 to 3300 mammograms. PCC estimates that to achieve benchmark standards of 65% of eligible women receiving mammograms, local safety net providers need a supply of 6500 mammograms. The funding would increase the supply of mammograms to 3850, bringing the local clinics closer to meeting benchmark standards.

The County Executive has recommended a Community Grant of $38,500 for this effort.

The Montgomery Cares Advisory Board also listed this project as #1 in priority order (tied for #1 in priority listing) They noted that it "was a very strong proposal and that all grant dollars go directly to patient services."

Staff Recommendation: The Committee does not need to make a recommendation regarding the $38,500 recommended for this program as the County Executive has recommended this funding as a Community Grant. It will be considered by the full Council along with all of the other County Executive-recommended Community Grants.

**For the Committee's information, PCC did not submit this grant application to the Council. PCC submitted a larger request to the Executive than he has recommended. Under policies previously adopted by the Council, for those Executive-recommended Community Grants not previously submitted to the Council, the Council will only consider the funding amount recommended by the Executive and not amounts originally requested by the organization.

2. Mobile Medical Care: $47,900 for enhanced monitoring and treatment to 1000 low-income, uninsured adults with diabetes. Mobile Medical Care notes that 20% of its 6000 patients have diabetes and 78% of the diabetes patients also have cardiovascular disease, putting them at higher risk for amputations, blindness and other complications. They propose to provide Hemoglobin testing on site (currently patients must be referred to an outside lab), and optometry and podiatry services a half-day per week.

The Advisory Board listed this project #2 in its list of priorities (after the preceding three proposals which were tied for #1) and noted that "the proposal was strong with clear measurable goals and a reasonable budget.

Staff Recommendation: Add to Reconciliation List for potential funding.

3a. (tied) Mercy Health Clinic #1: $20,000 for organization's Health Education program lifestyle, diabetes, and medication management. The Clinic's over 70 volunteer physicians served over 2000 patients in the past 12 months and indicates the patients they serve are primarily Latina women. The Clinic sees over 600 patients with diabetes and/or hypertension each year. The Clinic received a $10,000 Council grant for FY13 for this program. The majority of the FY14 requested funding is for consultants for individual and group sessions in Spanish as well as English.

The Advisory Board listed this proposal as tied for #3 in priority, noting it is a continuation of a health education effort that began this current fiscal year.

Staff Recommendation: Add to Council Reconciliation List for potential funding.

3b. (tied) Mercy Health Clinic #3: $75,000 to establish new position of Clinical Director. The Clinical Director will be the head of clinical operations, overseeing development of new clinical protocols, quality measures, implementation of electronic records system, and recruitment of volunteer medical providers. The Clinical Director will also see patients. Mercy Health Clinic will provide 53% of the funds needed for this position. The Clinic also indicates that establishment of the Clinical Director position, in addition to improving the quality of care, will allow the Executive Director to focus more on business development, including fundraising. The proposal indicates that the Clinic has operating reserves that can make up for a temporary shortfall in funding.

The Advisory Board listed this proposal as tied for #3 in priority, noting it is "very thorough and addresses Montgomery Cares priorities. Sustainability will be a challenge, but the clinic appears to have alternative funding identified."

Staff Recommendation: FY14 start-up County funds for this position are appropriate but the Clinic needs to develop other funding sources to sustain the position in future years. The Montgomery Cares per encounter payment is intended to help sustain the operations of Clinics, including clinical care professionals such as this position. Add to Council Reconciliation List for potential funding.

4a. (tied) Chinese Culture and Community Services Center: $38,000 for lab costs, vaccines, and partial salary support for the Hepatitis B program. The organization requests funding to continue its free screening, treatment, outreach and prevention services, noting that Hepatitis B virus (HBV) infection is among the most serious health disparities facing the Asian American community. Among the 3 million HBV infected in the U.S., more than one-third are of Asian origin. The services, begun in late 2011, are provided at the Pan Asian Volunteer Health Clinic. To date, the organization's project has screened more than 400 patients, vaccinated about 150 patients and referred more than 25 HBV infected patients to treatment. With the requested funds, the organization anticipates serving a similar number of patients in the upcoming year. The total cost of the project is $62,100 and the organization will provide the remainder of the funds for the project.

The Advisory Board listed this proposal as tied for #4 (tied) in priority, noting, "no one else is providing this service free of charge in the County. Hepatitis B is a serious problem in the Asian population and CCACC is a trusted and respected organization across the Asian community. The only problem we found is sustainability for the future, but given the economic market, we did not deduct many points."

Staff Recommendation: The County Executive has recommended partial funding of this request, $28,800, as a Community Grant. The Committee does not need to make a recommendation regarding that recommended amount. It will be considered by the full Council along with all of the other County Executive-recommended Community Grants.

For the Committee's information, the County is able to purchase the vaccine at discounted prices. As a significant portion of the organization's funding request is to purchase vaccines, which the County can assist with, staff believes the partial funding recommended by the Executive will be sufficient.

4b. (tied) Primary Care Coalition (PCC): $75,000 for technical assistance to clinics in becoming Medicaid providers. PCC will assist clinics with meeting the managerial and clinical quality expectations for Medicaid managed care participation. In addition to care quality, diversifying payer mix beyond the DHHS Montgomery Cares payments will increase the financial security of clinics. PCC has performed this work previously and with prior County funding, has assisted three Montgomery Cares clinics with the Medicaid application and contracting process. As of proposal submission, two clinics have completed the process and started to serve Medicaid patients and the third is in process. The total project cost is $135,000 and the remainder of the funds needed have been or will be raised from private foundations.

The Advisory Board listed this proposal as tied for #4 (tied) in priority, noting, the proposal is "...mission appropriate and purposeful. They were impressed with the way it anticipates the changes in reimbursement in health care and was able to impact services across the clinics."

Staff Recommendation: Add to Council Reconciliation List for potential funding.

5. Muslim Community Center Medical Clinic #1: $25,000 for case management, workshops and seminars, for the organization's domestic violence program. This program also received a Community Grant for $25,000 in FY13. The total cost of the program is estimated at $50,000 and the Muslim Community Center and Clinic will provide the remaining funds needed. The organization has hired a bilingual social worker, two workshops have been held, and the social worker and her assistant have conducted one on one outreach and counseling.

The Advisory Board listed this proposal as #5 in priority, noted that it is "a repeat project from last year,..was successful, and should see an additional year."

Staff Recommendation: The Committee does not need to make a recommendation regarding the $25,000 recommended for the domestic violence program as the County Executive has recommended this funding as a Community Grant. It will be considered by the full Council along with all of the other County Executive-recommended Community Grants.

6. Community Ministries of Rockville #2: $85,000 for mental health services and additional podiatry services at Mansfield Kaseman Health Clinic. In FY13 the organization received a Community Grant for $62,660 for these two services. This request is for continued and enhanced funding. The organization has entered into a partnership with Family Services Inc. who will provide on site behavioral health services at the Kaseman Clinic. The organization indicates total expenses for this program, including in-kind services, are $1.96 million. Approximately one-third of the Clinic's patients are in need of some type of behavioral health treatment. Additionally, the requested funding would allow the Clinic to add additional hours of Podiatry services, a service in demand at the Clinic due to the large number of patients with diabetes (one of the top three diseases presented by Clinic patients). The Clinic's Podiatry and Behavioral Health Services will be available to patients of other clinics.

The Advisory Board listed this proposal #6 in priority and noted, "if funds are available, this is a worthy project to fund."

Staff Recommendation: Add to Council Reconciliation List for potential funding.

7. Mercy Health Clinic #2: $30,000 for operating support for the Clinic's on-site Pharmacy program, which has been in existence for more than 10 years. Requested funds would be primarily for staff at the on-site Pharmacy. The organization provides medications free of charge, noting it enhances patient compliance with taking medications, as does the convenience of receiving medications while at the Clinic visiting the doctor. The organization has a partnership with the University of Maryland's School of Pharmacy where final year pharmacy students and recent graduates meet individually with the most acute diabetic patients and any patient taking 5 or more medications. This medication management system has received national recognition from the U.S. Department of Health and Human Services as a model for replication. The organization receives over $450,000 in pharmaceuticals annually through the State Medbank program and the County Pharmedix program.

The Advisory Board listed this proposal #7 in priority and noted, "it is an ongoing project that the clinic has had for several years, although the reviewers thought this was the first year that Council

support has been requested."

Staff Recommendation: Add to Council Reconciliation List for potential funding. Staff agrees with the Advisory Board that this request is a lower priority for funding, and would also highlight the substantial pharmacy assistance the organization receives and that patients at the Clinic receive the medications for free.

There are two grants that are not recommended by the MCAB.

- **Care for Your Health: $32,037** to test a pilot project of virtual case management with one case manager serving several sites, via Skype connection with the micropractice clinician. The organization notes it is finding an increasing number of complex cases that require additional case management beyond that the physician can provide. The proposal does not state how many patients are seen annually, nor how many cases require case management. The majority of the funds requested are for consultant services, presumably for the case manager. The organization indicates it has one clinical site in NE Montgomery County and is planning for a second site in Long Branch. The proposal states that once the organization has tested the virtual case management and made necessary changes, it will incorporate the cost into its operational budget. It also indicates it will share resources with other organizations that do not have case management capacity, offering a fee for service model to access the virtual case management and providing additional income for the service.

The Advisory Board does not recommend funding for this proposal, noting "the applicant did not describe the expected number of patients to be served, how the project fits within the County's priorities, how the outcomes will be measured or how the program will be sustained."

Staff Recommendation: Concur with Advisory Board; do not add to Reconciliation List.

- **Muslim Community Center Medical Clinic #2: $50,000** to purchase and operate a handicap equipped shuttle van service to provide free access to the Clinic from public transportation hubs. The Clinic has limited public transportation accessibility during weekdays and none on Sundays when the Clinic is open all day. The Clinic has been relying on limited shuttle service by another organization but has not found that to be an approach that meets their needs. They estimate the total cost of the project at $100,000 with $50,000 for the cost of the van and to convert it to make it handicap accessible and $50,000 to cover the cost of the driver's salary, gas and vehicle maintenance. The project budget indicates that the County funds are for purchase and conversion costs of the vehicle. The Clinic plans to run the shuttle only during the hours when public transportation is not available. According to the Clinic's needs assessment survey, 25% of their patients showed an interest in using public transportation. Based on that survey, they estimate 875 patients will make trips to and from the Clinic using public transportation instead of private vehicles.

The Advisory Board does not recommend this project for funding, commenting "there needs to be a better justification for the service including an analysis of alternatives to a van such as Metro Access or transportation vouchers. The proposal does not provide the number of patients in need of special transportation arrangements. Sustainability is very uncertain."

Staff Recommendation: The Committee does not need to make a recommendation regarding this request as the County Executive has recommended this funding as a Community Grant. It will be considered by the full Council along with all of the other County Executive-recommended Community Grants.

Staff Note: While recognizing the value of transportation services to help patients access clinics, staff believes these types of requests are somewhat ancillary to the main mission of the Clinics. In future years, any transportation requests of this nature should be reviewed by the Council's Grants Advisory Group along with similar transportation requests from other safety net providers.

C. Communicable Disease and Epidemiology

The Executive is recommending a total of $2,008,010 and 18.3 FTEs for this program.

1. Multi-program Adjustments
+$98,677 and +1.0 FTEs

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.**

D. Community Health Services

The Executive is recommending a total of $11,607,762 and 127.8 FTEs for this program.

1. Decrease Maryland Children's Health Program/PWC Grant
-$159,992 and 0.0FTEs

This is a technical adjustment to align the budget with the actual funding received in FY13. There should be no impact on services to clients. The Maryland Children's Health Program uses Federal and State funds to provide health care for children up to age 19 and to pregnant women. **Council staff recommends approval.**

2. Multi-program Adjustments
- $539,708 and -1.0 FTEs

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.**

E. Dental Services

The Executive is recommending a total of $2,268,113 and 15.75 FTEs for this program.

1. Dental Services

The Executive is not recommending any specific adjustments to the dental program; however one new position is added through the Ryan White grant but is included in the multi-program adjustments. The Council added $100,000 in FY13 to the DHHS Dental Programs to try and expand capacity and reduce the wait time for dental services. The Committee has previously discussed the growing body of evidence about the link between oral health and other diseases, such as heart disease. The Montgomery Cares mid-year report shows that there were 1,586 encounters in the dental program at the Spanish Catholic Center and 736 Encounters at the DHHS Clinic. There are still significant waits: 180-210 days for new patients and 28 to 30 days for established patients at the Spanish Catholic Center, and a 21 day wait for both new and established patients at the DHHS Adult Clinic.

In addition to Montgomery Cares, DHHS Dental Services provides care to children in the Care for Kids Program, School-based Health Centers, Head Start, Social Services; clients in the Maternity Partnership Program, and adults in Montgomery Cares, Minority Health Programs, Aging and Disability Services, Nursing Homes/Senior Care Facilities, homeless shelters, and as a part of HIV Case Management.

2. Multi-program Adjustments
$118,830 and 1.0FTEs

The 1.0 FTE in these multi-program adjustments is the addition of a Dental Assistant that is funded through the Ryan White grant program.

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.**

F. Environmental Health Regulatory Services

The Executive is recommending a total of $3,150,333 and 30.0 FTEs for this program.

Multi-program Adjustments
$65,313 and 0.0FTEs

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.**

G. Health Care and Group Residential Facilities

The Executive is recommending $1,522,673 and 12.5 FTEs for this program.

1. Multi-program Adjustments
- $39,465 and 0.0FTEs

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.**

H. Cancer and Tobacco Prevention

The Executive is recommending funding of $1,140,194 and 3.0 FTEs for this program.

1. Multi-program Adjustments
-$9,778 and -1.0FTE

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.**

I. STD/HIV Prevention and Treatment Program

The Executive is recommending $7,218,746 and 43.65 FTEs for this program area.

1. Ryan White Part A Grant	***$131,645 and 0.9FTE***
Ryan White Consortia Services Grant	***-$100,031 and -1.0FTE***

These are technical adjustment to align the grant funds with the amounts that are expected for FY14. At this time there is no expected impact on services to clients. **Council staff recommends approval.**

2. HIV Prevention Services and AIDS Case Management Grants
-$63,128 and 1.1FTE

This is an adjustment to align this grant with the amount of funds that are now expected in FY14. **Council staff recommends approval.**

3. Multi-program Adjustments
$213,746 and 2.65FTEs

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.**

J. Tuberculosis Services

The Executive is recommending $1,656,570 and 16.2 FTEs for this program.

1. Multi-program Adjustments
-$105,251 and 0.0FTEs

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.**

K. Women's Health Services

The Executive is recommending $2,804,990 and 19.65 FTEs for this program.

1. Administrative Care Coordination Grant
$0 and -1.0 FTE

This is a technical adjustment to align the FTEs with the grant dollars. **Council staff recommends approval.**

2. Multi-program Adjustments
$11,053 and 0.97FTEs

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.**

L. Public Health Emergency Preparedness and Response

The Executive is recommending funding of $1,172,710 and 10.3FTEs for this program.

1. Cities Readiness Initiative
-$144,836 and 0.0FTEs

This is a technical adjustment to align this grant with a new grant structure from the Department of Health and Mental Hygiene. **Council staff recommends approval.**

2. Multi-program Adjustments
-$72,941 and 0.0FTEs

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.**

M. Service Area Administration

The Executive is recommending $1,708,406 and 12.5 FTEs for this program.

1. Health Officer State Salary Increase
$31,315 and 0.0FTEs

The Health Officer is a State employee and this adjusts the Health Officer salary based on State actions. **Council staff recommends approval.**

2. Multi-program Adjustments
$172,037 and 2.0FTEs

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.**

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 FY14 Operating Budget for the Department of Health and Human Services is $253,791,455, an increase of $1,488,293 or 0.6 percent from the FY13 Approved Budget of $252,303,162. Personnel Costs comprise 58.6 percent of the budget for 1304 full-time positions and 332 part-time positions. A total of 1547.26 FTEs includes these positions as well as any seasonal, temporary, and positions charged to or from other departments or funds. Operating Expenses account for the remaining 41.4 percent of the FY14 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 FY13 estimates reflect funding based on the FY13 approved budget. The FY14 and FY15 figures are performance targets based on the FY14 recommended budget and funding for comparable service levels in FY15.

Measure	Actual FY11	Actual FY12	Estimated FY13	Target FY14	Target FY15
Multi-Program Measures					
Percentage of students identified by schools to be at risk who are stabilized utilizing community resources without hospital intervention	95	96	95	95	95
Percent of REVIEWED HHS client cases that demonstrate beneficial impact from received services	98.0	86.0	92.0	92.0	92.0
Percentage of client cases needing assistance with multiple services for which effective team formation is documented	81.0	78.0	71.0	73.0	75.0
Percentage of client cases needing assistance with multiple services for which effective team functioning is documented	70.0	67.0	67.0	69.0	70.0
Percent of Medical Assistance applications approved for enrollment	76.0	71.0	N/A	N/A	N/A
Percentage of seniors and adults with disabilities who avoid institutional lacement while receiving case management services	93.8	94.9	95.0	95.0	95.0
eighted composite of HHS client cases that demonstrate beneficial mpact from received services: Improved health and wellness (1-100 scale)	51.5	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	90.2	86.1	86.0	86.0	86.0

	Actual FY11	Actual FY12	Estimated FY13	Target FY14	Target FY15
scale)					
Weighted composite score of HHS client cases that demonstrate beneficial impact from received services: Risk mitigation (1-100 scale)	83.7	82.5	83.0	83.0	83.0
Weighted percent of DHHS customers satisfied with the services they received from DHHS staff	95.4	96.4	95.0	96.0	96.0
Percentage of current "health and human services" contracts derived from Requests for Proposals that contain performance measures related to beneficial impact and customer satisfaction[1]	93.3	97.7	98.0	98.0	98.0

[1] Beneficial impact will be specific to the program and will focus on risk mitigation, greater independence, and improved health.

ACCOMPLISHMENTS AND INITIATIVES

- ***Add two School-Based Health Centers at Viers Mill and Weller Road Elementary Schools and two High School Wellness Centers at Gaithersburg and Watkins Mill High Schools to provide coordinated medical care, preventive and psychosocial services, quality counseling, positive youth development, and health education to students and families in the school community.***

- ***Add one Linkages to Learning site at Georgian Forest Elementary School to provide prevention and early intervention services include health, mental health, social services, and educational support to students and their families.***

- ***Add resources to develop a countywide Mobility Management System (MMS) that can leverage other resources and coordinate them to meet the transportation needs of low and middle-income older adults in Montgomery County. The funds will also result in the development of a strategic marketing communications plan to publicize transportation programs to seniors which will leverage existing county resources for implementation.***

- ***Enhance Home Delivered Meal Services to eliminate the waiting list and expand the services to the upper northwest corner of the County which currently has no home delivered meal providers.***

- ***Enhance the Escorted Transportation Project with the Jewish Council for the Aging to expand and coordinate new and existing escorted transportation services.***

- ***Add funding to support the implementation of the Electronic Health Record System in order to interface with the State of Maryland's Health Information Exchange.***

- ***Add funding to support the ongoing operational and maintenance needs of the Enterprise Integrated Case Management System funded in the Capital Budget.***

- ***Add four core previously grant-funded staff positions to support various developmental disability services.***

- ***The Specialty Behavioral Health Services Adult Drug Court Treatment Program provided services to 120 offenders. The Adult Drug Court Program from its beginning through FY12 has had 96 graduates. The Clinical Assessment and Transition Services Program conducted 9,448 screenings and 2,200 assessments on individuals arrested in FY12.***

- ***The Street Outreach Network served 286 clients in FY12, a 64 percent increase in the number of clients served the prior year. As part of the Network, the Upcounty Youth Opportunity Center opened in FY12. The Crossroads Youth Opportunity Center and the Upcounty Youth Opportunity Center served 496 clients, an increase of 87 percent.***

- ***The African American Health Program (AAHP) worked on a year long HIV educational campaign and on June 27, 2012, National HIV Testing Day, the AAHP "Testing by the Hundreds" campaign exceeded its goal of educating and testing 1,000 African Americans and people of African descent in Montgomery County.***

- ***In FY12, the Asian American Health Initiative (AAHI) conducted 5,421 educational encounters, 1,412 basic health screenings, including 540 on Hepatitis B, and 362 referrals for additional health services. During this time, AAHI promoted health and the prevention of diseases that disproportionately impact Asian Americans including cancer, Hepatitis B, diabetes, osteoporosis, and tobacco control.***

- ***In tax year 2011, the Community Action Agency's Volunteer Income Tax Assistance (VITA) Partnership completed 1,806 total tax returns that helped residents to access refunds totaling $3,969,451, including $1,548,510 from Earned Income and Child Tax Credits, saving taxpayers $341,334 in tax preparation fees. Taxpayers were expected to return $665,494 in State and Federal taxes owed. Over 5,000 volunteer hours were utilized by the program.***

- ***The Mandatory Flu Vaccination Policy became a legal requirement this year in the State of Maryland for covered employees in the local health department. Six months of planning with various partners including the Department's Public Health Services, Aging and Disability Services, Behavioral Health and Crisis Services, Office of Human***

Resources, and the Municipal and County Government Employees Organization's union officials led to the launch of this policy in the fall of 2012.

- *HIV Services and Montgomery Cares Program will begin to explore a partnership to offer comprehensive care to the County's indigent HIV-infected residents. The HIV program at Dennis Avenue Health Center will provide expert HIV medical care and case management to those residents in need receiving primary care through the safety net clinics.*

- *In FY12, the Medical Assistance Eligibility Program had an application compliance rate of 90 percent for pregnant women and children and maintained an 85 percent compliance rate for children and families. State mandated compliance rates are 80 percent for pregnant women, children, and families.*

- *Montgomery Cares Homeless Hospital Discharge Program was the recipient of "Best in Category" award from the National Association of Counties (NACo) for the "Safe Transitions."*

- *During FY12, the Women's Cancer Control Program provided 3,319 free breast cancer screening and diagnostic procedures for low income, uninsured female residents of Montgomery County.*

- *School Health Services had 582,175 visits to health rooms during FY12; 88 percent of these visits (511,119) resulted in children returning to class.*

- *In FY 12, Special Needs Housing held its first Homeless Resource Day on October 19, 2011. The event served over 300 homeless persons and provided them access to over 50 vendors offering access to income supports, flu shots, medical screening, vision checks, behavioral health programs, podiatrists, and haircuts.*

- *Special Needs Housing provided more than 5,400 emergency assistance grants totaling $3.8 million to resolve housing and utility emergencies.*

- *The Welcome Back Center - Workforce Solutions Program participants increased their wages, from entry into the program to being hired as registered nurses by an average of 181 percent.*

- *Productivity Improvements*

  - *Environmental Health Regulatory Services was able to reduce overtime by 16 percent in FY12 by eliminating after hours calls from the Fire Department regarding fires that occur at establishments and consolidating weekend special events. The Environmental Health Regulatory Services program performs the proper inspection to the facility the following morning before it is reopened after fires.*

  - *The Tuberculosis (TB) Control Program continues its partnership with the Maryland Department of Health & Mental Hygiene, to implement usage of a new blood test (QFT). The QFT provides increased sensitivity and accuracy, resulting in a decreased number of people needing X-rays and treatment for latent TB infection. As a result, the TB Control Program was able to eliminate a backlog of over 400 people waiting for treatment of latent TB infection. It has brought Montgomery County, which consistently has the highest rate of TB in the State, into a state-of-the-art realm of TB treatment.*

  - *In 2012, the Montgomery County Child Care Resource and Referral Center doubled the number of childcare providers trained to 1,258; the number of providers receiving technical assistance and consultation services increased by 1,200. Health consultation services continued to increase in FY12 with 5,373 child care providers receiving visits, telephone consultations, or training. Referrals and service to families in the Infants and Toddlers Program increased in FY12 by 277. ChildLink program referrals were up in FY12 by 188.*

  - *Child Welfare Services (CWS) was able to increase the number of children placed with relatives after they were removed from their parents' custody for safety reasons. This was a result of having more family involvement meetings before children are removed from their home. The parents can invite relatives or other supportive people, and CWS works with the extended family to design a plan where the child is safe. Relatives now have a guardianship subsidy (equal to foster care rates) so there is no financial barrier to taking relatives' children. Kinship providers were given custody and guardianship by the courts for 60 children. The total number of children in out of home placement was reduced by five percent to 474.*

  - *In FY12, as a result of the Behavioral Health and Crisis Services reorganization, the Clinical Assessment and Transition Services (CATS) Program rapidly expanded services, both in terms of coverage and types of services provided. CATS also developed new programming without interruption in client care or quality of services.*

  - *The Senior Nutrition Program (SNP) purchased and implemented an automated system (i.e., Univeral Participant Tracking - UPT) that allows customers at senior congregate meal sites to use a magnetic card swipe system to sign in for meals. The UPT system is used in several other SNPs nationally, and enhances both the accuracy of*

data and reduces staff time and expenditures.

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 FY12	Budget FY13	Estimated FY13	Recommended FY14	% Chg Bud/Rec
COUNTY GENERAL FUND					
EXPENDITURES					
Salaries and Wages	71,394,135	76,994,791	75,776,129	77,263,681	0.3%
Employee Benefits	24,355,398	28,282,969	27,882,029	28,878,139	2.1%
County General Fund Personnel Costs	***95,749,533***	***105,277,760***	***103,658,158***	***106,141,820***	***0.8%***
Operating Expenses	74,338,870	76,455,375	76,338,375	79,470,374	3.9%
Capital Outlay	0	0	0	0	—
County General Fund Expenditures	***170,088,403***	***181,733,135***	***179,996,533***	***185,612,194***	***2.1%***
PERSONNEL					
Full-Time	753	763	763	770	0.9%
Part-Time	292	288	288	289	0.3%
FTEs	1,043.80	1,117.09	1,117.09	1,128.64	1.0%
REVENUES					
Core Health Services Funding	4,501,842	3,601,470	3,666,098	3,838,256	6.6%
Federal Financial Participation Reimbursements	8,194,565	8,163,248	8,237,390	8,237,390	0.9%
Health and Human Services Fees	1,299,945	1,375,868	1,430,928	1,447,928	5.2%
Health Inspection: Restaurants	1,682,620	1,580,540	1,580,540	1,580,540	—
Health Inspections: Living Facilities	285,096	233,200	234,370	234,370	0.5%
Health Inspections: Swimming Pools	531,505	535,165	535,165	535,165	—
Marriage Licenses	277,947	260,000	286,100	286,100	10.0%
Medicaid/Medicare Reimbursement	1,027,768	1,059,000	1,865,226	1,865,226	76.1%
Miscellaneous Revenues	1,049,531	0	0	0	—
Nursing Home Reimbursement	628,667	0	649,000	649,000	—
Other Charges/Fees	25	0	0	0	—
Other Fines/Forfeitures	205	0	0	0	—
Other Intergovernmental	176,639	1,345,881	44,077	44,077	-96.7%
Other Licenses/Permits	72,712	88,160	71,915	71,915	-18.4%
County General Fund Revenues	***19,729,067***	***18,242,532***	***18,600,809***	***18,789,967***	***3.0%***
GRANT FUND MCG					
EXPENDITURES					
Salaries and Wages	31,045,984	31,091,508	31,091,508	31,518,334	1.4%
Employee Benefits	9,988,745	11,106,162	11,106,162	11,049,733	-0.5%
Grant Fund MCG Personnel Costs	***41,034,729***	***42,197,670***	***42,197,670***	***42,568,067***	***0.9%***
Operating Expenses	29,320,590	28,372,357	28,372,357	25,611,194	-9.7%
Capital Outlay	0	0	0	0	—
Grant Fund MCG Expenditures	***70,355,319***	***70,570,027***	***70,570,027***	***68,179,261***	***-3.4%***
PERSONNEL					
Full-Time	559	558	558	534	-4.3%
Part-Time	45	44	44	43	-2.3%
FTEs	441.90	441.51	441.51	418.62	-5.2%
REVENUES					
Federal Grants	19,172,381	10,923,610	10,923,610	15,169,917	38.9%
HB669 Social Services State Reimbursment	31,968,050	32,233,072	32,233,072	33,187,682	3.0%
Medicaid/Medicare Reimbursement	2,370,349	0	0	0	—
State Grants	16,788,298	26,953,745	26,953,745	19,681,662	-27.0%
Other Intergovernmental	5,458,593	459,600	459,600	140,000	-69.5%
Grant Fund MCG Revenues	***75,757,671***	***70,570,027***	***70,570,027***	***68,179,261***	***-3.4%***
DEPARTMENT TOTALS					
Total Expenditures	**240,443,722**	**252,303,162**	**250,566,560**	**253,791,455**	**0.6%**
Total Full-Time Positions	**1,312**	**1,321**	**1,321**	**1,304**	**-1.3%**
Total Part-Time Positions	**337**	**332**	**332**	**332**	—
Total FTEs	***1,485.70***	***1,558.60***	***1,558.60***	***1,547.26***	***-0.7%***

	Actual FY12	Budget FY13	Estimated FY13	Recommended FY14	% Chg Bud/Rec
Total Revenues	*95,486,738*	*88,812,559*	*89,170,836*	*86,969,228*	*-2.1%*

FY14 RECOMMENDED CHANGES

	Expenditures	FTEs
COUNTY GENERAL FUND		
FY13 ORIGINAL APPROPRIATION	**181,733,135**	**1117.09**
Changes (with service impacts)		
Add: High School Wellness Centers at Gaithersburg and Watkins Mill High Schools	1,594,640	1.80
Add: School Based Health Centers at Viers Mill and Weller Road Elementary Schools [School Health Services]	489,440	1.80
Add: Recurring Costs of the Electronic Health Record System [Office of the Chief Operating Officer]	433,212	0.00
Enhance: Server Hosting and License Renewal for the Enterprise Integrated Case Management System [Office of the Chief Operating Officer]	230,000	0.00
Add: Linkages to Learning Site at Georgian Forest Elementary School [Linkages to Learning]	170,640	0.00
Enhance: Home Delivered Meals [Senior Nutrition Program]	82,000	0.00
Add: Mobility Management Administrator [Senior Community Services]	60,000	0.00
Enhance: The Escorted Transportation Project with the Jewish Council for Aging [Senior Community Services]	55,000	0.00
Add: Victims Compensation Fund Match - Legal Mandate	10,931	0.00
Other Adjustments (with no service impacts)		
Increase Cost: FY14 Compensation Adjustment	3,024,104	0.00
Increase Cost: Retirement Adjustment	610,805	0.00
Increase Cost: Group Insurance Adjustment	499,821	0.00
Replace: State Resource Coordination Services Grant for Developmental Disabilities [Community Support Network for People with Disabilities]	325,305	3.75
Increase Cost: Motor Pool Adjustment	174,950	0.00
Increase Cost: Annualization of FY13 Lapsed Positions	147,516	0.20
Increase Cost: Other Labor Contract Costs	136,393	0.00
Increase Cost: Annualization of FY13 Broker Positions in Older Adult Waiver Program [Senior Community Services]	118,476	0.00
Technical Adj: FY13 Mid-Year Changes	53,830	3.20
Shift: Charges from PIO to HHS for MC311 [Office of the Director]	51,973	0.80
Increase Cost: Health Officer State Salary Increase [Service Area Administration]	31,315	0.00
Increase Cost: Printing and Mail Adjustment	26,405	0.00
Decrease Cost: Risk Management Adjustment	-5,730	0.00
Decrease Cost: Elimination of One-Time Items Approved in FY13	-14,900	0.00
Shift: Charges from DOT-Transit to HHS for Senior Transporation Services [Senior Community Services]	-142,500	0.00
Decrease Cost: Elimination of FY13 $2,000 Lump Sum	-1,885,366	0.00
Increase Cost: Annualization of FY13 Personnel Costs	-2,399,201	0.00
FY14 RECOMMENDED:	**185,612,194**	**1128.64**
GRANT FUND MCG		
FY13 ORIGINAL APPROPRIATION	**70,570,027**	**441.51**
Changes (with service impacts)		
Enhance: Federal Alcohol and Drug Abuse Administration Treatment Block Grant	672,316	0.00
Add: Money Follows the Person Option Couseling Grant [Home and Community Based Waiver Services for Older Adults]	275,000	0.00
Add: Homeless ID Grant [Behavioral Health Planning and Management]	72,345	0.00
Enhance: Maryland Strategic Prevention Framework [Outpatient Behavioral Health Services - Child]	33,475	0.00
Reduce: Community Services Block Grant [Office of Community Affairs]	-4,598	0.00
Eliminate: Medicaid Waiver Adminstration and Case Management [Home and Community Based Waiver Services for Older Adults]	-224,403	0.00
Eliminate: State Resource Coordination Services Grant for Developmental Disabilities	-3,473,245	-23.75
Other Adjustments (with no service impacts)		
Increase Cost: HB669 Grant	954,611	0.20
Increase Cost: Title III Older Americans Act [Senior Nutrition Program]	158,945	0.00
Technical Adj: Ryan White Part A Grant [STD/HIV Prevention and Treatment Program]	131,645	0.90
Technical Adj: School Based Health Center Grant [School Health Services]	7,271	-0.50
Technical Adj: Administrative Care Coordination Grant [Women's Health Services]	0	-1.00

	Expenditures	FTEs
Shift: Montgomery County Child Care Resource and Referral Funding [Early Childhood Services]	-3,394	0.00
Decrease Cost: Annualization of FY13 Personnel Cost	-29,214	-0.84
Technical Adj: HIV Prevention Services and AIDS Case Management Grants [STD/HIV Prevention and Treatment Program]	-63,128	1.10
Decrease Cost: Group Senior Assisted Housing	-80,136	0.00
Decrease Cost: Kasier Community Benefit Grant [Health Care for the Uninsured]	-95,000	0.00
Technical Adj: Ryan White Corsortia Services Grant [STD/HIV Prevention and Treatment Program]	-100,031	-1.00
Technical Adj: Emergency Preparedness - Cities Readiness Initiative [Public Health Emergency Preparedness & Response]	-144,836	0.00
Decrease Cost: Maryland Children's Health Program Grant [Community Health Services]	-159,992	0.00
Shift: Infants and Toddlers State Grant [Infants and Toddlers]	-318,397	2.00
FY14 RECOMMENDED:	**68,179,261**	**418.62**

FUNCTION SUMMARY

Program Name	FY13 Approved Expenditures	FY13 Approved FTEs	FY14 Recommended Expenditures	FY14 Recommended FTEs
Aging and Disability Services	37,788,586	163.55	35,119,493	143.55
Behavioral Health and Crisis Services	38,542,416	208.70	39,216,928	209.70
Children, Youth, and Family Services	59,684,101	431.54	61,086,327	430.03
Public Health Services	72,002,636	566.16	72,399,913	570.98
Special Needs Housing	18,899,119	61.90	19,425,348	62.50
Administration and Support	25,386,300	126.75	26,543,446	130.50
Total	**252,303,158**	**1558.60**	**253,791,455**	**1547.26**

CHARGES TO OTHER DEPARTMENTS

Charged Department	Charged Fund	FY13 Total$	FY13 FTEs	FY14 Total$	FY14 FTEs
COUNTY GENERAL FUND					
Sheriff	Grant Fund MCG	34,870	0.50	0	0.00

FUTURE FISCAL IMPACTS

Title	CE REC. FY14	FY15	FY16	($000's) FY17	FY18	FY19
This table is intended to present significant future fiscal impacts of the department's programs.						
COUNTY GENERAL FUND						
Expenditures						
FY14 Recommended	**185,612**	**185,612**	**185,612**	**185,612**	**185,612**	**185,612**
No inflation or compensation change is included in outyear projections.						
Annualization of Positions Recommended in FY14	**0**	**33**	**33**	**33**	**33**	**33**
New positions in the FY14 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 positians in the outyears.						
Elimination of One-Time Items Recommended in FY14	**0**	**-11**	**-11**	**-11**	**-11**	**-11**
Items recommended for one-time funding in FY14, including Victims Compensation Fund, will be eliminated from the base in the outyears.						
Labor Contracts	**0**	**4,187**	**5,382**	**5,382**	**5,382**	**5,382**
These figures represent the estimated cost of general wage adjustments, new service increments, and associated benefits.						
Labor Contracts - Other	**0**	**9**	**-116**	**-116**	**-116**	**-116**
These figures represent other negotiated items included in the labor agreements.						
High School Wellness Center	**0**	**0**	**797**	**806**	**806**	**806**
These figures represent the impacts on the Operating Budget of projects included in the FY13-18 Approved Capital Improvements Program.						
School Based Health & Linkages to Learning Centers	**0**	**0**	**0**	**0**	**0**	**177**
These figures represent the impacts on the Operating Budget of projects included in the FY13-18 Approved Capital Improvements Program.						
Subtotal Expenditures	***185,612***	***189,830***	***191,697***	***191,705***	***191,705***	***191,882***

ANNUALIZATION OF PERSONNEL COSTS AND FTES

	FY14 Recommended		FY15 Annualized	
	Expenditures	FTEs	Expenditures	FTEs
Add: High School Wellness Centers at Gaithersburg and Watkins Mill High Schools	149,440	1.80	166,040	1.80
Add: School Based Health Centers at Viers Mill and Weller Road Elementary Schools [School Health Services]	149,440	1.80	166,040	1.80
Total	**298,880**	**3.60**	**332,080**	**3.60**

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).

FY14 Recommended Changes	Expenditures	FTEs
FY13 Approved	**2,350,352**	**18.20**
Shift: Charges from PIO to HHS for MC311	51,973	0.80
Multi-program adjustments, including negotiated compensation changes, employee benefit changes, changes due to staff turnover, reorganizations, and other budget changes affecting multiple programs.	-215,066	-0.25
FY14 CE Recommended	**2,187,259**	**18.75**

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.

FY14 Recommended Changes	Expenditures	FTEs
FY13 Approved	**16,197,107**	**86.25**
Add: Recurring Costs of the Electronic Health Record System	433,212	0.00
Enhance: Server Hosting and License Renewal for the Enterprise Integrated Case Management System	230,000	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.	669,480	3.00
FY14 CE Recommended	**17,529,799**	**89.25**

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 accomplish 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 African American Health Program, Latino Health Initiative, and the Asian American Health Initiative.

rogram Performance Measures	Actual FY11	Actual FY12	Estimated FY13	Target FY14	Target FY15
ercentage of African Americans who demonstrate an increase in knowledge after taking diabetes education classes	100	92	90	90	90

8

FY14 Recommended Changes	Expenditures	FTEs
FY13 Approved	**6,838,841**	**22.30**
Reduce: Community Services Block Grant	-4,598	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.	-7,855	0.2(
FY14 CE Recommended	**6,826,388**	**22.50**

PROGRAM SUMMARY

Program Name	FY13 Approved Expenditures	FY13 Approved FTEs	FY14 Recommended Expenditures	FY14 Recommended FTEs
Office of the Director	2,350,352	18.20	2,187,259	18.75
Office of the Chief Operating Officer	16,197,107	86.25	17,529,799	89.25
Office of Community Affairs	6,838,841	22.30	6,826,388	22.50
Total	**25,386,300**	**126.75**	**26,543,446**	**130.50**

Public Health Services

FUNCTION

The functions of the Public Health Services programs are to protect and promote the health and safety of County residents. This is accomplished by monitoring health status and implementing intervention strategies to contain or prevent disease (including bio-terrorism and emerging diseases); fostering public-private partnerships, which increase access to health services; developing and implementing programs and strategies to address health needs; providing individual and community level health education; evaluating the effectiveness of select programs and strategies; and licensing and inspecting facilities and institutions affecting the public health and safety.

PROGRAM CONTACTS

Contact Dr. Ulder Tillman of the HHS - Public Health Services at 240.777.1741 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

Health Care for the Uninsured

This program area includes the Montgomery Cares, Care for Kids, Maternity Partnership, and Reproductive Health programs. Through public-private partnerships, these programs provide primary health care services for low-income uninsured children, adults, pregnant women, and the homeless, using private pediatricians, a network of safety net clinics, obstetricians, and hospitals, along with other health care providers. This program area also provides care coordination to uninsured children and adolescents with chronic or handicapping conditions needing specialty diagnostic, medical, and surgical treatment.

Program Performance Measures	Actual FY11	Actual FY12	Estimated FY13	Target FY14	Target FY15
Percentage of healthy birth weight babies (= or > 2,500 grams) born to pregnant women in the Maternity Partnership Program	95	95	94	94	94
Percent of vulnerable populations that have a primary care or prenatal care visit - CHILDREN	27.9	26.1	TBD	TBD	TBD
Percent of vulnerable populations that have a primary care or prenatal care visit - ADULTS[1]	24.2	27.5	TBD	TBD	TBD

[1] The Department is not projecting results for FY13-15 at this time due to the multiple variables related to health care reform.

FY14 Recommended Changes	Expenditures	FTEs
FY13 Approved	**13,072,847**	**6.00**
Decrease Cost: Kasier Community Benefit Grant	-95,000	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.	-115,384	0.00
FY14 CE Recommended	**12,862,463**	**6.00**

Communicable Disease and Epidemiology

Communicable Disease and Epidemiology is responsible for investigations, management, and control of the spread of over 65 infectious diseases as stipulated by Maryland law, including: rabies; hepatitis A, B, and C; salmonellosis; measles; cholera; legionellosis; and lyme disease. Emerging pathogens, such as H1N1 Influenza, are addressed with aggressive surveillance efforts and collaboration with State agencies of Agriculture, Health, and the Environment. Control measures for disease outbreaks in high-risk populations, such as residents of long-term care facilities, are implemented to prevent further spread of diseases to others. Educational programs are provided to groups that serve persons at risk for infectious diseases (homeless shelters, nursing homes, day care centers, etc.). The program also provides vital record administration and death certificate issuance. Immunizations, outreach, and education are available to residents, private medical providers, schools, childcare providers, and other community groups. The Refugee Health Program screens all persons who enter the County with refugee status for communicable diseases. Refugees are medically assessed and are either treated or referred to the private sector. The Migrant Health Program is also provided in compliance with Federal laws governing migrant laborers.

Program Performance Measures	Actual FY11	Actual FY12	Estimated FY13	Target FY14	Target FY15
Percent of investigations on reportable communicable diseases that follow appropriate protocols to limit further spread of the disease	100	100	100	100	100

FY14 Recommended Changes	Expenditures	FTEs
FY13 Approved	**1,909,333**	**17.30**
Multi-program adjustments, including negotiated compensation changes, employee benefit changes, changes due to staff turnover, reorganizations, and other budget changes affecting multiple programs.	98,677	1.00
FY14 CE Recommended	**2,008,010**	**18.30**

Community Health Services

Community Health Services provides preventive health access services to uninsured and underinsured populations, from newborns to the elderly. Services include nurse case management and home visits to targeted populations such as pregnant women, pregnant and parenting teens, children up to one year of age, and at-risk infants. This program includes the Community/Nursing Home Medical Assistance and Outreach Program in addition to the regional service eligibility units, to provide a single point of entry for eligibility screening, access, and assignment to Federal, State or County health programs. Other services include staffing support for immunization clinics, STD services, and pregnancy testing in regional health centers.

Program Performance Measures	Actual FY11	Actual FY12	Estimated FY13	Target FY14	Target FY15
Percentage of Infants At Risk (IAR) referrals that received a follow-up visit within 10 days by Community Health Service (CHS) nurse[1]	88	95	95	95	95

[1] Increases are due to full staffing levels.

FY14 Recommended Changes	Expenditures	FTEs
FY13 Approved	**12,307,462**	**128.80**
Decrease Cost: Maryland Children's Health Program Grant	-159,992	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.	-539,708	-1.00
FY14 CE Recommended	**11,607,762**	**127.80**

Notes: Multi-program adjustments reflect the increase of grants, the annualization of personnel costs, and turn over savings.

Dental Services

This program provides dental services to promote oral health in six dental clinics. Services include instruction in preventive health practices, primary assessments, targeted dental services, and emergency services. Services are provided to income-eligible Montgomery County children, pregnant women, adults, and seniors. This program also includes an HIV Dental Program, which provides comprehensive oral health services to HIV-positive clients.

Program Performance Measures	Actual FY11	Actual FY12	Estimated FY13	Target FY14	Target FY15
Percentage of children who complete their dental treatment plan	94	78	85	85	85

FY14 Recommended Changes	Expenditures	FTEs
FY13 Approved	**2,149,283**	**14.75**
Multi-program adjustments, including negotiated compensation changes, employee benefit changes, changes due to staff turnover, reorganizations, and other budget changes affecting multiple programs.	118,830	1.00
FY14 CE Recommended	**2,268,113**	**15.75**

Environmental Health Regulatory Services

This program issues permits for and inspects a variety of activities to protect the public health by ensuring that sanitation standards are met and maintained, and that there is minimal risk of injuries or spread of vector, food, and waterborne diseases in facilities licensed by the program. This program also enforces nutritional restrictions on trans fat in foods and enforces menu labeling regulations. Food service establishments, swimming pools, health-care facilities, group homes, private educational facilities for children and adults, hotels, motels, massage establishments, and a variety of other facilities used by the public are inspected and licensed. Inspections are conducted for compliance with health and safety standards established by the County and by State of Maryland laws and regulations. The County's rat control ordinance and smoking prohibitions and restrictions are enforced under th program. Complaints made by the public are investigated and orders for correction are issued as appropriate.

Program Performance Measures	Actual FY11	Actual FY12	Estimated FY13	Target FY14	Target FY15
Percentage of swimming pools found to be in compliance upon regular inspection	92	89	90	90	90

FY14 Recommended Changes	Expenditures	FTEs
FY13 Approved	**3,085,020**	**30.00**
Multi-program adjustments, including negotiated compensation changes, employee benefit changes, changes due to staff turnover, reorganizations, and other budget changes affecting multiple programs.	65,313	0.00
FY14 CE Recommended	**3,150,333**	**30.00**

Health Care and Group Residential Facilities

This program inspects and licenses nursing homes, domiciliary care homes (large assisted living facilities with less intensive care than nursing homes), adult day care centers, small assisted living facilities and group homes serving children, elderly, mentally ill, and developmentally disabled persons to ensure compliance with County, State, and Federal laws and regulations. Staff responds to complaints and provides advice and consultations to licensees to maintain high standards of care.

Program Performance Measures	Actual FY11	Actual FY12	Estimated FY13	Target FY14	Target FY15
Percentage of nursing homes with actual harm deficiencies	6	10	10	10	10

FY14 Recommended Changes	Expenditures	FTEs
FY13 Approved	**1,562,138**	**12.50**
Multi-program adjustments, including negotiated compensation changes, employee benefit changes, changes due to staff turnover, reorganizations, and other budget changes affecting multiple programs.	-39,465	0.00
FY14 CE Recommended	**1,522,673**	**12.50**

Cancer and Tobacco Prevention

The Tobacco Use Prevention and Cessation Program and the Cancer Prevention, Education, Screening and Treatment Program are two major programs funded through the State Cigarette Restitution Fund. State funding supports coordination activities among community groups for outreach, screenings, education, and treatment. Each program has established coalitions consisting of public health partners, community based organizations, hospitals, and other existing resources that work collaboratively to implement either tobacco-control programs or the statewide goal of early detection and elimination of cancer disparities, whether based on race, ethnicity, age or sex, as well as the establishment of tobacco-control programs.

FY14 Recommended Changes	Expenditures	FTEs
FY13 Approved	**1,149,972**	**4.00**
Multi-program adjustments, including negotiated compensation changes, employee benefit changes, changes due to staff turnover, reorganizations, and other budget changes affecting multiple programs.	-9,778	-1.00
FY14 CE Recommended	**1,140,194**	**3.00**

STD/HIV Prevention and Treatment Program

The Sexually Transmitted Diseases (STD) Program provides diagnosis and treatment to those who have contracted STDs. Contacts of infected patients are confidentially notified and referred for treatment. HIV counseling and testing is provided, with referral for medical and psychosocial support services if the test is positive. The HIV program provides primary medical care through all stages of HIV/AIDS, medication, as well as a broad spectrum of case management support services. Other services include home/hospice care, coordination of a regional HIV dental clinic, and housing services through the Housing Opportunities for People with AIDS program.

Program Performance Measures	Actual FY11	Actual FY12	Estimated FY13	Target FY14	Target FY15
New cases of Chlamydia per 100,000 population among County residents (15-24)[1]	1,157.6	1,313.4	NA	NA	NA

[1] Data are for the calendar year in which the fiscal year began. This measure is one of the three age cohort components. Projections are not made due to uncertainty as to when case numbers will fall.

FY14 Recommended Changes	Expenditures	FTEs
FY13 Approved	**7,219,157**	**43.65**
Technical Adj: Ryan White Part A Grant	131,645	0.90
Technical Adj: HIV Prevention Services and AIDS Case Management Grants	-63,128	1.10
Technical Adj: Ryan White Corsortia Services Grant	-100,031	-1.00
Multi-program adjustments, including negotiated compensation changes, employee benefit changes, changes due to staff turnover, reorganizations, and other budget changes affecting multiple programs.	118,500	-2.00
FY14 CE Recommended	**7,306,143**	**42.65**

Notes: Multi-program adjustments reflect the increase of grants, the annualization of personnel costs, and turn over savings.

School Health Services

This program provides health services to the students in Montgomery County Public Schools (MCPS). These services include: first aid and emergency care; health appraisal; medication and treatment administration; health counseling, consultation, and education; referral for medical, psychological, and behavioral problems; case management for students with acute and chronic health conditions, and pregnant and parenting teens; hearing, vision screenings, and Lead Certification screenings are provided to MCPS students. Immunizations and tuberculosis screenings are administered at School Health Services Centers, primarily to international students enrolling in MCPS. Primary health care, provided by nurse practitioners and physicians, is provided to students enrolled at one of the County's School Based Health Centers or High School Wellness Centers.

Head Start-Health Services is a collaborative effort of HHS, Office of Community Affairs, School Health Services, MCPS, and contracted community-based child care centers to provide comprehensive pre-kindergarten services to Federally eligible three and four year old children. School Health Services provides a full range of health, dental, and social services to the children and their families.

Program Performance Measures	Actual FY11	Actual FY12	Estimated FY13	Target FY14	Target FY15
Percentage of students who return to class after and are ready to learn following health room intervention	87	88	86	86	86

FY14 Recommended Changes	Expenditures	FTEs
FY13 Approved	**22,096,125**	**252.48**
Add: School Based Health Centers at Viers Mill and Weller Road Elementary Schools	489,440	1.80
Technical Adj: School Based Health Center Grant	7,271	-0.50
Multi-program adjustments, including negotiated compensation changes, employee benefit changes, changes due to staff turnover, reorganizations, and other budget changes affecting multiple programs.	598,710	2.55
FY14 CE Recommended	**23,191,546**	**256.33**

Tuberculosis Services

This program includes: testing persons for exposure to Tuberculosis (TB), treating active cases, identifying persons at risk of developing TB, performing contact studies to determine who may have been exposed to an infectious person, and medication therapy. A treatment plan is developed for each diagnosed patient and the patient receives supervised medication therapy. Special programs are provided to high-risk populations such as the homeless, addicted persons, incarcerated persons, and persons living in high-density areas of foreign-born populations.

Program Performance Measures	Actual FY11	Actual FY12	Estimated FY13	Target FY14	Target FY15
Percentage of clients with active infectious tuberculosis who receive and are scheduled to complete Directly Observed Therapy and successfully complete the treatment regimen[1]	95	95	95	95	95

[1] Data are for the calendar year in which the fiscal year began .

FY14 Recommended Changes	Expenditures	FTEs
FY13 Approved	**1,761,821**	**16.20**
Multi-program adjustments, including negotiated compensation changes, employee benefit changes, changes due to staff turnover, reorganizations, and other budget changes affecting multiple programs.	-105,251	0.00
FY14 CE Recommended	**1,656,570**	**16.20**

Women's Health Services

This program provides care coordination services for women and children in the Medical Assistance-managed care program. Referral services are provided for individuals with specific health issues (i.e., sexually transmitted diseases). Screening for early detection of breast cancer and cervical cancer including gynecological examinations, clinical breast examinations, mammograms, ultrasounds of

the breast and related case-management services are offered through the Women's Cancer Control Program to eligible women aged forty years and older.

FY14 Recommended Changes	Expenditures	FTEs
FY13 Approved	**2,793,937**	**19.68**
Technical Adj: Administrative Care Coordination Grant	0	-1.00
Multi-program adjustments, including negotiated compensation changes, employee benefit changes, changes due to staff turnover, reorganizations, and other budget changes affecting multiple programs.	11,053	0.97
FY14 CE Recommended	**2,804,990**	**19.65**

Public Health Emergency Preparedness & Response

This program is responsible for the planning, readiness, and response activities in the event of a public health emergency or bio-terrorism threat. Planning efforts are made in collaboration with the County Emergency Management Group; the Office of Emergency Management and Homeland Security; the Departments of Fire and Rescue Services; the Police Department; hospitals; and a variety of other County, State, regional, and Federal agencies. Efforts are targeted at training and staff development; communication strategies; emergency response drills; partnerships; resources and equipment; the establishment of disease surveillance systems; mass immunization clinics; medication dispensing sites; and readiness. This program manages the Advanced Practice Center for public heath emergency planning.

Program Performance Measures	Actual FY11	Actual FY12	Estimated FY13	Target FY14	Target FY15
Percentage of PHS Programs with Continuity of Operations (COOP) plans that have been reviewed and updated within the past 12 months	100	100	100	100	100

FY14 Recommended Changes	Expenditures	FTEs
FY13 Approved	**1,390,487**	**10.30**
Technical Adj: Emergency Preparedness - Cities Readiness Initiative	-144,836	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.	-72,941	0.00
FY14 CE Recommended	**1,172,710**	**10.30**

Notes: Multi-program adjustments reflect the decrease of grants, the annualization of personnel costs, and turn over savings.

Service Area Administration

This program area provides leadership and direction for the administration of Public Health Services. Service Area Administration also includes Health Planning and Epidemiology, the Community Health Improvement Process and Special Projects, as well as oversight for medical clinical volunteers, the Commission on Health, contracts, grants, and partnership development.

FY14 Recommended Changes	Expenditures	FTEs
FY13 Approved	**1,505,054**	**10.50**
Increase Cost: Health Officer State Salary Increase	31,315	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.	172,037	2.00
FY14 CE Recommended	**1,708,406**	**12.50**

PROGRAM SUMMARY

Program Name	FY13 Approved Expenditures	FY13 Approved FTEs	FY14 Recommended Expenditures	FY14 Recommended FTEs
Health Care for the Uninsured	13,072,847	6.00	12,862,463	6.00
Communicable Disease and Epidemiology	1,909,333	17.30	2,008,010	18.30
Community Health Services	12,307,462	128.80	11,607,762	127.80
Dental Services	2,149,283	14.75	2,268,113	15.75
Environmental Health Regulatory Services	3,085,020	30.00	3,150,333	30.00
Health Care and Group Residential Facilities	1,562,138	12.50	1,522,673	12.50
Cancer and Tobacco Prevention	1,149,972	4.00	1,140,194	3.00
STD/HIV Prevention and Treatment Program	7,219,157	43.65	7,306,143	42.65
School Health Services	22,096,125	252.48	23,191,546	256.33
Tuberculosis Services	1,761,821	16.20	1,656,570	16.20
Women's Health Services	2,793,937	19.68	2,804,990	19.65
Public Health Emergency Preparedness & Response	1,390,487	10.30	1,172,710	10.30

Program Name	FY13 Approved Expenditures	FY13 Approved FTEs	FY14 Recommended Expenditures	FY14 Recommended FTEs
Service Area Administration	1,505,054	10.50	1,708,406	12.50
Total	**72,002,636**	**566.16**	**72,399,913**	**570.98**

Nonprofit Montgomery

Nonprofit Montgomery Budget Hearing Testimony, April 11, 2013

Good evening and thank you for the opportunity to speak. My name is Marie Henderson. I am speaking to you as a member of the Steering Committee of Nonprofit Montgomery, an alliance of approximately 100 nonprofit organizations delivering services in Montgomery County.

I'd like to ask members who are present tonight to please stand. We deliver senior services, assistance to the developmentally and intellectually disabled, food, shelter, clothing, counseling, medical, dental and mental health care, substance abuse treatment, job training, legal services, education support and after-school activities, as well as programs in the arts and environment to diverse communities throughout the County. We reach approximately half of all residents.

We are a strong, committed coalition asking you to ***help restore funding and strengthen our partnerships with you.***

Despite signs of economic recovery, the nonprofit sector continues to see unprecedented demands for life-line services. Our shelters are full and thousands of people are on the waiting list for subsidized housing vouchers. Requests for food assistance –a good barometer of the health of our neighbors—increased nearly 10% over this time last year.

Nonprofits have been trying to address the increased demand with fewer public and private resources. During the worst of the economic downturn and beginning in FY10, funding for nonprofits through Country contracts was cut over a three-year period. While we appreciate the County Executive's support of specific nonprofit initiatives, **we request that the Council provide a generous inflationary increase to nonprofit providers to help restore recession era reductions.** A 9% inflationary adjustment amounts to **$5.5 million, a mere .1% of the total $4.8 billion county budget.** As you begin to reinvest in other critical institutions like schools, parks and libraries, please also begin to make up for the losses incurred by nonprofit service providers – some of which went as high as 15%.

As leaders and partners, we also ask the Council to strongly encourage businesses to increase their connection to community nonprofits. While many County businesses are civically involved, the connection between for-profit and non-profit needs to be broader and deeper. Civic engagement, ranging from serving on Boards of Directors to rewarding employee volunteerism to forging innovative partnerships, should be an expectation of doing business in Montgomery County. Help us to ***strengthen our partnerships.***

Nonprofit Montgomery members appreciate the partnership we have with County government, and would like to publicly acknowledge DHHS for their assistance in resolving some of the debilitating contracting issues. Successful communities see businesses, government, nonprofits and citizens coming together to identify and solve problems.

According to our recent report, *Beyond Charity*, the county's nonprofits employed over 40,000 people with total wages of $2.2 billion and total purchasing power of nearly $4 billion. As significant contributors to the local economy and quality of life, we ask local government to ***shore up its investment in nonprofits, starting with a generous inflationary adjustment.***

In closing, we know that you still face challenges providing adequate funding for crucial programs and services. However, given fiscal projections for FY14 that are more generous than years past, we hope that the future of nonprofits continues to be part of your rebuilding plans by ***restoring funding for nonprofit services and strengthening our partnerships.***

Thank you.

Montgomery County InterACC/DD

(Jubilee Assn) 10408 Montgomery Ave. Kensington, Md. 20895
Voice 301-949-8628, Fax 301-949-4628
Co-Chairs; Tim Wiens (twiens@Jubileemd.org) & Karen Lee (klee@seeconline.org)

Testimony before the Montgomery County Council
In Consideration of the FY14 Operating Budget

- Inter ACC/DD is requesting an increase of $665,000 in the DD Supplement in FY14.

- $350,000 of this is to pay for our growth in services in FY14. We expect that our State funded services will increase by $4.7 million in FY14 representing approximately 145 new individuals at a County supplement of $2,400 per person on average. If we do not receive this supplement for these new services we need to either pay staff working with these new individuals less or we need to take money from existing services and give it to these new services.

- $315,000 would be for a 4% cost of living adjustment for the existing supplement. We want to be able to give our employees cost of living increases and 4% would allow us to do so and begin to catch up with some of the lost earning power they have experienced over the last several years.

- The DD Supplement/Match is designed to pay a better wage for our direct service employees. The direct service wage rate included in our State funding rates is $9.13. We have agreed that all service providers should be required to pay at least $1 an hour more than that. We are working with DHHS to verify that all services providers are paying an average wage of at least $10.13 an hour. We expect to have those results and share them with you by the end of April.

Tim Wiens, Executive Director
Jubilee Association of Maryland and
Co-Chair Inter ACC/DD

Abilities Network/EFCR, The Arc of Montgomery County, CALMRA, CHI Centers, Community Support Services, Inc.,Compass Inc., Full Citizenship, CSAAC, Head Injury Rehab and Referral, Jewish Foundation for Group Homes, J.P. Kennedy Institute, Jubilee Assn., MedSource, R.O.I, SEEC, TransCen, The Rock Creek Foundation, Treatment and Learning Centers and other providers and government agencies serving individuals with developmental disabilities.

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-iocate program staff of OCA to maximize coordination.

African American
Health Program

HHS Meeting on Continental Africans
03/21/2013

Highlights from Remarks Made by
Dr. Bola Idowu, Project Director

STAFF COMPOSITION – 10

5 African Americans
1 Caribbean – Bermuda
3 Africans – Nigeria, Tanzania & Sierra Leone
1 Caucasian – USA

HEALTH PROMOTERS – 19

5 East Africans – Ethiopia, Tanzania & Kenya
4 West Africans – Cameroon & Ivory Coast (all French-speaking)
2 Caribbeans – Dominican Republic; Trinidad and Tobago (1- proficient in American Sign Language (ASL)
8 African Americans

PROGRAMS

Culturally sensitive programs:

1) Projet Santé Pour Tous – created by one of the African staff and delivered by our French-speaking health promoters at CASA de Maryland for African day laborers. Provide free high blood pressure screenings & referrals to primary care & specialty care services – STD clinic at Dennis; dental clinics at University of Maryland & Howard University; brought in a dentist to speak with them

2) HIV testing at an Ethiopian provider's clinic in Silver Spring on a bi-monthly schedule – Affordable High Quality Healthcare clinic - Dr. Ashenafi Waktola

3) African dining club – started March, 2012

4) Provide brochures & flyers to advertise all our health activities at local ethnic grocery stores and businesses

5) Provide training on cultural sensitivity on African health beliefs and practices to healthcare providers such as social workers, also to, shelters providers group in partnership with the County's continuing education training

6) Provide information on services through brochures translated from English to French and Amharic

STRATEGY FOR OUTREACH

AAHP follows the practice of "Meeting our clients where they are."

1) Health promoters' contacts in their neighborhoods; faith-based connections and ethnic associations

2) Staff contacts with ethnic associations

3) Referral from other agencies; CBOs and FBOs in the County

4) By invitation to health fairs; cultural day celebrations; fashion shows; participated each year in the African Health fair.

5) Partnerships with the following African organizations/events:
   a. Project BEAT IT – Adventist Health Disparities Center (staff part of their advisory committee)
   b. African Women's Cancer Awareness Association (AWCAA) – beneficiary of former AAHP mini grant; their health promoters trained by AAHP staff, Ms. Mwaluko
   c. Affordable High Quality Healthcare Clinic – Dr. Ashenafi Waktola
   d. American Cancer Society faith-based liaison – Dr. Adrien Ngudiankama
   e. African Immigrant & Refugee Foundation (AIRF)
   f. Lomack Healthcare Clinic & Affordable Healthcare Nurse Practitioner clinic by a Nigerian & Liberian nurses (they are invited to set up tables during health fairs)

g. CASA de Maryland Labor Center, Langley Park (Projet Sante Pour Tous project for African day laborers, presented in French by 2 of AAHP's health promoters)
h. Savanna International Market – Gaithersburg (permitting AAHP to set up table in front of the store, distribute flyers; health materials & blood pressure screening)
i. Tastes of Africa Expo (set up tables, educate attendees & distribute health information materials)
j. Fest Africa – Africa Youth Association
k. Jesus House DC (participate at their annual health fair)
l. Bethel World Outreach (dining club site)

Our Numbers

Given our limited resources in terms of staff and funds, we have served the emerging African population in the County as reflected in these numbers:

AAHP Unit	Total FY11/12	African American	African	Others
HIV	356 489	FY11 - 109 **(31%)** FY12 - 197 **(40%)**	FY11 - 120 **(34%)** FY12 - 126 **(26%)**	FY11 - 127 **(35%)** FY12 - 166 **(34%)**
Infant Mortality SMILE	165 158	FY11 - 70 **(42%)** FY12 - 65 **(41%)**	FY11 - 85 **(52%)** FY12 - 80 **(51%)**	FY11 - 10 **(6%)** FY12 - 13 **(8%)**
Diabetes Classes African dining - started March 2012	144 108 0	FY11 - 86 **(60%)** FY12 - 62 **(57%)** 0	FY11 - 12 **(8%)** FY12 - 7 **(7%)** FY12- 25	FY11 - 46 **(32%)** FY12 - 39 **(36%)** 0
Cardiovascular (BP screening)	792 570	FY11 - 206 **(26%)** FY12 - 154 **(27%)**	FY11 - 126 **(16%)** FY12 - 96 **(17%)**	FY11 - 460 **(58%)** FY12 - 320 **(56%)**

AFRICAN AMERICAN HEALTH PROGRAM
Fiscal Year 2012 FINAL REPORT
July 1, 2011—June 29, 2012

Submitted to the Montgomery County Department of Health and Human Services

Introduction

The African American Health Program (AAHP) was created to address health disparities among African Americans in Montgomery County, MD. The program is funded by the Montgomery County Department of Health and Human Services (DHHS) and administered by BETAH Associates, Inc. (BETAH).

AAHP operates in conjunction with a volunteer Executive Committee that provides strategic planning and advocates for increased AAHP funding. Along with the Executive Committee, there are two community-based coalitions: Infant Mortality and HIV/AIDS/STI. The coalitions work with the Project Director and other AAHP personnel to provide program guidance and direction in each specific area. In addition to the coalitions, a diabetes work group supports the AAHP Diabetes Unit.

Darlene Coles, RN, BSN, MBA, served as Project Director for the entire fiscal year. Under her leadership and with the assistance of her staff, AAHP continued to strengthen existing programs, develop new relationships with organizations within the County, and explore additional grant opportunities.

Services and Programs

AAHP provided the following programs and services at no cost to the Montgomery County community, which include but are not limited to the following:

- The SMILE program (Start More Infants Living Equally healthy), a prenatal infant case management program that includes childbirth education classes, lactation education classes, and STI and pregnancy prevention classes. (Infant Mortality Unit)
- HIV counseling, testing, referrals, and education. (HIV/AIDS Unit)
- WIGO (When I Get Out: A Healthy and Safer Lifestyle), a program designed to provide HIV/STI information and resources for soon-to-be-released male inmates. (HIV/AIDS Unit)
- Diabetes education classes, the Diabetes Dining Club (with a modest cost for dinner), and one-on-one diabetes counseling with a Certified Diabetes Nurse Educator. (Diabetes Unit)
- Blood pressure screening and smoking prevention activities geared toward adults and children, the Heart Health Symposium, and the Health Freedom Walk. (Cardiovascular Unit)

- The AAHP Community-based Health Promoters program that educated and informed the community about breast, colon, prostate, and lung cancers, as well as the available screenings for early detection and prevention of these cancers. (Cancer Unit)

- The "Did you know...?" Oral Health Awareness Campaign through which dental hygiene kits were distributed to children and adults at all health fairs AAHP attended. (Oral Health Unit)

Msache Mwaluko, AAHP Health Educator, continued to enjoy a strong working relationship with CASA of Maryland last fiscal year to allow the AAHP to serve as a resource for French-speaking, newly arrived Africans. "PROJECT SANTE POUR TOUS" or "Health for All Project" continued to grow this fiscal year. (Cancer and Health Promotion)

Major Program Accomplishments

More than 6,790 Montgomery County residents received AAHP services and referrals.

In total, AAHP either took part in or conducted 81 community outreach activities for FY12.

On June 27, 2012, National HIV Testing Day, the Testing by the Hundreds HIV campaign exceeded its goal of educating and testing 1,000 African Americans and people of African descent in Montgomery County.

AAHP was re-awarded the Minority Outreach and Technical Assistance grant through Holy Cross Hospital for the 2012 fiscal year. The grant allows the Health Promoters to educate County residents about all chronic disease prevention, as opposed to only cancer education and tobacco cessation as in previous years.

AAHP's Diabetes Self-Management Classes program was accredited by the American Association of Diabetes Educators, effective April 25, 2010, for a period of four years. Classes began in July 2003 and have been held for a minimum of nine 12-hour sessions per year, serving approximately 125 County residents.

More than 500 copies of the 2011 annual report were distributed electronically during the fiscal year.

This fiscal year, AAHP was named a President's Challenge Advocate to Promote the Presidential Active Lifestyle Award. The goal of this partnership is to encourage children and families to be physically active and maintain a more healthful lifestyle. The President's Challenge is a program of the President's Council on Fitness, Sports, and Nutrition (PCFSN) and is administered by the Amateur Athletic Union/Indiana University for the PCFSN.

AAHP was featured in *Montgomery Magazine* and *The Montgomery County Sentinel.* Both articles were written about the "Health Freedom: A Path to Celebration Walk" held June 11, 2011.

Approximately 1,710 oral health kits were distributed to County residents during the fiscal year.

On June 11, 2012, 146 people as well as 160 Circle of Friends members attended the seventh annual Health Freedom Walk at the Woodlawn Cultural Park in Sandy Spring.

Successes and Challenges of Fiscal Year 2012

During the month of August, the University of Maryland at Shady Grove Students Engaged in Public Health Club decided to award the proceeds of their first annual 2K Family Stroll for Healthy Babies to the SMILE Program. The actual walk took place in November 2011 and raised more than $4,700.

On August 3, 2011, AAHP held a Health Freedom Walk Conductor appreciation dinner at the Colesville United Methodist Church.

On August 10, 2011, Dr. Bola Idowu and Darlene Coles were featured on Sheila Stewart's Radio One Program. The topic of discussion was HIV/AIDS and the Testing by the Hundreds campaign.

The AAHP Project Director was invited to sit on the planning committee for the Adventist Center on Health Disparities Annual Conference that took place in November of 2011.

Robin Worsley, RN, CDE, who was employed at AAHP as the Diabetes Nurse Educator for more than four and a half years, resigned in September of 2011.

On September 17, 2011, the Montgomery Minority Infant Mortality Reduction Pilot Program and AAHP cosponsored a two-hour workshop at the Silver Spring Civic Center titled "Call of Duty." The workshop was geared towards educating Black men about their role in infant mortality.

The SMILE Nurse Case Managers independently made arrangements with three day care providers in Silver Spring and Montgomery Village to provide clients day care at a discounted rate because of the long WPA/POC waiting list. Nurse Case Managers are currently working to recruit more County day care centers.

Montgomery County awarded Dr. Bola Idowu a NaCo Award for the WIGO (When I Get Out: A Healthier and Safer Lifestyle) program Monday, November 7, 2011, in Rockville, MD.

The Health Promoters Program now has five male Health Promoters! This is important as we attempt to provide increased outreach to males in the County.

On October 19, 2011, Msache Mwaluko, Britne Kirkland, and Xerxeser Kayodé volunteered at the Montgomery County Homeless Day Resource Fair. Approximately 300 homeless people participated in the fair.

Msache Mwaluko was a panelist at the second annual Adventist Center on Health Disparities Conference. The presentation highlighted the role of the AAHP Community Health Workers in prevention and wellness activities. AAHP also participated in a poster session; the title of the poster was "African American Health Program Community-based Health Promoters Program: Bridging the Gap between the Community and the Health Care System." There were an estimated 250 attendees at the conference.

WPGC 95.5 radio station invited AAHP to participate in its Annual Turkey Trot Tuesday, November 22, 2011. AAHP was one of four sites for the annual event. Approximately 20 Thanksgiving dinners were provided and distributed by WPGC radio hosts and staff to AAHP's clients and residents of Montgomery County. Everyone who received a dinner was very grateful to receive such a special gift during the holidays.

The Diabetes Unit had its End-of-Year Celebration November 17, 2011, with 61 club members, 21 guests, three performers, and eight staff members in attendance. In total, 114 people attended the celebration. Entertainment included a saxophonist accompanied by a piano player and a comedienne. The event was a great success!

In December, Rosie Martin, RN, CDE, joined the AAHP staff as the new Diabetes Nurse Educator.

AAHP was invited to attend the Annual Alpha Phi Alpha Dr. Martin Luther King Jr. Memorial Breakfast. AAHP was the first and only organization other than a March of Dimes sponsor to display at the event. This event is attended by at least 1,000 Montgomery County residents annually.

The AAHP HIV Unit developed and conducted the First Annual "MoCo Getting Real and Going in Teen Summit" in observance of National Black HIV/AIDS Awareness Day. The event was featured on the WUSA News 9 Web site.

The final quarter's Childbirth Education Class, cosponsored by Holy Cross Hospital, has been the most successful class to date. The SMILE Nurses reported that the participants were engaged and very involved in the learning process.

On March 1, 2012, the AAHP's first African Dining Club took place at the East County Service Center. Twenty-five Continental Africans who were Montgomery County residents attended the club.

At various outreach events, some clients with very high blood pressure readings refused to seek urgent care due to financial constraints. Evaluations from the events reveal that they do not understand the importance of getting their blood pressure rechecked by a health care professional. Rosie Martin, Diabetes Nurse Educator, wrote and presented a hypertension program class to 17 members of the Asian American Health Initiative on April 30. This hands-on education session included Health Promoters and other staff and included pathophysiology, prevention, interpretation of blood pressure results, and practice time.

WTOP announced the Diabetes Dining Club on the radio and also featured an online article on the Diabetes Dining Club and class caterer Chef Gayle Plummer-Owens.

Mayor Phyllis Marcuccio of Rockville attended this year's Health Freedom Walk and presented AAHP with a Proclamation welcoming the AAHP and Health Freedom Inc. to the City of Rockville.

On June 27, 2012, National HIV Testing Day, the Testing by the Hundreds campaign exceeded its goal of educating and testing 1,000 African Americans and people of African descent in Montgomery County. Xerxeser Kayodé conducted a radio interview with Majic 102.3 radio station to announce the Testing by the Hundreds Campaign closeout event.

On June 19, 2012, AAHP staff members Denise Dixon and Xerxeser Kayodé attended a Radio One Town Hall meeting as a guest of Sheila Stewart. They were also invited to conduct a pre-recorded interview with Ms. Stewart that aired on Majic 102.3 and Praise 104.1 radio stations.

Staffing

Darlene Lyric Coles, RN, BSN, MBA	Project Director
Xerxeser Kayode, BS	Program Assistant

Infant Mortality

Nia Williams, RN, BSN, MPH	Nurse Case Manager
Saundra Jackson, RN	Nurse Case Manager
Melanie Hunter, RN	Nurse Case Manager

Diabetes

Rosie Martin, RN, CDE	Certified Diabetes Nurse Educator
Diane Herron	Community Outreach Specialist

Cardiovascular/Cancer Partnerships
Community Outreach

Msache Mwaluko, BS	Health Educator
Denise Dixon, BS, MSM	Outreach Specialist

HIV/AIDS

Dr. Bola Idowu, DrPH	Health Educator

Department of Health and Human Services

Linda Goldsholl MS, RD	Diabetes Program Coordinator

SMILE (Start More Infants Living Equally Healthy)

The Infant Mortality Case Management Program, SMILE, is a pre-conceptual health program that focused on the development and maintenance of a healthful lifestyle. Three Registered Nurses conducted home visits to high-risk pre-natal and postpartum women and their infants. In addition, the Infant Mortality Unit offers a biannual Child Birth and Lactation Education Series, a three-day, six-hour class geared towards high-risk expectant moms in the African-American/Black community.

Nurse case-management services were provided to women before and after they gave birth up until the infants' first birthday. Over the past fiscal year, AAHP provided services to **215** clients. SMILE clients were made up of pregnant and postpartum African-American women and women of African descent and their babies. During the year, AAHP made **1,666** home visits in areas as far away as Damascus, Gaithersburg, Germantown, Clarksburg, and Rockville.

Quarter	Number of client referrals	Number of unduplicated clients	Number of home visits	Number of term deliveries	Number of pre-term deliveries	Number of low birth weight infants	Number of very low birth weight infants
First	35	121	384	21	1	0	0
Second	43	123	401	15	1	2	1
Third	43	136	438	13	2	1	0
Fourth	43	137	443	14	4	1	2
TOTAL	156	130 average	1,666	63	8	4	3

Women enrolled in the SMILE program were often referred to other services throughout the County. In FY12, **510** referrals were made to other support programs. The programs referred to included:

Birthright
Car Seat Program
Caring Connection
Catholic Charities
Child Care Connection
Community Clinic
Cribs for Kids
Depression Services
Families Foremost
Food and Friends
Gaithersburg HELP
Health Insurance
Healthy Mothers Healthy Babies
Healthy Start
Holiday Giving Project
Holy Cross Clinic
Housing Opportunities Commission
Infants at Risk
Interfaith Clothing
Interfaith Housing
Job Training
Manna Food
Mental Health Services
Mission of Luv
MHIP
MOMS
Rockville Pregnancy Center
Services Eligibility Unit
Shady Grove Pregnancy Center
Shelters
Temporary Cash Assistance
Wider Circle Furniture
Women, Infants, and Children Program

Breast Pump Loan Program

Another valuable offering of the SMILE program was the breast pump loan program. Mothers were encouraged to breastfeed their newborns. Those who returned to work were provided with AAHP subsidized breast pumps, breast pump kits, and breast-feeding training with an AAHP-certified lactation consultant, RN. During each quarter of FY12, all 11 of the program's breast pumps were in use each month. Mothers were required to show proof of a negative HIV test or be willing to get tested by the SMILE nursing staff before being allowed into the breast pump loan program. During the fiscal year, an average of 48.4 percent of SMILE mothers breastfed every month for at least three months. This is significantly greater than the 40 percent national average reported by the Centers for Disease Control and Prevention breastfeeding report card 2010.

Sudden Infant Death Syndrome Mid-Atlantic (SIDSMA)

AAHP maintained its partnership with SIDSMA, which allowed the SMILE program to provide cribs to women who were not able to afford them.

Childbirth Education Series/Lactation Education Series

These classes were offered to the residents of Montgomery County free of charge. The classes were held at the Eastern Montgomery County Regional Services Building in Briggs Chaney, MD. Classes were held two times during the fiscal year. The two classes ran for three hours on each evening. The classes were interactive and informative, as they prepared the mommy-to-be and her partner for the birth experience and the early weeks of parenthood. The curriculum included:

The Anatomy and Physiology of Pregnancy
Signs and Symptoms of Pregnancy
Fetal Growth and Development
Signs and Symptoms of Preterm Labor
Special Circumstances in Pregnancy
The Bradley Childbirth Method
Prenatal Belly Dancing Session
True Labor vs. False Labor
Phases and Stages of Labor
What Happens in the Hospital?
Vaginal and Caesarean Delivery
Breastfeeding Positioning and Latching On
Procedures Performed on Baby after Birth
Newborn Care at Home
Safe Kids of Montgomery County (car seat safety and new car seat laws)

Free incentives for the participants who completed all three of the childbirth education classes were:

- Pack-and-play cribs given to each prenatal woman or a car seat voucher.
- Hygiene kits given to each prenatal woman.
- Pregnancy information AAHP tote bags given to each prenatal woman.

Below is a demographic breakdown of the SMILE Childbirth Education series participants for FY 2012:

	September 12-14 2011	March 27-29 2012
Number of Pregnant Women	20	36
American/African Descent	14	30
Caucasian	0	2
Latina	4	3
Asian	2	1
Number of Fathers Present	9	13
Number of Car Seat Vouchers Given	8	12
Number of Crib Vouchers Given	11	10

The May 2012 Childbirth Education class was generously sponsored by Holy Cross Hospital located in Silver Spring, MD.

Smoking

Although AAHP has not received funding from the cigarette restitution fund for two fiscal years, the program has continued to incorporate an anti-tobacco message throughout all of the strategic areas. The biannual Childbirth Education classes contain a unit on the dangers of first- and second-hand smoke. In addition, we distributed smoking cessation literature and referral information at all of the health fairs that we attended during the fiscal year.

Diabetes

AAHP planned, organized, and implemented the "Diabetes Self-Management" health education series and the "Diabetes Dining Club" throughout Montgomery County. Linda Goldsholl, MS, RD (Montgomery Department of Health and Human Services), Diane Herron, Community Outreach Worker, and Rosie Martin, RN, CDE, worked on these initiatives. The team also worked with Chef Gayle Owens of Catering to You. The focus of these health education classes and activities was to empower individuals with the knowledge to make positive changes in their control over diet, exercise, and medication to improve blood glucose control and reduce the complications of diabetes.

The narrative information that follows provides all post and Follow-up data for participants who "graduated" with at least three classes of the diabetes education course during FY12 in groups 77 through 85 and end-of-year dining club outcomes.

Diabetes Classes

Results and outcomes of the classes remain very consistent over time. In general, participants report increasing fruit and vegetable consumption and physical activity levels, weight remained the same and there was a decline in 69% of the A1cs (7.7 to 7.0) on the 31 participants with Follow-up data. The two greatest challenges during the year have been maintaining the schedule of classes

and club events, as well as time needed for outreach and promotion. There was a 24% decrease in the number of new participants this year compared with FY11 (147). There has been much discussion regarding the possible causes. However, evidence shows that if people attend classes, there is a 71% "graduation" rate. In addition, 40% of the total class population completed all four classes. Comments on nightly evaluations are consistently positive and 82% are "very satisfied" and 9% "satisfied" with the classes. Class outcomes are provided in the charts following the summary below.

Diabetes Dining Clubs

New African Immigrant Dining Club

African Immigrants make up 16% of the diabetes class participants. This year a third Diabetes Dining Club was created and it was designed to help African Immigrants learn how to remain healthy in America, whether they do so by eating cultural foods from their country of origin or transitioning to an American diet. The club was built as a partnership with a Nigerian nurse CDE from HealthBeam Outreach Inc. and a Ghanaian dietitian from Medical Nutrition Consultant LLC. The club has been in the planning stages for nearly three years and had been delayed due to a lack of grant funding. This year, however, one of the African-American dining clubs was cancelled due to poor attendance. Because of this, those funds were redistributed to the immigrant club. The actual monthly organizing of the club is done through evening conference calls. The club learning sessions are created by the club leaders, the menus are done through the club leaders working to find the caterer and the club dietitian getting the recipes to the AAHP diabetes program manager, who then analyzes and modifies them as necessary to make healthier versions. In order to build group rapport and cohesiveness, the physical activity portion has been done this year by one of the AAHP Health Promoters with fitness credentials. In April, a new coordinator position was created to assist the program manager in managing the workload.

The club's objectives are to learn about the specific needs of this population and to document them. Additional questions were added to the club registration form regarding languages spoken in the home, length of time participants have had diabetes, and whether participants were diagnosed in the U.S. or their land of origin. Attempts will also be made to track the types of modifications needed to make recipes more healthful and document this to share the learning experience with other health professionals.

The club started in March with a grand first night of about 25 and then settled into a small group of 18 registered participants and a monthly attendance average of 15. This is a more manageable size for the new club leaders and from which to grow and is similar to the start of the other clubs. Comments from participants indicate the club is already making an impact.

African American Diabetes Dining Clubs

The three main objectives for the clubs this calendar year were addressing the high blood pressure of club members, increasing physical activity participation at clubs, and increasing test scores.

1. Blood Pressure: Blood pressure (BP), its complications, and talking to their doctor about it were the subject matter for the club learning sessions in April and May. A "BP Healthy Bucks" project was launched to encourage people to get BPs taken at club and collect the bucks for raffle entries to win BP monitors. When BPs are taken, club members are asked to record them on a card and indicate whether they are "safe" or "unsafe."

2. Physical Activity Healthy Bucks: Participants now earn healthy bucks for participating in the physical activity portion of the club. At the end of the year, rather than giving awards for attendance, awards will go to the people who have participated in physical activity and earned the greatest number of healthy bucks.

3. Pop Ups: A new strategy was created to increase test scores on the 10-question test. Because there are subject areas not routinely covered in the learning sessions, and there are participants who might not attend classes every month, the new strategy consisted of giving 10 participants one question each, have them stand up, turn the question into a statement, and report it to the group. Thus far, this approach has had a positive effect on class participation and engagement.

Classes and Clubs ER Referrals

The significance of the potential life-changing nature of this program can be exemplified in ER referrals. This fiscal year, through BP monitoring in classes, five people were referred to the ER. Two of the 5 were admitted to the hospital, one taken to the ER and released, and two refused to go. From a club meeting, one person was sent to the hospital by ambulance and admitted for four days.

Outcomes

In summary, the following data supports the effectiveness of the classes and clubs. Unfortunately, quality-of-life issues and reduction in complications and chronic disease cannot be captured. However, based on the positive comments from the participants, the total impact may be far greater than the numbers convey.

Data and Outcomes

Diabetes Classes

Nine class series were held in FY12. The sites included community centers and four African-American churches.

Knowledge and behavioral data was collected from participants on the first night of class. Throughout the program post data is collected. Knowledge (i.e., course content) is assessed at the end of each evening and lifestyle behaviors at the beginning and end of the series for all participants. Medical data is collected during the second week. Follow-up is done three months later on people who have attended at least three of the classes.

For each of the outcomes measured in this report, percentages are determined by the number of participants who completed the classes *and* had pre/post data. Therefore, the data sample for each outcome is significantly lower than those who initially enrolled in the classes.

Attendance

There were 112 new contacts during the year and an additional 21 chose to finish the class series or attend additional classes. Eighty people (71%) completed the class series with a minimum of three classes and of that group over half of them (45 people) completed all four classes.

			Attendance				# Who Took:			
Location / Group #	**Total New**	**Total Contacts**	**Class 1**	**Class 2**	**Class 3**	**Class 4**	**1 class**	**2 classes**	**3 classes**	**4 classes**
July-Paisner-77	8	10	9	6	4	7	3	0	3	2
78-Victory Christian	15	17	14	16	15	14	0	0	5	10
79-Pilgrim Baptist	10	13	9	8	7	9	2	1	5	2
80-Germ	8	10	8	7	8	10	0	1	5	2
81-MidCo CC	9	11	4	7	5	3	5	1	3	0
82-Wheaton CC	26	27	21	22	18	16	7	2	7	10
83-Goshen United Methodist	16	17	11	12	16	14	0	5	3	8
84-Gwen Coffield CC	11	13	6	7	9	10	2	0	1	8
85-Victory Christian	9	15	11	9	9	8	2	1	3	3
Total	112	133	93	94	91	91	21	11	35	45
TOTAL HOURS OF INSTRUCTION						**1107**				
PERCENT COMPLETING							**19%**	**10%**	**31%**	**40%**

FY12 Attendance: Total African Americans and Black Immigrants

African Americans and Black Immigrants made up 73% of the total class population.

Group	Total New Contacts	Total New AA/BI	Total New AA	Total New BI
FY12	**109***	**79**	**62 (57%)**	**17 (16%)**

- ***Three people are missing on computer printed demographic report**
- **Additional data based on this total of 109 people that the data system is counting**

Profiles: African Americans and Black Immigrants: Education and Insurance Status

Although African Americans had more education as defined by "any college degree," in FY12 African Americans (87%) had lower rates of health insurance than African Immigrants (94%).

	African American				Black Immigrants		
Group	**Total**	**College Degrees**	**Health Insurance**		**Total**	**College Degrees**	**Health Insurance**
FY12	**62**	**36 (58%)**	**54 (87%)**		**17**	**6 (35%)**	**16 (94%)**

Participants with Diabetes

In FY12, of the 109 total new contacts, 71 individuals had diabetes and **11**, not shown here, were diagnosed with pre-diabetes.

Group	Total New Contacts	Total New with Diabetes	Total AA/BI with Diabetes	Total AA With Diab	Total BI With Diab	Total Non-Blacks with Diabetes
FY12	109	**71**	**49**	37	12	**22**

Those Receiving Diabetes Education: African Americans / Black Immigrants

For FY12, rates of attending diabetes classes or having seen a dietitian were very low for both groups.

	African Americans				Black Immigrants		
Group	**Total AA w/Diab**	**Has Seen A Dietitian**	**Has Been to A Class**		**Total BI w/Diab**	**Has Seen A Dietitian**	**Has Been to A Class**
FY12	**37**	**18 (49%)**	**11 (30%)**		**12**	**5 (42%)**	**4 (33%)**

Post-Behavior Changes FY12 Groups 77 – 85

Participant Self-Reported Behavior Changes

These behavior changes were checked off on a list of possible behavior changes recommended through the class series. Interestingly, participants often perceive they are making, or have made, behavior changes in greater numbers than are supported by comparison of other frequency data that are collected.

	FY12

Total Participants Entering the Program	105
Total Participants Completing Classes and Handing in Paperwork	76
Total Reporting Positive Behavior Changes	**72 (96%)**
Taking Med More Reg	25
More Physical Activity	33
More Calcium	14
Less Sat & Trans Fats	39
Read Food Labels	**55 (76%)**
More Fruits & Veg	45
Less Salt	46
More Whole Grains	27
General Eating Healthier	36
Portion Control	**49 (68%)**
Eating Fewer Carbs	39

For FY12, 96% of participants reported positive changes. The behaviors most improved were reading food labels **(76%)** and controlling portion sizes **(68%)**. All of these behaviors have the potential to help individuals control weight and blood sugar over time.

Description of Data Analysis

Percentages on the following charts are derived from comparisons of pre and post data for those in groups 77 through 85 who completed the paperwork, not for all those entering the program. For each parameter measured there is a different number for the amount of paperwork collected. This is a result of some people absent the night paperwork is collected or omissions or unclear markings on the paperwork. Attempts are made to clear up discrepancies on paperwork, but it is not always possible to reach people and repeated attempts are not feasible.

For People with Diabetes

	FY12
Total People with Diabetes Starting the Classes	71
Total People with Diabetes Completing Class Series	53 (75%)
Total Participants Completing Classes and Paperwork	**48 (68%)**

Increased Confidence in Managing Blood Sugar – Self-Reported Perception Pre to Post
In FY12, 29 (60%) of those with diabetes thought they were more confident in managing their blood sugar.

	FY12
Total People with Diabetes Completing Class Series	71
Total Participants Completing Classes and Paperwork	48
Total Reporting Increased Confidence at Post	**29 (60%)**

*Patients can identify as: I do not know how to handle most of my blood sugar problems; I know a little but I am not confident; I know some tips that I can try before calling my health care provider; I

am confident that I know what to do for most blood sugar problems (goal). Any movement along the continuum is recorded.

Testing of Blood Sugar by People with Diabetes – Self-Reported Perception Pre to Post
41 (85%) of those with diabetes thought they were testing their blood sugar more often.

	FY12
Total with Diabetes Starting the Program	71
Total with Diabetes Completing Classes and Paperwork	48
Total Reporting Increased Blood Sugar Testing	**41 (85%)**
Testing BG More	10
Testing BG More & Doing Something About It	31

Increased Blood Sugar Testing – Comparison of Frequency Data Pre to Post
In FY12, although 41 participants above perceived an increase in testing blood sugar, only 21 (44%) had that verified by comparing the actual number of times they tested pre and post.

	FY12
Total People with Diabetes Completing Class Series	71
Total Participants Completing Classes and Paperwork	48
Total Reporting Increased Blood Sugar Testing	**21 (44%)**

For all participants with and without diabetes:

Increased Days of Physical Activity - Comparison of Frequency Data Pre to Post
For the chart below, the Access database only includes those people who completed at least three classes and came to Class 2 (physical activity). It does not capture the people who missed class 2.

	FY12
Total Participants Completing Class Series (incl. Class 2)	69
Total Participants Completing Classes and Paperwork	
Total Reporting Increased Days Physical Activity	**20 (29%)**

Increased Consumption of Fruits and Vegetables - Comparison of Frequency Data Pre to Post
56% of completers indicated an increase in the number of servings of fruits and vegetables consumed.

	FY12
Total Participants Completing Class Series (incl. Class 1)	63
Total Participants Completing Classes and Paperwork	
Total Reporting Increased Consumption of Fruits and Vegetables	**35 (56%)**

Medical Data Summary

Blood Pressure

48 people (58%) of the participants entered the program with hypertension and 20 (24%) had pre-hypertension. Thirty people (36%) made an appointment with their physician to follow up on the blood pressure reading taken at class and only five people actually achieved a lower blood pressure classification.

	With Diabetes	Without Diabetes	FY12
N =	58	25	**83**
Hypertension	37	11	**48 (58%)**
Pre-hypertension	8	9	**20* (24%)**
Normal	10	2	**14*(17%)**
# with HBP making Dr. appt. by post (last class)	21	9	**30 (36%)**
# with reduced BP			**8**

(The count in the database is off by 3.)

Knowledge Assessment

Pre and post knowledge scores remained very consistent over time. The pre score averaged 48% and the post score 78%.

	FY12
	43 matched sets
Average Correct Answers Pre	**8.6 (48%)**
Average Correct Answers Post	**14.0 (78%)**

For People with Diabetes: Knowledge of A1c

For all of those entering the program with diabetes, most AA and others knew that the A1c test was an average of the blood sugar over the last three months. This percentage has been steadily increasing over the years. African Immigrants were very low in the knowledge of A1c.

	FY12	
	Total with Diabetes	**Knew of A1c**
African Americans	37	**26 (70%)**
African Immigrants	12	**7 (58%)**
Others	22	**16 (73%)**

Follow-up Data

Percentages are derived from comparisons of pre and Follow-up data for the subgroup that came back to follow up and completed the paperwork. These are the outcomes for this highly motivated group.

1. Reported Behavior Changes

	FY12 Total
Total People with Diabetes Starting Class Series	69
Total People with Diabetes Completing Class Series	53

Increased Confidence in Managing Blood Sugar at Follow-up – Comparison of Self Reported Perception Pre to Follow-up

Three months after the classes, 18 (56%) of the returning participants with diabetes felt more confident about managing their blood sugars. The average score rose from 1.8 to 2.7 out of a possible "4."

Total Participants Completing Classes and Follow-up Paperwork	32
Total Reporting Increased Confidence in Managing Blood Sugar at Follow-up	**18 (56%)**

*Patients can identify as: I do not know how to handle most of my blood sugar problems; I know a little but I am not confident; I know some tips that I can try before calling my health care provider; and I am confident that I know what to do for most blood sugar problems (goal). Any movement along the continuum is recorded.

Increased Blood Sugar Testing at Follow-up – Self-Reported Perception Pre to Follow-up

25 (76%) believed they were testing blood sugar more often and/or doing something about the numbers they were getting.

	FY12
Total Participants Completing Classes and Follow-up Paperwork	33
Total Reporting Increased Blood Sugar Testing at Follow-up	**25 (76%)**
Testing BG More	10
Testing BG More & Doing Something about it	15

Increased Blood Sugar Testing at Follow-up – Comparison of Frequency Data Pre to Follow-up

Comparing actual frequency data, 42% of the participants increased blood sugar testing.

	FY12
Total Participants Completing Classes and Follow-up Paperwork	33
Total Reporting Increased Blood Sugar Testing at Follow-up	**14 (42%)**

For all participants with and without diabetes:

Increased Days of Physical Activity - Comparison of Frequency Data
36% of recipients reported an increase in physical activity at follow up.

	FY12
Total Participants Entering Class Series (including Class 2)	76
Total Participants Completing Classes	69
Total Participants Completing Classes and Follow-up Paperwork	45
Total Reporting Increased Days of Physical Activity at Follow-up	**16 (36%)**

Increased Consumption of Fruits and Vegetables - Comparison of Frequency Data
58% of recipients reported an increase in consumption of fruits and vegetables at Follow-up.

	FY12
Total Participants Entering Class Series (including Class 1)	81
Total Participants Completing Classes	63
Total Participants Completing Classes and Follow-up Paperwork	45
Total Reporting Increased Consumption of Fruits and Vegetables at Follow-up	**26 (58%)**

2. Follow-up Medical Data - BMI
Eleven (24%) of the 46 people returning for follow up weights had a decreased BMI and 41% had "any weight loss" defined as a "less than three-pound weight loss." For several of the class participants the weight loss was visible upon their return to class. The pre-weight average was 187.61 and the post weight was 187.9. Twenty-three people gained weight, 16 lost weight, and seven stayed the same.

	FY12
Number of Participants with Initial Weight	77
Number of Participants with Follow-up Weight	46
Number of Participants with Decreased BMI (Reduction of .5 or Greater)	**11(24%)**
Number of Participants with Any Weight Loss	**19(41%)**

Follow-up Blood Pressure Data
Blood pressure continued to be a persistent problem in the community. Fifty-two percent had high blood pressure at Follow-up. Only six (14%) people had normal blood pressure and only eight people had improved blood pressure status.
*May include some who reported appointment at post test also.

	With Diabetes	Without Diabetes	FY12 YTD

N =	29	13	**42**
Hypertension	17	5	**22 (52%)**
Pre-hypertension	8	6	**14 (33%)**
Normal	4	2	**6(14%)**
Number with reduced blood pressure	*5*	*3*	***8***
# with HBP making Dr. appt. by Follow-up	20	7	**27**

Knowledge Assessment at Follow-up

Follow-up test scores remained very high indicating a high level of retention of the knowledge gained in the classes. Seventy-one pre tests were collected with an average score of 8.6. Of the 48 matched sets the averages are as follows:

	FY12	
	N=	**Average Score**
Average Correct Answers Pre	48	**8.7**
Average Correct Answers at Follow-up	48	**12.5**

A1c

The initial 31 A1c's averaged 7.7. The follow-up average was 7.0.

	FY12
Number of Participants with Follow-up A1c	**32**
Number of Participants with Decreased A1c (decrease of .2 or greater)	**22 (69%)**
Number less than 6.5 at initial test	**3**
Number less than 6.5 at Follow-up	**10**

Diabetes Dining Clubs

Attendance

The following chart shows attendance for the clubs. Mt. Calvary continues to be the most active club. The Colesville/Mt. Jezreel Dining Club was permanently cancelled in August and funding was channeled to the creation of the African Immigrant club. The attendance at Colesville/Mt. Jezreel was too low to justify its continuation. The club was being held in a very active church and the competing activities interfered with attendance. In addition, many of these church activities were

nutrition- and physical-activity oriented, thereby giving the congregation access to such resources. Some club members moved to either Mt. Calvary or to the African Immigrant club.

FY12 Totals

									FY12 Total	
	July	Aug	Sept	Oct	Mar	Apr	May	June	Total	Monthly Average
Goshen	20	13	22	19	14	20	13	22	143	18
Mount Calvary	27	24	27	23	27	27	24	27	206	26
African Club					25	12	11	11	59	15
Colesville	8	2	4							
Totals	55	39	53	42	66	59	48	60	422	53

FY12: Number of hours of instruction: 1055

The following were the learning topics and physical activities presented during the year:

Month	Learning Topic	Physical Activity
July 2011	Fruit Veg Serving Sizes/ General Q & A	Line Dancing
Aug 2011	Kidney Health	More Line Dancing
Sept 2011	Dr. Franklin and the Vegan Diet	Chair Volleyball
Oct 2011	Chef Gayle: Cooking with Spices and Herbs	Line Dancing
Nov 2011	Holiday Celebration – Healthy Holidays	
Mar 2012	Depression and Diabetes and the NIH Teen Study by Dr. Lauren Shomaker	Zydeco Dancing
Apr 2012	HBP: Treating to Target	Scarf Exercise
May 2012	Talking to your Doctor About High Blood Pressure	Zumba
June 2012	Conversation Map: Your Journey with Diabetes	Dancing

Sessions for the African Immigrant Club:

Month	Learning Topic	Physical Activity
March	Stress and Diabetes	Imagery and Relaxation
April	Portion Control	Scarf Exercise
May	Questions and Answers	Stretch Fit
June	Food Labels and Pop-up Test Questions	African Dancing

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/June on the Goshen and Mt. Calvary club members. (The African Immigrant club was still too new.) The following chart compares data collected in May/June to that of the club members when they entered the club.

Parameter	Number Assessed	Improved	Stayed the Same	Regressed	Average Pre	Average Post
Fruit and Veg Consumption	44	31 (70%)	6 (14%)	7 (16%)	3.3	4.6
Knowledge Score	38	29 (76%)	2 (5%)	7 (18%)	4.0	6.2
Days of Physical Activity	41	20 (49%)	8(20%)	13 (32%)	2.7	2.9
Weight Change	40	19 (48%)	5 (13%)	16 (40%)	194.5	191.5

Significant Changes

In September 2011, the nurse CDE resigned and a new CDE started in January 2012.

CDE Counseling

Rosie Martin, AAHP's Diabetes Nurse Educator, has conducted one-on-one diabetes self-management education sessions for clients this fiscal year who were referred from AAHP's diabetes education classes and dining clubs.

During the initial one-on-one visit, a client's diabetes knowledge is assessed and his or her current treatment plan is reviewed. With the client's input, a diabetes plan of care is developed. This plan is then implemented, evaluated, and later modified to improve the patient's overall glycemic control and prevent complications from diabetes. During each visit, medical data such as a glucose reading and vital signs are collected. Any abnormal medical data are identified and this information is communicated to the client's primary care provider. The frequency of the visits is based on the needs of the client.

Any class participant who has attended at least three out of four classes may make an appointment with the CDE for individual counseling. During FY12, 63 individual 1:1 counseling sessions took place, 40 clients received teaching on glucose meter and/or insulin administration, 70 Follow-up telephone calls were made, and 12 clients were referred to the emergency room, a primary care physician, or an endocrinologist.

Diabetes Self-Management Education (DSME) 1:1 Sessions
Fiscal Year 2012

FY 2012 (July 1, 2011 – June 30, 2012)

Month	Participants/Clients DSME 1:1 Sessions **New Referrals	Participant/Clients Face-to-Face Visits	Contacts/Consultations via Telephone (T) and/or Electronic (E)	Participants/Clients Received a Free Diabetes Emergency Med-ID Diabetes & Wellness Foundation Bulk Program	Participants/Clients Referred to Emergency Room and/or PCP/Specialist	Participants/Clients That Received DSME-Skills Teaching (Glucose Meter and/or Insulin)
July	**5	**1 + *3= 4	**10+*10 = 20	0	**2 + *3=5	**1 +*5 =6
Aug	**6	**2 + *2 = 4	**11 + *15 = 26	6	**3 +*1 =4	**9
Sept	CDE POSITION VACANT					
Oct	CDE POSITION VACANT					
Nov	CDE POSITION VACANT					
Dec	CDE POSITION VACANT					
Jan	CDE POSITION FILLED	0	0	0	0	0
Feb	CDE POSITION FILLED	2	3	0	0	1
Mar	2 (I SELF-REFERRAL ,1 FROM SMILE NURSE	12 (DURING BREAKS AT CLASSES)	4	7 (WILL NOT CONTINUE)	0	16
Apr	0	15	12	3 (WILL NOT CONTINUE)	1	3
May	0	7	1	0	1	3
June	3	3	4	0 (FORM DISTRIBUTED)	1 (REFUSED)	2
Grand Total	**16**	**47**	**70**	**16**	**12**	**40**

**New Participants/Clients*Follow-up Participants/Clients

54

HIV/AIDS Services Unit

Goals

- To provide HIV prevention education to Montgomery County residents in non-traditional health care settings.

- To provide HIV counseling, testing, and referral to County residents at community health centers.

- To serve as an entry point and facilitate referral to treatment and care for screened and new HIV cases.

Outcome Objectives

- By June 2012, AAHP HIV Prevention Services will have provided comprehensive prevention education to 700 County residents in non-health care settings.
  - Indicators: Record of sign-in sheets.
  - Implementation: At least two outreach events per month.

- By June 2012, 1,000 residents will be screened for HIV.
  - Indicators: Tally of the number of individuals tested at each event.
  - Implementation: 1) Offer testing at all current testing sites; 2) Offer testing at two outreach events per month.

WIGO (When I Get Out)

WIGO was created by AAHP HIV Services Coordinator, Bola Idowu, DrPH. It was designed to provide health education to inmates in the Montgomery County Detention Center/Prison systems who are preparing to re-enter the community.

WIGO is a four-week five-hour program that provides preventive health information and motivates inmates to set goals and gain skills in order to help them navigate more healthful and safer lifestyles.

The WIGO curriculum covered the topics of oral health, nutrition, mental health, STDs, HIV, and AIDS. Demonstrations included proper use of toothbrush and flossing, reading food labels, models for food portion sizes, and steps in condom use. This fiscal year, 51 inmates participated in the program.

WIGO's effectiveness was measured through indicators such as identification and action plans to adopt one healthful and one safe lifestyle strategy upon return to the community; pre- and post-show of intent to get tested for HIV; evaluation feedback; and the request for the program's continuation by facility authorities.

WIGO continued to evolve over the fiscal year as staff and inmates continued to identify new needs and areas of interest.

Program Objectives

At the end of four weeks:

- At least 75% of the participants will identify and discuss action plans on one healthful lifestyle and one safer lifestyle to adopt upon return to the community.
- At least 30% of the participants who have not been tested for HIV in the past 12 months will get tested for HIV.
- At least one of the inmates will agree to present on one of the topics to the succeeding group as a peer educator.

Desired Program Outcomes

- An increase in knowledge through pre and post questionnaires on each topic.
- The selection of one more healthful lifestyle by at least 75% of participants by the end of the four-week class.

2012 WIGO Curriculum Schedule

	Topic	**Presenter**	**Details**	**Related Activities on Healthful & Safer Practices**
05/18/2011	Healthy Practices	AAHP	Prevention and Screening/Oral Health	Importance of prevention/ demonstrate brushing & flossing
05/25/2011	Healthy Practices	Nutrition Network	Nutrition- Shopping for Health	Identify portion sizes & reading labels
06/1/2011	Healthy Practices	Adventist Behavioral Health	Mental Health Stress & Coping	List general mental health/stress issues; coping methods
06/08/2011	Safer Practices	AAHP	STI/HIV- Contraceptive Use	List different contraceptive methods; steps in condom use
BREAK				
06/29/2011	Healthy Practices	AAHP	Prevention and Screening/ Oral Health	Importance of prevention/demonstrate brushing & flossing

07/06/2011	Healthy Practices	Nutrition Network	Nutrition- Shopping for Health	Identify portion sizes & reading labels
07/13/2011	Healthy Practices	Adventist Behavioral Health	Mental Health Stress & Coping	List general mental health/stress issues; coping methods
07/20/2011	Safer Practices	AAHP	STI/HIV- Contraceptive Use	List different contraceptive methods; steps in condom use

The AAHP HIV Unit Women's Support Group (Women of Heart)

One of the CDC's guidelines in addressing the HIV epidemic is to encourage the inclusion of people living with HIV in prevention activities such as support groups. This group was led by Dr. Bola Idowu. This fiscal year the Women of Heart HIV positive support group met one evening per month. Attendance for the year ranged between 10 and 12 women at each meeting.

Plans are being made through the state training center for women in this group to be trained on one of Centers for Disease Control and Prevention's Diffusion of Effective Behavioral Interventions modules on Healthy Relationships (designed for individuals with HIV). This will be of immense value to members given the complex and challenging issues they face in relationships. This will hopefully occur during the first quarter of fiscal year 2012.

Topics of discussion for the year included good nutrition, understanding medical laboratory slips, safer sex methods, including a demonstration of how to use a female condom, the importance of medication adherence, and updates on new/different medications in use for the treatment of HIV.

Journeys Women Rehabilitation Center

The HIV unit provided prevention education classes and HIV testing at Journey's Rehabilitation Center for Women. The women who attend Journey's are women who are in recovery from addiction to drugs and alcohol. Classes and HIV testing was offered every fourth Monday of the month.

Testing by the Hundreds Campaign

On June 27, 2012, National HIV Testing Day, the Testing by the Hundreds campaign exceeded its goal of educating and testing 1,000 African Americans and people of African descent in Montgomery County. This included:

1. Testing 1,000 African Americans and people of African descent for HIV.

2. Establishing partnerships and collaborations that address HIV/AIDS with Montgomery County's community organizations, business owners, and residents.

3. Providing reader-friendly, culturally competent, public outreach tools and other resources to community leaders in their efforts to become grassroots advocates promoting HIV/AIDS awareness and prevention.

Weekly testing continued at AAHP's three major locations:

- Montgomery County STD Clinic (Silver Spring, MD)
- Rockville Pregnancy Clinic (Rockville, MD)
- Dr. A. Waktola, Internal Medicine (Silver Spring, MD)

Dr. Barney Graham from the National Institutes of Health, Margot Kirkland-Isaac from the National Association of People with AIDS, and Dr. Bola Idowu served as the keynote speakers at a celebratory event at the campaign's conclusion. WTTG Fox 5 and Radio One's Majic 102.3 FM attended and broadcast the event.

AAHP has found great support for the theory that community partnerships are vital to establishing and sustaining health and wellness at the local level. The Testing by the Hundreds campaign will undergo evaluation by the AAHP HIV/AIDS/STI Coalition members, AAHP Director, and HIV Unit Manager to determine the focus for the next fiscal year.

Partners

- Alpha Kappa Alpha Sorority, Inc. (Gaithersburg-Xi Sigma Omega Chapter)
- Alpha Phi Alpha Fraternity, Inc.
- CHEER
- Delta Sigma Theta Sorority, Inc. (Montgomery Alumnae Chapter)
- DC Family Alliance, Inc
- Gap Buster Learning Center
- GOALS, Inc.
- Good Hope Union United Methodist Church
- Journeys Treatment Center
- Montgomery County Health Department-STD Clinic
- Montgomery College Takoma Park Campus AIDS Resource Center
- Montgomery College Takoma Park Nursing Department
- Montgomery College Takoma Park Student Life Department
- Office of Minority Health Resource Center
- RaC3, Inc.
- Radio One, Inc.
- Rockville Pregnancy Clinic
- Shady Grove Fertility Center
- Southern Christian Leadership Conference
- Street Wize Foundation

Other Supporting Agencies

- Sasha Bruce Youthwork, Inc. provided testing at two events, the Resurrection Baptist Church health fair, and the Alpha Kappa Alpha Sorority, Inc. community health fair.

- Heart to Hand, Inc. provided testing on behalf of the campaign at the Alpha Kappa Alpha Sorority, Inc. community health fair.
- Montgomery County Department of Recreation-Gwendolyn Coffield Recreation Center.
- MD State Take Charge, Take the Test, was held at Progress Place.

HIV Testing Statistics Outside of Testing by the Hundreds

Table 1 shows the data for testing activities for each month at a glance and Tables 2 and 3 depicts testing activities by Gender and Race.

Table 1
Testing Activities by month

Month	Number
July 2011	15
August	26
September	13
October	14
November	23
December	58
January 2012	44
February	54
March	53
April	110
May	41
June 2012	38
Final Total	489

Table 2
Testing Activities by Month and Gender

Month	Number	Male	Female
July 2011	15	12	3
August	26	12	14
September	13	10	3
October	14	8	6
November	23	18	5
December	58	25	33
January 2012	44	20	24
February	54	17	37
March	53	28	25
April	110	49	61
May	41	11	30
June 2012	38	19	19
Final Total	**489**	**229 (47%)**	**260 (53%)**

This table shows that more women got tested than men, 53% for the former and 47% for the latter population category.

Table 3 below shows distribution by race. The "other" category consists of Asians who also came to be tested. The other population groups could not be refused testing because they got tested at Dennis Avenue STD county clinic.

Table 3
Testing Activities by Race

Month	Number	AA	AB	CB	W	Hispanic	Others
July 2011	15	4	6	0	4	1	0
August	26	11	8	0	0	5	2
September	13	4	3	2	2	2	0
October	14	6	2	1	2	2	1
November	23	7	8	0	4	4	0
December	58	29	13	3	7	2	4
January 2012	44	16	9	2	5	8	4
February	54	24	10	2	8	2	8
March	53	20	14	0	12	5	2
April	110	46	32	5	12	3	12
May	41	15	11	0	10	3	2
June 2012	38	15	10	0	1	9	3
Total	**489**	**197 (40%)**	**126 (26%)**	**15 (3%)**	**67 (14%)**	**46 (9%)**	**38 (8%)**

Cardiovascular Health

AAHP provided two major programs that were designed to help eliminate risk factors that predispose African Americans to cardiovascular disease. In addition, AAHP staff members and MOTA Health Promoters provided health education geared towards major risk factors for cardiovascular disease, which include hypertension, obesity, smoking, sedentary lifestyle, high salt intake, and stress.

During FY12, multiple individuals were screened for pre-hypertension and hypertension at the many events attended by AAHP staff. Over 50 percent were found to be hypertensive or pre-hypertensive and were counseled to meet with their health care provider.

Hypertension screenings proved to be essential for engaging community members for one-on-one education. This fiscal year, 405 community members were screened for hypertension.

Heart Health Screening Day

One of our two major cardiovascular events took place on February 11, 2012, at the Fifth Annual Heart Health Day held in partnership with Holy Cross Hospital. The fair traditionally includes screenings for oral health, blood pressure, body mass index, glucose, and cholesterol. In the previous fiscal year, there were approximately 200 community members who attended the event. Msache Mwaluko was the event chair and Xerxeser Kayodé was the event co-chair.

Health Freedom Walk

Although funding from CHAMP was substantially decreased this fiscal year, CHAMP still partnered with AAHP to hold the Eighth Annual Health Freedom: A Path to Wellness Celebration Walk on Saturday, June 16, 2012. CHAMP is currently researching additional grant opportunities. Xerxeser Kayodé served as chair and Msache Mwaluko served as co-chair.

The Health Freedom Walk, a 3.75-mile adventure, is an innovative project to promote increased physical activity while making creative use of Maryland's integral role in the Underground Railroad. Each year Maryland residents walk a section similar to the historical route slaves traveled in their quest for freedom, and, in turn, become motivated to achieve their own freedom from the bondage of poor health habits, a sedentary lifestyle, and the associated effects. Walkers are given the name of an abolitionist, Quaker, or slave and walk in honor of both those who walked for freedom and those who assisted in the struggle. Walkers are also encouraged to walk in honor of a loved one.

Registration for this year's walk began at 8:00 a.m. and the walk started promptly at 9:00 a.m. The walk commenced and ended at Israel Park (behind Lincoln Park Community Center) in Rockville, with a route that includes several historical sites significant to the African-American community.

AAHP and Health Freedom, Inc. partnered with local organizations in Montgomery County including the Boy and Girl Scouts of Troop 96 and Troop 6260, Lincoln Park Historical Society, Lincoln Park Community Center, Montgomery Parks, Walgreens, and local nursing students to make this year's walk a success. In fact, Phyllis Marcuccio, the Mayor of Rockville, and approximately **146** participants and **160** Circle of Friends attended the walk. We express sincere gratitude to Anita Powell of the Lincoln Park Historical Foundation and the Crutchfield Family for their instrumental support of this year's walk.

PALA

AAHP remains an Advocate of the President's Challenge Program to promote the Presidential Active Lifestyle Award (PALA). The PALA challenge was developed to add physical activity to the lives of Americans and help improve their eating habits. This challenge is for anyone, from students to seniors, but is geared toward people who want to set themselves on the road to a healthier life through positive changes from physical activity and more healthful eating behaviors.

Blood Pressure (BP) Data

The process of inputting all AAHP blood pressures and demographic data into an SAS database began in October of 2011. One goal is to generate a report showing BP outcomes.

The total number of blood pressures input during FY 2012:

October	2011	330
November	2011	414
December	2012	256
January	2012	1,032
February	2012	575
March	2012	430
April	2012	96
May	2012	701
June	2012	None entered

The total data entered in FY 2012 was 3,834.

African-American Community-based Health Promoters Program

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 were trained to identify African Americans and individuals of African descent that live in Montgomery County and who have risk factors for various health disorders. These disorders include diabetes, HIV, high blood pressure, infant mortality, and cancer. Those at risk are referred to free or low-cost health care services available in the County. Health Promoters also help to inform the community about the need for early detection and screenings for breast, cervical, lung, prostate, oral, and colorectal cancer. This MOTA program is funded by a Cigarette Restitution Grant through Holy Cross Hospital.

The goal of the program is to promote the improvement of the health care status of African Americans and individuals of African descent who live in Montgomery County by participating in and facilitating health education, disease prevention, and health promotion activities, as well as providing links to screening, treatment, and care as needed. AAHP had a total of 17 Health Promoters for the FY12 year.

The free trainings for each Health Promoter, conducted by Msache Mwaluko, AAHP Health Educator, or an AAHP staff member included: an orientation; HIPAA guidelines; cancer 101; blood pressure measurement; and CPR and various other health-related classes. These trainings were provided by AAHP and Holy Cross Hospital as part of Minority Outreach and Technical Assistance.

Health Promoters met monthly to discuss outreach strategies for communicating important information to the community.

During the fiscal year, Health Promoters participated in 58 outreach events, reaching an estimated 1,529 community members.

Other outreach activities were implemented as part of the Susan G. Komen Grant. Hypertension screenings proved to be essential for engaging community members for one-on-one education. This fiscal year, 405 community members were screened for hypertension.

Health Promoter Training and Activities
2011

July 8 - African American Health Program, Silver Spring. Community member Nancy Margai (Towson University community health student) participated in a 1:1 orientation session on the AAHP Community-based Health Promoter program with Msache Mwaluko.

July 11 - African American Health Program, Silver Spring. Community member Enkenyellesh Atlabachew (nursing student) participated in a 1:1 orientation session on the AAHP Community-based Health Promoter program with Msache Mwaluko.

July 18 - African American Health Program, Silver Spring. Community member Rodolphe Machia participated in a 1:1 orientation session on the AAHP Community-based Health Promoter program with Msache Mwaluko.

July 21 - African American Health Program, Silver Spring. Msache Mwaluko met with Health Promoter JaNee White to discuss potential outreach activities targeting breast health education.

July 25 - African American Health Program, Silver Spring. Community member Jill Greene participated in a 1:1 orientation session on the AAHP Community-based Health Promoter program with Msache Mwaluko.

July 27 - African American Health Program, Silver Spring. Community member Dessalegn Abraham (physician assistant student) participated in a 1:1 orientation session on the AAHP Community-based Health Promoter program with Msache Mwaluko.

August 26 - African American Health Program, Silver Spring. AAHP staff member Msache Mwaluko met with three Health Promoters for a brainstorming session on an upcoming health education session designed for French-speaking African Immigrants (Health for All Project-Project Santé Pour Tous).

August 31 - African American Health Program, Silver Spring. Ten Health Promoters participated in a training session titled "Breast Cancer Education and Outreach," which was facilitated by Msache Mwaluko. Health Promoters also discussed upcoming programs.

September 6 - African American Health Program, Silver Spring: Community member Seid Beshir Ali participated in a 1:1 orientation session on the Health Promoters program with Msache Mwaluko.

September 10 - African American Health Program, Silver Spring: Three Health Promoters working with a French-speaking population were trained on an upcoming health education program by Msache Mwaluko.

September 24 - African American Health Program, Silver Spring: Three Health Promoters working with a French-speaking population were trained on an upcoming health education program by Msache Mwaluko.

September 29 - African American Health Program, Silver Spring: Twelve Health Promoters attended a Blood Pressure Screening and outreach workshop facilitated by Nia Williams, RN.

October 26 - Holy Cross Hospital, Silver Spring. Eleven Health Promoters participated at a technical assistance training facilitated by Ruth Martin from DHHS. Ms. Martin discussed a community Web site known as "Healthy Montgomery," which tracks data about community health and the social and environmental determinants of health.

November 8 - African American Health Program, Silver Spring. Msache Mwaluko facilitated a meeting with four Health Promoters who work with the French-speaking health education project.

November 10-18 - Holy Cross Hospital, Silver Spring. Msache Mwaluko and three Health Promoters attended a four-day Chronic Disease Self-Management Lay leader certification training at Holy Cross Hospital.

November 30 - African American Health Program, Silver Spring. Nine Health Promoters participated at the monthly Health Promoters meeting in which upcoming programs were discussed.

December - No Health Promoter training took place in December because of the Holiday Season.

2012

February 1- African American Health Program, Silver Spring. Msache Mwaluko met with seven Health Promoters to discuss the upcoming heart health event at Holy Cross Hospital and other upcoming activities.

February 28 - Holy Cross Hospital, Silver Spring. In collaboration with other MOTA partners, five Health Promoters participated in an advocacy training workshop facilitated by Evelyn Kelly of the Common Health Action Organization.

March 15 - African American Health Program, Silver Spring- Community members Anita Mwalui (Public Health graduate candidate) and Silas Yoya (Registered Nurse) participated in a 1:1 orientation session on the AAHP Community-based Health Promoters program with Msache Mwaluko.

March 17- Holy Cross Hospital, Silver Spring. Eight Health Promoters participated in the annual "Cancer: It Does Not Discriminate" conference. Ms. Anita Mwalui read testimony on the importance of health promotion and highlighted the Health Promoters' work in the community.

March 28 - Holy Cross Hospital, Silver Spring. In collaboration with other MOTA partners, nine Health Promoters participated in a smoking cessation workshop facilitated by Dr. Carlo Di-Clemente, the director of MD Quitline.

April 17- Mount Saint Mary's Conference Center, Frederick – Msache Mwaluko and Anita Mwalui attended a training titled "Using Data to Build Strategic Partnerships" hosted by the Mid-Atlantic Public Health Training Centre.

May 14 - Mental Health Association of Montgomery County (MHA), Rockville – Msache Mwaluko met with MHA staff members Jamilla Allouane and Karishma Seth and planned a mental health education workshop for AAHP Health Promoters.

May 16 - Suburban Hospital, Bethesda – Msache Mwaluko and five Health Promoters attended the bi-monthly cancer coalition meeting. A presentation on genetic testing was given by Suburban Hospital staff.

May 17- African American Health Program, Silver Spring – Community member Seid Ahmed participated in a 1:1 orientation session on the AAHP Community-based Health Promoters program with Msache Mwaluko.

May 24 - Montgomery County Mental Health Association, Rockville. Eleven Health Promoters participated in a workshop on mental health issues in the immigrant community. The session was facilitated by Jamilla Allouane, a mental health specialist.

Cancer

During the fiscal year, Health Promoters participated in 58 outreach events, reaching an estimated 1,529 community members. Other outreach activities were implemented as part of the Susan G. Komen Grant.

Oral Health

Did you know...?
The oral health unit's ongoing program "*Did you know?*" educates Montgomery County residents on the importance of good oral health and how it relates to overall health. This fiscal year, 1,710 kits were distributed.

Grants

Minority Technical Assistance Program-(MOTA)	Joint submission through Holy Cross Hospital	AWARDED	6/1/2012

Susan G. Komen Grant	Joint submission through Holy Cross Hospital	AWARDED	6/1/2012

AAHP Community Outreach Activities

AAHP staff and community partners were able to reach more than 6,700 Montgomery County residents of African descent in various settings, including community health fairs, church gatherings, school health fairs, libraries, and The People's Community Wellness Center. In total, AAHP either took part in or conducted 81 community outreach activities for FY12.

AAHP Data Evaluation – Data System Enhancement Process

Consistent with the DHHS focus on reviewing and tracking performance and outcomes for all programs and services supported by the agency, in May of 2011, the AAHP Data Subcommittee, led by Chair Dr. Marilyn Gaston, commenced a review of the available data collected for the SMILE and Diabetes programs in an effort to identify measurable outcomes that demonstrate the impact that AAHP has on the health outcomes of African American residents. Given the considerable data tracked and reported by SMILE, a specific focus was placed on its outcomes. As a result of a study commissioned by BETAH Associates in support of the Data Subcommittee's efforts, a number of challenges with the SMILE data system were discovered. While the system had proven effective in collecting a wealth of historical data, the challenges encountered in the operation of the system had increased over time.

With an eye towards enhancing the SMILE data system and preparing it for integration with other DHHS information management systems, BETAH engaged an information technology vendor to conduct an analysis of the system to identify the root cause of the challenges and issues and to recommend opportunities for enhancement. The vendor provided a comprehensive report detailing those opportunities, and recommended actions on how to enhance the system. The recommendations were submitted to DHHS for consideration in May 2012 and approval was granted to proceed with enhancing the system using a customizable commercial off-the-shelf software platform. This enhanced system will allow for greater flexibility, accuracy, and have significant impacts on operational efficiency and the long-term integrity of the information collected. The IT vendor will begin implementation of the data system enhancement process in the 2013 fiscal year.

Staff Development and Training

2011

July 29 - Holy Cross Hospital, Silver Spring. Msache Mwaluko participated in a meeting with other MOTA partners. Resident services specialists from the Housing Opportunity Commission (HOC) were invited to discuss a possible collaboration between HOC and MCEP partners.

August 17 - Women, Infants, and Children's (WIC) Health Fair Melanie Hunter (50 people in attendance).

September 7 - Prematurity Summit (Melanie Hunter, RN).

October 3 - Health Disparities Conference (Saundra Jackson, RN).

October 4 - Maryland Health Workforce Conference (Melanie Hunter, RN).

October 14 - INR Conference (Saundra Jackson, RN).

October 27 - Labor Pains: The Birth of a New Health Care System (Melanie Hunter, RN).

November 2 - Adventist Center on Health Disparities Conference at the University of Maryland (Diane Herron, Saundra Jackson, Darlene Coles, Melanie Hunter, Dr. Bola Idowu).

November 6 - Holy Hospital Cross Baby Fair (Nia Williams, RN, Saundra Jackson, RN).

November 8 - Team-building workshop organized by the Mid-Atlantic Public Health Training Center at Johns Hopkins Bloomberg School of Public Health. The training focused on helping participants understand the difference between groups and teams, barriers to teamwork, and managing team conflict (Dr. Bola Idowu).

December 12 - Childbirth Education Recertification (Saundra Jackson, RN and Melanie Hunter, RN).

2012

March 1 - Rosie Martin, RN, CDE completed 1.5 CE activities as required for program recognition.

March 20 - Ten Oaks ballroom, Clarksburg. Msache Mwaluko and Anita Mwalui attended a workshop on grant writing facilitated by the Mid-Atlantic Public Health Training Center.

March 29 - March of Dimes Tri-State Summit held in Washington, DC Melanie Hunter, RN.

April 1 - Statewide CTR coordinator's meeting during the month. New changes in testing were discussed in which the new testing kits would be able to cover both antigen and antibody screening. The forms for partner services were also redesigned and distributed. (Dr. Bola Idowu, Denise Dixon).

April 3 - Lion's Club monthly meeting, Kensington. Msache Mwaluko gave a presentation about AAHP to a group of 13 members of the Kensington Lion's Club and the club's District Governor Rich Barb. AAHP and the Lion's Club discussed future collaborations.

April 19 - NIH/DHHS Conference (Melanie Hunter, RN).

May 17 - Gestational Diabetes Seminar by PESI Healthcare (Melanie Hunter, RN).

May 22 - Practical Grant Writing class by the Mid-Atlantic Public Health Training Center (Xerxeser Kayodé).

June 1 - Professional Competencies Completed, 1.5 continuing education activities (Rosie Martin).

June 6 - SMILE Services Interview with March of Dimes (Nia Williams).

June 7 - The Sheraton Hotel, Columbia –Logic modeling training facilitated by the Mid-Atlantic Public Health Training Center (Msache Mwaluko and Anita Mwalui).

June 7 - Health care provider's CPR recertification (Saundra Jackson, Denise Dixon, Darlene Coles, Xerxeser Kayodé, and Diane Herron).

June 13 - SMILE Infant Supply Drive (Nia Williams).

June 14 - Montgomery County Department of Recreation Teen Reality Check event (Denise Dixon).

June 15 - Maryland Department of Health and Mental Hygiene, MSM Response Team meeting (Denise Dixon).

June 16 - Health Freedom: A Path to Wellness Celebration Walk (AAHP staff).

June 17 - Testing by the Hundreds campaign closeout (Dr. Bola Idowu, Darlene Coles, Denise Dixon, and Xerxeser Kayodé).

June 18 - Virtual Carbohydrate Class (Diane Herron).

June 19 - Radio One Town Hall meeting (Denise Dixon, Xerxeser Kayodé).

Staff Presentations

July 12 - Washington Adventist University Nursing Program. Dr. Bola Idowu gave a presentation on the topic "Engaging the Community in HIV/AIDS Outreach." Twelve students attended the class as a part of their community health requirement.

September 12-14 - Childbirth/Lactation Education Classes (Melanie Hunter, RN, Saundra Jackson, RN and Nia Williams, RN).

October 11 - Montgomery College Workforce Development Center, Wheaton (Msache Mwaluko facilitated a presentation on health care resources in Montgomery County to a group of 13 students at the English for Speakers of Other Languages [ESOL] class for health care professionals).

November 2 - University of Maryland, College Park (Msache Mwaluko was a panelist in the prevention and wellness discussion at the annual Adventist Health Disparities Conference. There were an estimated 250 attendees).

November 28 - Montgomery College, Silver Spring campus (Msache Mwaluko conducted a presentation on health care resources available in Montgomery County to a group of seven students at the ESOL class for health care professionals).

December 1 - World AIDS Day at the People's Community Baptist Church (Dr. Bola Idowu served as a panelist at the HIV and African-American males discussion organized by the Montgomery County chapter of Delta Sigma Theta Sorority, Inc. and the People's Community Baptist Church. The National Institutes of Health was represented by Dr. Barney Graham, and both the Chief Health Officer for the County, Dr. Ulder Tillman, and Dr. Bola Idowu presented from the community perspective).

February 8 - Dr. Bola Idowu served as a panel member at the MoCo Teen Summit.

February 20 - Denise Dixon conducted an HIV Workshop at Journeys Treatment Center, Rockville, MD.

March 27-29 - Childbirth/Lactation Education Classes (Melanie Hunter, RN, Saundra Jackson, RN and Nia Williams, RN).

June 17 - Testing by the Hundreds campaign closeout. Dr. Bola Idowu served as one of the keynote speakers for the closeout of the campaign.

Community Outreach for the 2012 Fiscal Year

July 3 - Ellsworth Drive, Silver Spring. Information on breast health and cancer, health care resources, cardiovascular disease, diabetes, and nutrition was distributed to 100 community members who participated at the International Festival. At the event, 32 women learned to perform breast self-exams.

July 17 - Ellsworth Drive, Silver Spring. Information on breast health and cancer, health care resources, cardiovascular disease, diabetes, and nutrition was distributed to 87 community members who participated at the Afro Diaspora Festival. At the event, 40 women learned to perform breast self-exams.

July 23 - The Willows apartment complex, Gaithersburg. Health Promoters distributed information on HIV/AIDS, nutrition, cardiovascular health, and access to health care services for the uninsured to an estimated 75 residents. At the event, 27 women learned to perform breast self-exams.

August 2 - Tanglewood Apartments, Silver Spring. Various pieces of literature on breast health, general cancer, nutrition, and cardiovascular disease were distributed to 75 participants at the national night out event. Six women learned to perform self-breast exams.

August 4, 11, 18, 25 - Victory Christian Church, Gaithersburg. In collaboration with the AAHP diabetes education and management team, Health Promoters assisted with registration and height and weight measurements at the four-week session diabetes education classes. There were 17 attendees in the class.

August 13 - Civic Building at Veterans Plaza, Silver Spring. Information on breast health and cancer, health care resources, cardiovascular disease, diabetes, and nutrition was distributed to 52 community members participating at the annual Fest Africa event; 32 community members were screened for blood pressure; and 15 women learned to perform breast self-exams.

August 14 - Civic Building at Veterans Plaza, Silver Spring. Information on breast health and cancer, health care resources, cardiovascular disease, diabetes, and nutrition was distributed to 100 community members participating at the annual Fest Africa event; 61 residents were screened for hypertension; and 25 women learned to perform breast self-exams.

September 1 - East County Regional Services Center, Silver Spring: Five women received a 1:1 educational session on breast and colorectal cancer. AAHP staff distributed literature on breast health and general cancer to all participants.

September 8 - Pilgrim Baptist Church, Silver Spring: In collaboration with AAHP's diabetes education and management team, Health Promoters assisted with registration and took height and weight measurements at the four-week diabetes education and prevention classes. There were nine class attendees.

September 12 - Mount Calvary Baptist Church, Rockville: In collaboration with AAHP's diabetes education and management team, Health Promoters assisted with registration and took height and weight measurements at the Diabetes Dining Club. There were 28 class attendees.

September 17 - Georgian Courts Community, Silver Spring: AAHP staff distributed literature on breast health and cancer, health care resources, cardiovascular disease, HIV/AIDS, diabetes, and nutrition to 34 participants. Fifteen participants were screened for hypertension; one was referred to the SMILE program; and five were referred to a Montgomery Cares clinic.

September 17 - Hinsdale Community Park, Silver Spring: Health Promoters distributed literature on HIV/AIDS, breast cancer, cervical cancer, nutrition, and diabetes to 60 participants at the Great Mifi-Ethnic Association open door event.

September 17 - East County Regional Services Center, Briggs Chaney: Health Promoters distributed literature on HIV/AIDS, breast cancer, and nutrition to 25 community members who participated in the three-county ethnic initiative event.

September 19 - Goshen United Methodist Church, Gaithersburg: In collaboration with AAHP's diabetes education and management team, Health Promoters assisted with registration and took height and weight measurements at the four-week diabetes education and prevention classes. There were 24 class attendees.

September 24 - Marilyn J. Praisner Center, Burtonsville: AAHP staff distributed literature and shower cards on breast cancer to 25 participants. AAHP staff also distributed literature on diabetes, nutrition, HIV/AIDS, colorectal, cervical, and prostate cancer to those in attendance at the annual Burtonsville Day event.

October 1 - Mt. Jezreel Baptist Church, Silver Spring. Literature on breast health, general cancer, nutrition, and cardiovascular disease was distributed to 38 participants at the annual health fair.

October 1 - City Place Mall, Silver Spring. Health Promoters distributed information on HIV/AIDS, Montgomery Cares clinics, nutrition, cardiovascular health, and breast, cervical, and prostate cancer to 100 community members.

October 6 - East County Regional Services Center, Silver Spring. A 1:1 educational session on breast and colorectal cancer was given to one participant.

October 7 - Civic Center Veterans Plaza, Silver Spring. Health Promoters distributed information on health care resources to 16 clients at the annual DB Consulting Group Community Health Fair. One client learned to perform a breast self-exam.

October 7 - Holy Cross Hospital, Silver Spring. Health Promoters performed blood pressure screenings to 11 community members and distributed literature on breast health, cardiovascular health, and diabetes to 18 people at the annual Cancer Screening and Education Day.

October 12 - Progress Place, Silver Spring. In partnership with the University of Maryland nursing school students, 35 oral health kits were distributed to homeless clients. Literature on HIV/AIDS,

health care resources, cancer, and diabetes was distributed to 21 participants. Overall outreach was provided to 55 clients, and 21 clients were referred to Montgomery County Service Eligibility Units for dental services.

October 13 - LA Fitness Center, Silver Spring. Information on breast cancer, nutrition, diabetes, and cardiovascular health was distributed to nine members of the LA Fitness Club during Customer Appreciation Day. Five women learned to perform breast self-exams.

October 17 - Journeys Women's Rehabilitation Center, Rockville. AAHP staff educated 18 women on hepatitis and distributed 18 brochures on STDs.

October 22 - Marilyn J. Praisner Recreation Center, Burtonsville. Health Promoters distributed information on obesity, cardiovascular health, smoking cessation, cancer, and infant mortality to 17 participants at the annual AKA Health and Wealth Fair.

October 23 - Sharp Street United Methodist Church, Olney. AAHP staff educated 17 women on breast health and cancer, and the women learned to perform breast self-exams at the Pretty in Pink Breast Cancer Awareness Day.

October 24 - Journeys Women's Rehabilitation Center, Rockville. AAHP staff educated 19 women on STDs and distributed 19 brochures on STDs.

October 27 - Epworth United Methodist Church, Gaithersburg. AAHP staff reached out to 13 participants at the Health Fair for foster parents and families and distributed information on breast health, various cancers, existing health care resources, child safety resources, and cardiovascular health.

October 29 - Manchester Apartments, Silver Spring. AAHP staff distributed literature on nutrition, cardiovascular health, and breast, cervical, and colorectal cancer to 25 community members at the annual Fall Festival. Fifteen participants were also screened for hypertension.

October 31 - Journeys Women's Rehabilitation Center, Rockville. In partnership with a Holy Cross Hospital ethnic Health Promoter, 18 women were educated on breast health and cancer and received shower cards and handouts on breast cancer.

November 3 - East County Regional Services Center, Silver Spring. A 1:1 educational session on breast and colorectal cancer was given to four participants.

November 5 - Holy Cross Hospital, Silver Spring. Health Promoters conducted 30 blood pressure screenings and distributed literature on breast health, cardiovascular health, and diabetes to 38 women at the Women's Health Event.

November 7 - Journeys Women's Rehabilitation Center, Rockville. Eighteen women were educated on diabetes and received 18 brochures on diabetes.

November 10 - People's Community Wellness Center, Silver Spring. A 1:1 educational session on colorectal cancer and hypertension was given to six participants, who also received literature on colorectal cancer and blood pressure. The target population was multiethnic, uninsured men.

November 10 - Casa de Maryland, Langley Park. Eleven participants were educated about disease prevention, early detection, and health maintenance. Ten participants were screened for hypertension and two participants were referred to Muslims Medical Center for primary care.

November 14 - Journeys Women's Rehabilitation Center, Rockville. Eighteen women were educated on general cancer and received 18 brochures on early detection.

November 15 - Piccard Drive Health Department, Rockville. Msache Mwaluko attended the bi-monthly cancer coalition meeting. Coalition members were informed that the County Cancer Crusade would no longer accept colorectal cancer referrals until the new fiscal year.

November 17 - Casa de Maryland, Langley Park. Eighteen participants were educated about personal and domestic hygiene, and 14 of them were screened for hypertension.

November 29 - Holy Cross Hospital, Silver Spring. Health Promoters provided information on obesity, cardiovascular health, smoking cessation, cancer, and infant mortality to 18 participants at the annual Native American Pow Wow, who were also screened for hypertension.

December - People's Community Baptist Church, Silver Spring. AAHP staff distributed literature on HIV/AIDS, breast, colorectal, cervical, prostate cancers, nutrition, cardiovascular health, and health care resources to 96 participants at a World AIDS Day commemoration event.

December 1 - CASA de Maryland, Langley Park. AAHP educated 24 participants on general cancer.

December 1 - Nyamburu Cultural Center, College Park. In recognition of World AIDS Day, AAHP staff and Health Promoters participated at an HIV Testing and Awareness Day event. Information on health care resources, HIV/ AIDS, and breast cancer was distributed to 59 participants, 33 students were tested for HIV, and five women learned to perform breast self-exams.

December 1 - People's Community Wellness Center, Silver Spring. Nine women learned to perform breast self-exams and participated in a 1:1 educational session on breast health and cancer.

December 13 - Journeys Women's Rehabilitation Center, Rockville. Natalie Webb educated 21 women on healthy eating and nutrition.

December 29 - CASA de Maryland, Langley Park. Natalie Webb educated 24 participants on nutrition, diabetes, and obesity.

February 2 - East County Regional Services Center, Silver Spring. A 1:1 educational session on breast and colorectal cancer was provided to one participant.

February 2 - CASA de Maryland labor center, Langley Park. A culturally competent health education session on cardiovascular health was given to a group of 14 men and women. All participants were screened for hypertension.
February 7 - Montgomery College, Takoma Park. Health Promoters distributed literature on HIV/AIDS, breast cancer, nutrition, and cardiovascular health to 75 community members participating at the National HIV Testing and Awareness Day, where 23 participants were screened for HIV/AIDS.

February 8 - Gwendolyn Coffield Community Center, Laytonsville. The African American Health Program hosted the first annual Montgomery County Teen Summit. Health Promoters provided information on obesity, cardiovascular health, smoking cessation, cancer, infant mortality, and sexually transmitted diseases to 100 participants.

February 11 - Holy Cross Hospital, Silver Spring. In collaboration with the Holy Cross Hospital Department of Community Outreach, 120 community members participated in the annual heart health screening and education event. Free screenings offered included glucose and cholesterol (105), oral health, body fat analysis, and blood pressure screening (67). Three participants with high blood pressure readings were referred to the Holy Cross Hospital emergency room for urgent care.

February 16 - CASA de Maryland labor center, Langley Park. A culturally competent health education session on respiratory health was given to a group of 24 men and women. Information on oral cancer and dental kits were distributed to all participants. All participants were screened for hypertension.

March 1 - East County Regional Services Center, Silver Spring. In collaboration with the AAHP, Health Promoters assisted with registration and took height and weight measurements at the African Immigrants Diabetes Dining Club. There were 25 attendees in the class.

March 5 - Goshen United Methodist Church, Gaithersburg. In collaboration with the AAHP diabetes education and management team, Health Promoters assisted with registration and took height and weight measurements at the Diabetes Dining Club. There were 20 attendees in the class.

March 7, 14, 21, 28 - Wheaton Community Center, Wheaton. In collaboration with the AAHP diabetes education and management team, Health Promoters assisted with registration and took height and weight measurements at the Diabetes Dining Club. There were 21 attendees in the class.

March 8 - East County Regional Services Center, Briggs Chaney. Eleven participants were screened for hypertension and were given information on existing health care resources, cardiovascular health, and cancer information for men. Health Promoters distributed 33 pieces of literature.

March 9 - Progress Place, Silver Spring. In observance of the National Black HIV/AIDS awareness month, Health Promoters distributed 30 pieces of literature on diabetes, nutrition, HIV/AIDS, and colorectal, cervical, and prostate cancer to 17 participants.

March 9-10 - National Women & Girls HIV Awareness Day: This awareness day activity took place at the Progress Place, a shelter for men and women. This activity was organized in partnership with the state program, Take Charge, Take the Test campaign. During the event, 17 people were tested at this event (only five were women).

April 11 - Montgomery College, Rockville campus – Health Promoters distributed brochures on breast cancer, prostate cancer, colorectal cancer, health care resources, cardiovascular disease, diabetes, and oral health information kits to 118 students. In addition, 36 students were tested for HIV.

April 18 - CASA de Maryland labor center, Langley Park – In collaboration with the Mental Health Association of Montgomery County, Jamila Allouane conducted a culturally competent health education session on mental health for a group of 30 men and women, who were all screened for hypertension.

April 23 - Montgomery College, Takoma Park – Msache Mwaluko gave a presentation on access to health care resources in Montgomery County to a group of five students at the English for Speakers of Other Languages program at Montgomery College.

April 25 - Progress Place, Silver Spring – Health Promoters distributed information on cardiovascular health, breast, and colorectal cancer to 15 participants at an HIV testing session at the Progress Place shelter. Ten participants were tested for HIV.

April 28 - Community of Faith Church, Clarksburg – Information on diabetes, cardiovascular health, breast, prostate, and colorectal cancer was distributed to 36 participants at the annual health fair. Nine participants were screened for HIV and 15 participants were screened for hypertension.

April 28 - Holy Cross Hospital, Silver Spring – At the annual "To Your Health" event, Health Promoters screened 50 participants for hypertension and distributed information on breast health, prostate cancer, cardiovascular disease, diabetes, and nutrition to an estimated 70 participants. Eleven participants were taught how to perform breast self-exams.

April 28 - Richard Montgomery High School, Rockville – AAHP staff distributed 25 pieces of literature on cardiovascular disease, diabetes, and breast and prostate cancer to participants at the Jack and Jill Potomac, MD, chapter meeting.

May 10 - East County Regional Services Center, Silver Spring – AAHP staff conducted a 1:1 educational session on hypertension and colorectal cancer for eight men. In addition, 15 pieces of literature on breast health and general cancer were distributed to all participants.

May 12 - Lincoln Park Community Center, Rockville – AAHP staff distributed 30 pieces of literature on cardiovascular disease, diabetes, and breast and prostate cancer to an estimated 70 participants at the Anwar Temple and Court annual health fair.

May 17 - Holy Cross Hospital, Silver Spring – Health Promoters distributed information on stroke, heart disease, diabetes, and nutrition at the annual Stroke Awareness Day to an estimated 25 participants.

May 31 - Holly Hall senior apartments, Silver Spring – AAHP staff conducted a health education session on hypertension for 11 senior residents. All participants were screened for hypertension.

June 2 - Gaithersburg Pavilion, Gaithersburg – AAHP distributed 50 information packets on breast health, prostate cancer, HIV/AIDS, cardiovascular health, and diabetes to 100 residents at the annual Gospel Jubilee.

June 7 - East County Regional Services Center, Silver Spring – AAHP conducted 1:1 educational sessions on breast and colorectal cancer for six women and gave them literature on breast health and general cancer.

June 9 - Gaithersburg Elementary School, Gaithersburg – AAHP distributed information packets on diabetes, cardiovascular health, and breast, prostate, and colorectal cancer to 40 participants.

June 12 - Mid-County Recreation Center, Silver Spring – Health Promoters participated in a Teen Reality Check Forum. AAHP distributed information packets on HIV/AIDS and other sexually transmitted diseases, breast health, nutrition, and physical fitness to an estimated 35 teenagers.

June 13 - Progress Place, Silver Spring – Health Promoters distributed information packets on HIV/AIDS breast health and cancer to 10 participants.

June 14 - Radio One, Silver Spring – Health Promoters participated at the Radio One employee health fair and distributed information packets on cardiovascular disease, men's health, breast health, and cancer to 15 employees.

June 14 - Marilyn J. Praisner Recreation Center, Burtonsville – Health Promoters conducted blood pressure screenings and education sessions to a group of 10 seniors.

June 16 - Israel Park, Rockville – Health Promoters distributed information packets on access to health care services, cardiovascular health, fitness, diabetes, and HIV/AIDS to an estimated 40 participants at the Eighth Annual Health Freedom: A Path to Wellness Celebration Walk.

June 18 - Journeys Treatment Center, Rockville – AAHP conducted a health education session on breast health and cancer for a group of 19 participants.

June 21 - Holy Hall Seniors apartments, Silver Spring – AAHP educated 11 residents on stroke and cardiovascular disease.

June 22 - CASA de Maryland labor center, Langley Park – AAHP conducted a culturally competent health education session on disease prevention, health maintenance, and access to health care for a group of 18 men and women. Eleven participants were screened for hypertension and AAHP distributed literature to 24 participants.

June 23 - People's Community Baptist Church, Silver Spring – Health Promoters distributed information on AAHP, HIV/AIDS, diabetes, and cardiovascular health to an estimated 50 participants who attended the jailhouse ministry volunteers banquet.

AAHP Committees and Coalitions

Executive Committee	Chair: Mrs. Arva Jackson
HIV/AIDS/STI Coalition	Chair: Mrs. Beatrice Miller
Infant Mortality Coalition	Chair: Ms. Arva Jackson
Data Subcommittee	Chair: Dr. Marilyn Gaston

Staff Committee and Workgroup Memberships

AAHP staff are members of several committees and workgroups. The staff also attended many coalition and community meetings throughout FY12. They included:

Nia Williams	Infant Mortality Coalition, Teen Health President
Melanie Hunter	Fetal Infant Mortality Review, Infant Mortality Coalition
Saundra Jackson	Interagency Coalition on Adolescent Pregnancy (ICAP), Prematurity Infant Health Network
Msache Mwaluko	Breast Cancer Workgroup, MOTA, Cancer Coalition, AHP Newsletter, Health Freedom Walk Co-Chair, Heart Health Screening and Education Committee Chair
Darlene L. Coles	HIV/AIDS/STI Committee, Infant Mortality Coalition, ICAP, AAHP Newsletter, Heart Health Screening and Education Committee, Health Freedom Walk Work Group, Community Action Team, American Kidney Fund Engagement Council, CROWN Board Member

Xerxeser Kayodé	Health Freedom Walk Co-Chair, Infant Mortality Coalition, HIV/AIDS/STI Committee, AAHP Newsletter Editor, AAHP Website, Testing By the Hundreds Working Group
Dr. Bola Idowu	HIV/AIDS/STI Committee, AAHP Newsletter, Regional AIDS Administration, Testing By the Hundreds Working Group Chair
Diane Herron	Health Freedom Walk Working Group, Diabetes Work Group, Heart Health Screening and Education Committee
Denise Dixon	HIV/AIDS/STI Coalition, Testing By the Hundreds Work Group Co-Chair
Rosie Martin	Diabetes Work Group

New AAHP Media

Facebook - In addition to its group page, AAHP has created a Fan Page to communicate to its audience.

Twitter - www.twitter.com/onehealthylife.

www.OneHealthyLife.org.

AAHP Publications

All AAHP publications are posted on the AAHP Website www.onehealthylife.org.

Newsletter, *One Healthy Life* – AAHP distributed more than 1,000 copies of the newsletter electronically, by direct mail, and at community outreach events.

AAHP service brochure – Distributed 1,000 copies at community outreach activities, presentations, and meetings.

Annual Report FY11 – Fifty hard copies and 500 electronic copies were distributed in the County.

SMILE Infant Mortality program brochures – Distributed 500 copies to County members.

Maternal/Paternal Child Health calendar – Distributed 1,000 copies to the Montgomery County community.

Asian American Health Initiative

Montgomery County, Maryland

Department of Health and Human Services

Annual Report FY 2012

Together to Build a Healthy Community

19

Message from Leadership

With a year full of improvements and achievements, the Asian American Health Initiative is proud to release its Fiscal Year 2012 (FY12) Annual Report to showcase its endeavors in eliminating health disparities facing Asian Americans. As the Asian American population continues to grow at a rapid pace, addressing their unique needs has become an increasingly important priority. AAHI worked relentlessly in FY12 to implement and enhance culturally competent programs to address the health needs of the Asian American community and work towards health equity. Due to its continued efforts in enhancing data collection, strengthening partnerships, and empowering communities, AAHI had a remarkable year improving the health status of the County's Asian American community.

Through the support of its dedicated partners, the Steering Committee, a cohort of health promoters, and Montgomery County Department of Health and Human Services (MCDHHS), AAHI was able to reach out to isolated communities and effectively address barriers to healthcare services. From offering hepatitis B screenings, vaccinations, and treatment referrals to implementing on-site health education for local business owners, AAHI provided essential resources and services to optimize the health of the Asian American community. Programmatic enhancements were also plentiful for AAHI this year despite budget reductions. AAHI recruited a new group of health promoters dedicated to an improved small business outreach initiative that reaches the most vulnerable populations.

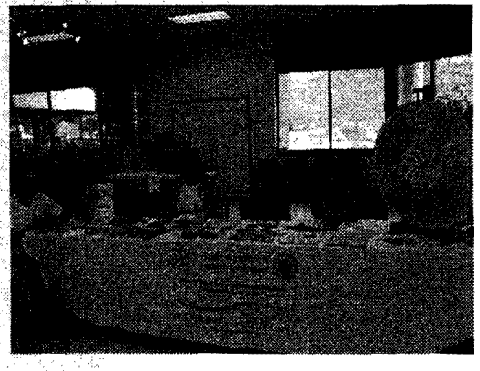
AAHI continued to serve as a voice for the Asian American community within the MCDHHS, ensuring that this population's needs are not overlooked. AAHI also aligned its efforts with the dynamic approaches in the Department and in the public health field, to look into systematic changes to address the complex social and environmental determinants of health disparities. As FY13 comes around, AAHI will continue to build on lessons learned and past achievements to efficiently and effectively respond to the health needs of Asian Americans in Montgomery County.

Sam Mukherjee, PhD, LCTC
AAHI Steering Committee Chair

Perry Chan

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

Table of Contents



83

About AAHI

BACKGROUND

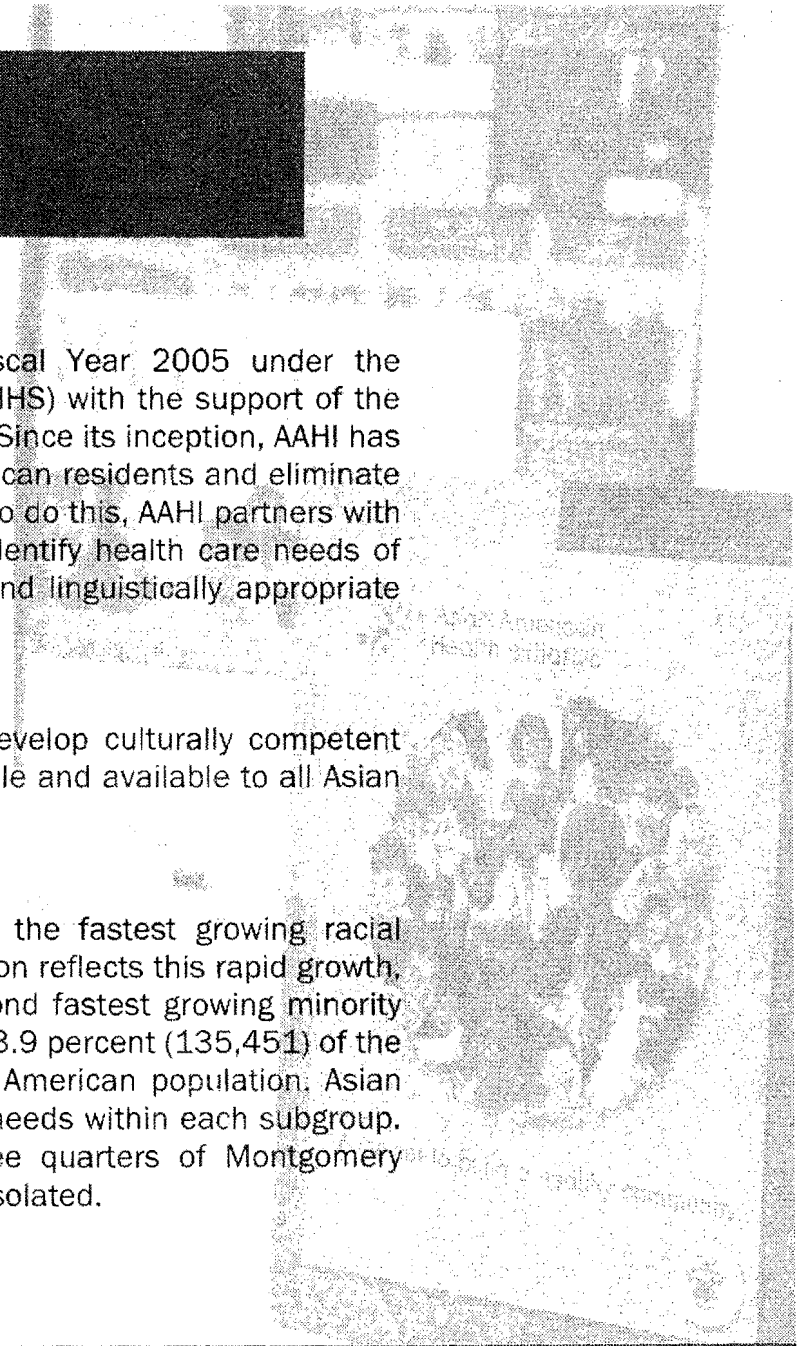
The Asian American Health Initiative (AAHI) was established in Fiscal Year 2005 under the Montgomery County Department of Health and Human Services (MCDHHS) with the support of the Montgomery County Executive, County Council, and community leaders. Since its inception, AAHI has worked to address the 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 programs that are accessible and available to all Asian Americans in Montgomery County.

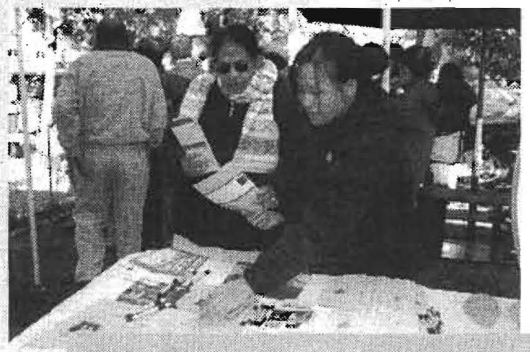
COMMUNITY PROFILE

According to the 2010 U.S. Census, Asian Americans are currently 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 show that almost three quarters of Montgomery County's Asian population are foreign born and a third are linguistically isolated.



84

FY2012 At a Glance



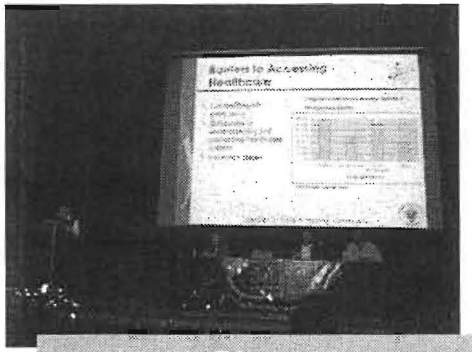
AAHI In the Community

Health Education Articles

Hepatitis B Projects

Health Promoter Program

E.C.H.O. Project



Health Disparities Conference

FY12 Accomplishments at a Glance

Enhancing Access to Culturally and Linguistically Competent Care

- Patient Navigator Program
  - 5,532 total client encounters
  - 4,087 calls received
  - 95.65% of clients linked to County services
  - 78% of callers had no insurance
  - 1,144 on-site medical interpreting sessions
  - 301 medical interpreting sessions by phone
- Health Education in Ethnic Media
  - 10 articles published
  - 4 media sources
  - 6 health topics covered

Strengthening Partnerships and Collaborations

- 7 AAHI 101 introductory presentations
- 10 workgroups participated

Enhancing Data Collection and Reporting

- 2 hepatitis B evaluation reports published electronically
- 7 professional presentations
- 1 annual report published electronically

Promoting Community Mobilization and Empowerment

- Health Promoter Program
  - 34 health promoters
  - 16 languages and dialects spoken
  - 16 ethnic communities represented
  - 10 trainings attended
  - 9 new health promoters in FY12
  - 14 health promoters with 3+ years of experience in the program
- Empowering Community Health Organizations Project
  - 2 workshops
  - 108 individuals attended
  - 41 organizations represented
- Community Outreach
  - 41 outreach events*
  - 5,421 educational encounters*
  - 362 health service referrals*
  - 7,531 pieces of literature distributed*
  - 19 communities reached*
  - 1,412 health screenings performed*

*cumulative total from health fairs, hepatitis B projects, education workshops, and small business outreach (Connect)

Hepatitis B Project
- 3 hepatitis B projects
- 540 participants
- 100% of at-risk participants referred to vaccinations, of whom 80% completed the three-shot vaccination series
- 100% of infected participants referred to follow-up care, of whom 73% accessed treatment
- 99.5% of participants reported they would urge family and friends to be screened and/or vaccinated
- 100% of participants reported overall satisfaction with program

Health Education Workshops
- 3 workshops
- 2 topics covered
- 63 educational encounters

Connecting Communities to Services Project
- 106 small businesses and communities reached
- 599 educational encounters
- 837 pieces of literature distributed
- 37 health service referrals

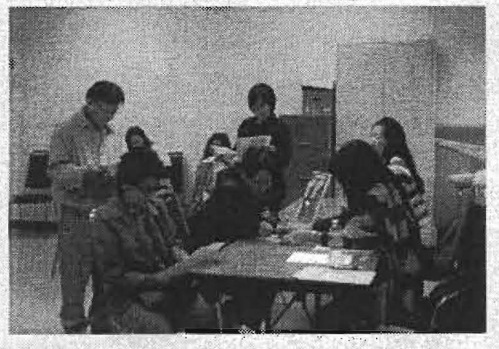
Please see the respective sections for details.

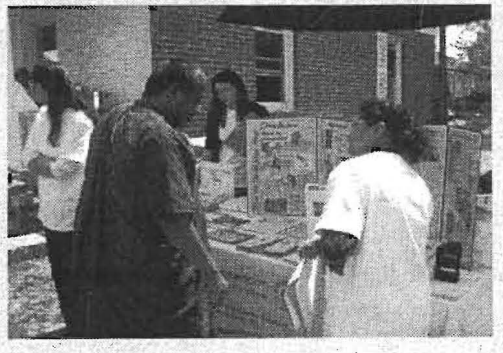
Enhancing Access to Culturally and Linguistically Competent Care

The Asian American community in Montgomery County is an incredibly diverse group, representing more than a dozen countries and speaking more than two dozen languages and dialects. Given the diversity in Montgomery County, health care services need to be culturally and linguistically tailored to increase access and ensure that the unique health needs of the County's residents are being met. However, according to the Asian American Health Initiative's 2008 Countywide health needs assessment, many barriers that prevent Asian Americans from accessing quality health care services are still prevalent. Such obstacles include insurance status, financial difficulties, transportation (particularly for seniors), language barriers, and lack of Asian language providers.

In response to this, AAHI continued to work diligently to implement programs to remove cultural and linguistic barriers so that County residents can be connected to essential health care services. In FY12, AAHI continued its Health Education in Ethnic Media Campaign, in addition to its Patient Navigator and Health Promoter programs, to raise public awareness of health issues and health resources available in the County. With the dedication, advocacy, and support of AAHI's passionate volunteers and Steering Committee members, AAHI continued to expand its reach into the limited English proficient and socially isolated Asian American communities.

By continuing ongoing partnerships with community organizations and forging relationships with new collaborators, AAHI increased access to free or low-cost preventative screenings and vaccinations for the community. AAHI also worked to understand the community needs more comprehensively and tailor its efforts to improve the health of Asian Americans in Montgomery County. Some of AAHI's greatest successes comes through its dedication to increasing access to culturally and linguistically competent care, as highlighted in this section.

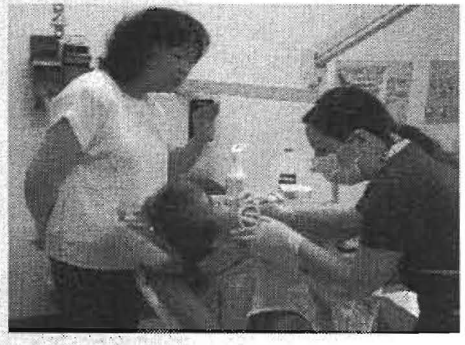


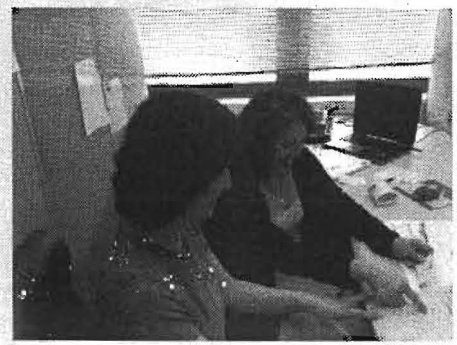


Highlights: Patient Navigator Program

In 2010, the percentage of uninsured Asian Americans in the U.S. increased to 18.1% from 16.5% in 2009.

U.S. Census Bureau, 2010



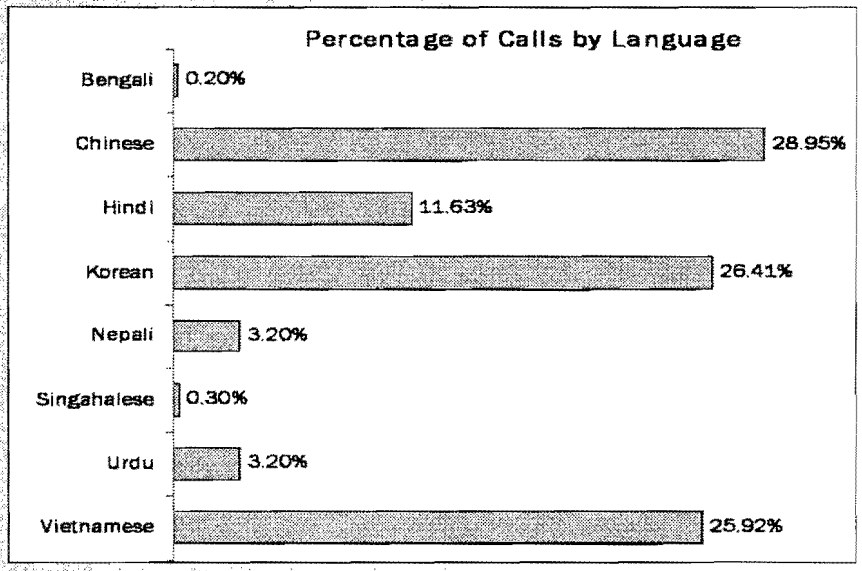


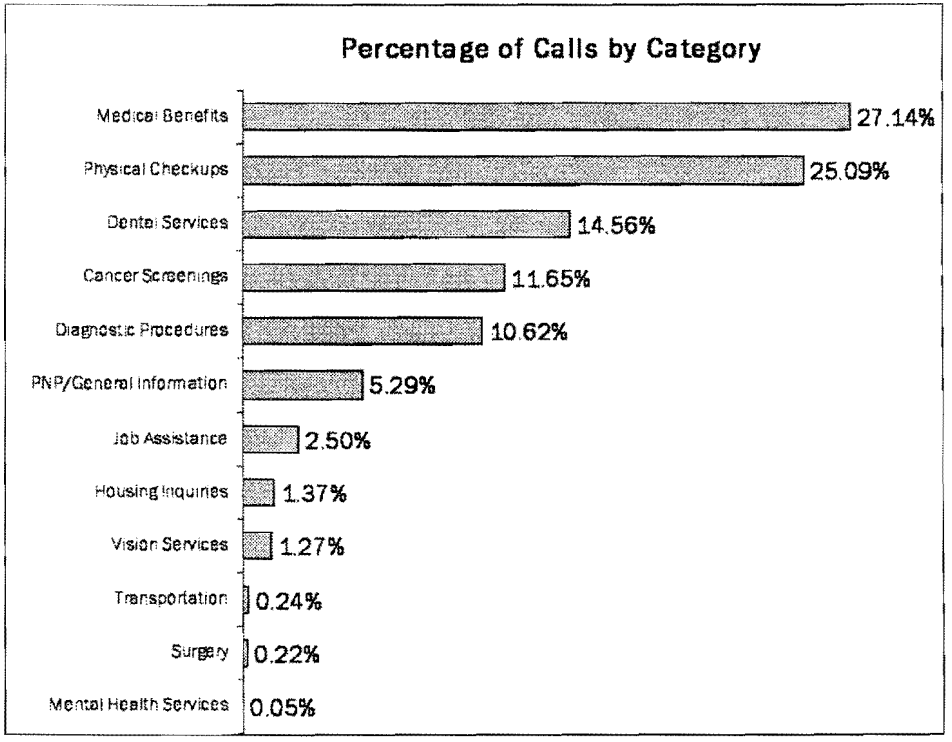
Asian Americans with limited English proficiency oftentimes cannot communicate effectively to health care providers. This can result in inaccurate diagnoses, poor follow-up care, and low health status outcomes. In addition, there is a lack of medical providers who can provide culturally and linguistically appropriate services to Asian Americans. To combat this, the Asian American Health Initiative partnered with Cross Cultural InfoTech to establish the Patient Navigator Program in 2008. Since the program's inception, AAHI patient navigators have helped patients navigate the County's health care services, providing face to face medical interpretation during appointments and translating medical forms and educational materials.

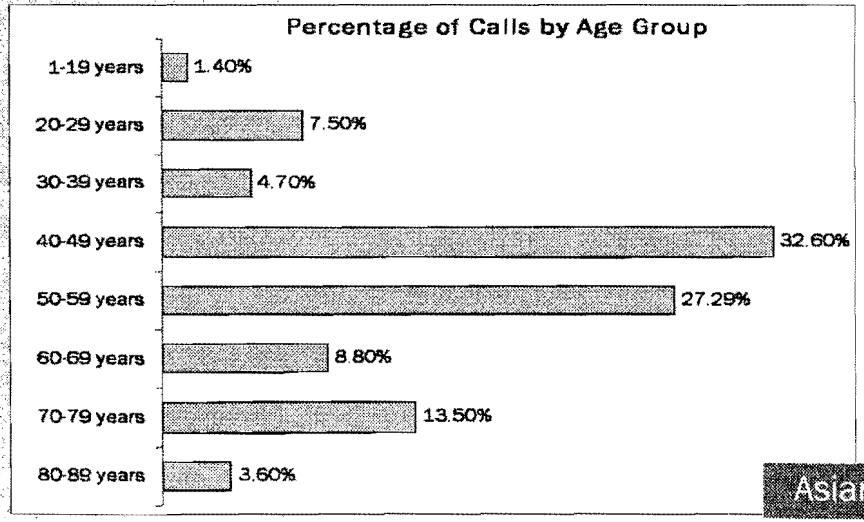
The program is made up of two components: (1) Multilingual Health Information and Referral Telephone Line to provide general health information and navigate callers to health care services and (2) Trained Multilingual Medical Interpreters who accompany clients to medical appointments and provide translation services. Interpretation is available in four Asian languages: Chinese, Hindi, Korean, and Vietnamese.

5,532 total client encounters
4,087 calls received
95.65% of clients linked to County services
78.0% of callers had no insurance
1,144 on-site medical interpreting sessions
301 medical interpreting sessions by phone

Highlights: Patient Navigator Program

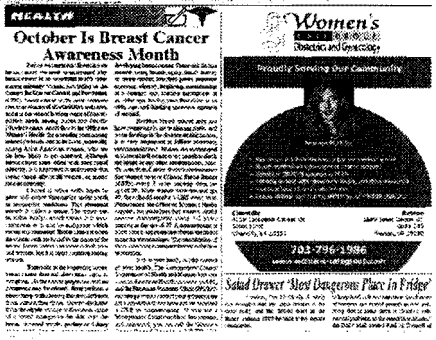






98

Highlights: Health Education in Ethnic Media



To reach the limited English proficient and isolated households of the Asian American population in Montgomery County, the Asian American Health Initiative implemented the Health Education in Ethnic Media Campaign in FY11 and continued its efforts through FY12. AAHI published a series of informational health articles in a variety of ethnic media—both in print and online English and Asian language news sources—as a way to provide health information to community members in their native language.

The articles are reviewed by experts in the field and widely distributed through the ethnic media so that AAHI can educate hundreds of Montgomery County residents. AAHI further developed its Ethnic Media Campaign this fiscal year by establishing a partnership with two ethnic media sources to have AAHI's health articles published on a regular basis. With many of those in the Asian American community, especially non-English speaking residents, utilizing local ethnic media as a source of news and information, the Health Education in Ethnic Media Campaign will continue to provide vital health information in a culturally and linguistically appropriate manner.

10 articles published
4 media sources:
- Epoch Times
- India This Week
- Korea Times
- Washington Chinese News

6 health topics covered:
- Breast cancer
- Diabetes
- Heart health
- Hepatitis B
- Osteoporosis
- Tobacco use prevention

Promoting Community Mobilization and Empowerment

Communities serve a vital role as influencing partners in health initiatives and in improving health outcomes. According to the Centers for Disease Control and Prevention's *Community Mobilization Guide,* the benefits of community involvement include promotion of local ownership in decision making, reduction in service redundancy, and the creation of a unified effort and voice. Therefore, in addition to working to increase access to culturally and linguistically competent care, the Asian American Health Initiative also dedicates time and effort towards empowering communities to take a proactive role in articulating and addressing their own defined health concerns.

To accomplish this, AAHI interacts with community organizations, leaders, and individuals from diverse settings and backgrounds to educate them on defining their health priorities, taking individual action, and advocating for their respective communities. Additionally, the high level of community collaboration allows AAHI to obtain timely, meaningful information to tailor its programs to best meet emerging concerns in the Asian American community.

In FY12, AAHI focused its resources on outreach and educational programs, providing expertise and technical assistance on program planning, implementation and evaluation to local community organizations. AAHI also provided workshops to enhance community leaders' skills to address other issues in their community. AAHI's health promotion efforts were also important in disseminating health information beneficial to the well-being of the community. As FY12 closed, it was clear that it was a year of great successes in mobilizing and empowering communities to better the welfare of the community.

Highlights: Health Promoter Program

The Health Promoter Program was developed to help reduce cultural and linguistic barriers to accessing health services. Health promoters are the gatekeepers of their respective communities and allow AAHI to serve a wider network of Asian Americans in Montgomery County. They assist with AAHI's outreach activities, provide preventative education in their communities, and connect residents to the County's services.

The health promoters are a valuable group for AAHI; they help to identify community partners and offer intimate knowledge of their respective communities. Through the passionate work of these health promoters, community members gain important knowledge to improve their own health and well-being.

AAHI Health Promoter:

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

34 health promoters
16 languages and dialects spoken
16 ethnic communities represented
10 trainings attended
9 new health promoters in FY12
14 health promoters with 3+ years of experience in the program

Highlights: Community Outreach Events

To help ensure that County health services and programs reach all segments of the community, the Asian American Health Initiative plans community outreach events throughout the year to educate and connect community members with the health care that they need. These events give AAHI oppotunities to provide information on pertinent health concerns, reach out to isolated communities, and learn about community needs. Community outreach is an essential component to AAHI's health promotion efforts, increasing awareness and knowledge for individuals to feel empowered to take steps towards a positive change in their health.

In FY12, AAHI planned a variety of events ranging from health fairs to educational workshops. During these outreach events, AAHI disseminated valuable health information and connected community members with local, free or low-cost screenings and referral services in the County. Through diverse partnerships, AAHI also provided technical assistance to community- and faith-based organizations to help enhance and strengthen their ability to implement their own health outreach programs.

41 outreach events
5,421 educational encounters
362 health service referrals
7,531 pieces of literature distributed
19 communities reached
1,412 health screenings performed

In FY12, AAHI's community outreach events included health fairs, hepatitis B projects, health education workshops, and small business outreach (Connect).

Highlights: Hepatitis B Projects

Asian and Pacific Islanders make up less than 5% of the total United States population, but account for more than 50% of Americans living with chronic hepatitis B.

Center for Disease Control and Prevention, 2012

Health disparities are visibly evident when comparing the risk of hepatitis B among Asian Americans to the general US population and non-Hispanic whites in particular. As many as 1 in 10 Asian Americans has chronic hepatitis B compared to 1 in 1000 Caucasian Americans. Therefore AAHI developed projects to provide health education, screening, vaccination, and treatment referrals for hepatitis B in the Asian American community.

In FY12, AAHI conducted three hepatitis B projects with various community partners: 1) Screening, Treatment, Outreach, and Prevention of Hepatitis B (STOP B) Program with the Chinese Culture and Community Service Center, 2) Screening, Management, Awareness, Solutions for Hepatitis B (SMASH B) Program with the Viet Nam Medical Assistance Program, and 3) Active Care & Treatment of Hepatitis B (ACT Hep B) Program with the Korean Community Service Center of Greater Washington. Through these collaborations, AAHI provided technical assistance and empowered these organizations to continue their own health programs in the future.

(Funding for the FY12 SMASH B is supported by the Montgomery County Council Grant.)

540 participants

100% of at-risk participants referred to vaccinations, of whom 80% completed the three-shot vaccination series

100% of infected participants referred to follow-up care, of whom 73% accessed treatment

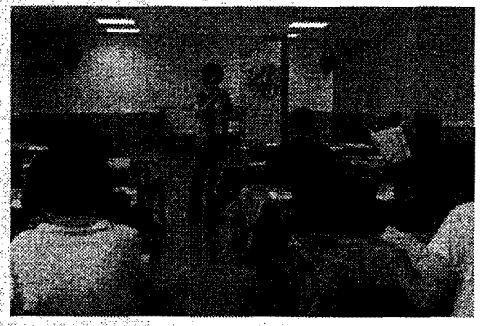
99.5% of participants reported they would urge family and friends to be screened and/or vaccinated*

100% of participants reported overall satisfaction with program*

*Not reported in the STOP B Program.

For data from each individual project, see the corresponding evaluation report on AAHI's website www.AAHIinfo.org.

Highlights: Health Education Workshops



In keeping with its goal to provide health education programs that are accessible and available for all Asian Americans in Montgomery County, AAHI planed numerous health education workshops for the community. The workshops are a vital tool for AAHI to promote important health information and link the community to services and screening opportunities. They also provide a more interactive environment than the traditional health fair or outreach event and are presented in appropriate languages to meet the linguistic and cultural needs of the audience.

AAHI works with the community to determine what health concerns need to be addressed and confers with experts in the field to develop the content of the health education workshops. During FY12, AAHI fostered a partnership with the Housing Opportunities Commission of Montgomery County to host two educational workshops at its senior residences. The workshops were presented in Mandarin to fit the target population, Chinese-speaking seniors. Another health education workshop was arranged in collaboration with the Japanese community as part of a health fair. Through these workshops, AAHI provided knowledge and education for community members to be empowered to improve their health status.

3 workshops conducted in the community
2 topics covered: Mental Health and Osteoporosis
63 educational encounters

Highlights: Connecting Communities to Services (Connect)

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

Survey of Business Owners, 2007

To enhance its reach to isolated communities, the Asian American Health Initiative implemented a pilot program called the Independent Outreach Project in FY11. Due to the high number of Asian small business owners in the County, AAHI designed this program to reach marginalized local business owners and their employees, along with congregants of smaller community and religious organizations, who may not have the knowledge or time to attend health fairs or access health services. AAHI provided on-site health education and linkage to health care services to these hard-to-reach community members.

In FY12, AAHI evaluated this program and made improvements to further develop its impact on the community. With a few revisions, the program, now known as Connecting Communities to Services (Connect), flourished with five newly recruited health promoters assigned primarily to this program. Through their passion and expertise, AAHI is able to ensure that a wider portion of the Asian American community is reached through their health promotion efforts.

106 small businesses and communities reached
599 educational encounters
837 pieces of literature distributed
37 health service referrals

90

Highlights: E.C.H.O. Project

Given the diversity of health concerns and needs in the community, faith-based and community-based organizations are encouraged to develop their own programs that will improve health outcomes for community members. To achieve this, AAHI implemented the Empowering Community Health Organization (E.C.H.O.) Project, a series of training workshops aimed to build the capacity and sustainability of community organizations that serve Asian Americans in Montgomery County. AAHI initially conducted a needs assessment in FY11 to generate a list of topics that would closely match the needs of the community prior to planning and implementing the workshops. Thereafter, the first workshop was hosted in FY11 to provide education on the numerous services and resources made available by Montgomery County's Department of Health and Human Services.

In FY12, AAHI successfully hosted two workshops on grant writing, a topic of strong interest in the community. The first workshop, entitled *Grants 101*, included a panel of experts representing the U.S. Department of Health and Human Services Office of Minority Health, Montgomery County Council, Community Foundation for Montgomery County, and Holy Cross Hospital Foundation to provide an overview of various types of grants. The second workshop, entitled *Grants 102*, was led by the MCDHHS Grants Manager and provided a more in-depth training on grant writing skills. Both workshops were well received by the community with attendance more than doubled from the first workshop in FY11.

Grants 101 Workshop
56 individuals attended
27 organizations represented

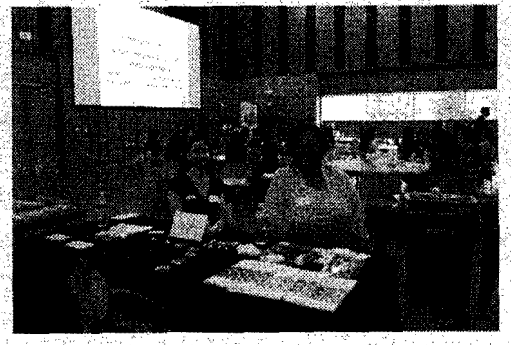
Grants 102 Workshop
52 individuals attended
21 organizations represented

17

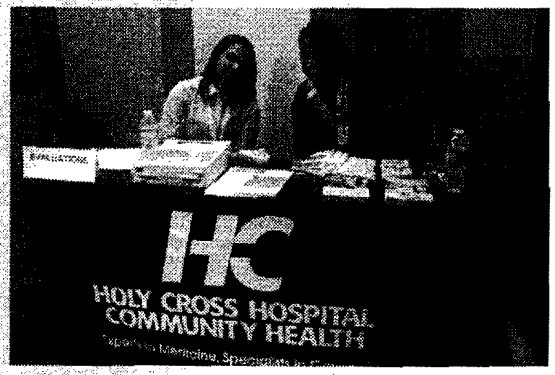
Strengthening Partnerships and Collaborations

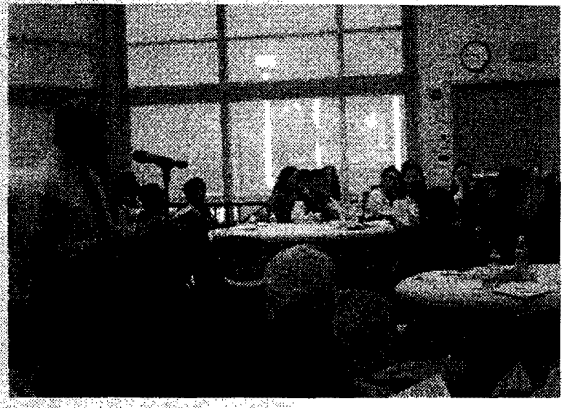
AAHI has fostered strong ties with Asian American community- and faith-based organizations throughout Montgomery County. Through collaborations with diverse stakeholder groups at the local, state, and national level, AAHI has built a firm foundation of partnerships to better the well-being of the underserved, Asian American community. Lasting partnerships between public health agencies and community- and faith-based organizations are incredibly valuable in producing outcomes which are not achievable alone. This exchange of knowledge, ideas, and resources paves the way for AAHI and other community organizations to meet their mission of serving Montgomery County's residents.

In FY12, AAHI continued to fortify existing relationships and initiate new partnerships with organizations aligned with its own vision and community commitment. Such public-private partnerships included collaborations with local hospitals, non-profit organizations, and universities. AAHI worked with its partners to implement effective outreach methods and provided technical assistance to community organizations to host their own culturally competent programs. The benefits of these partnerships included building a better understanding of each group's respective population, and helping to reduce the duplication of services and enable a larger scope of service delivery for all.



Highlights: Minority Communities Empowerment Project





In FY12, AAHI continued to take part in the Minority Communities Empowerment Project (MCEP) in collaboration with Holy Cross Hospital, Community Ministries of Rockville, the African American Health Program, and the Maryland Commission on Indian Affairs. Funded by the Maryland Department of Health and Mental Hygiene's Minority Outreach and Technical Assistance (MOTA) program, MCEP conducts outreach and trainings for minority communities in order to educate and empower community members about cancer prevention and tobacco cessation.

Through the MOTA trainings, AAHI health promoters and collaborators gained valuable technical skills and culturally-competent means of assisting the public. Together, they shared knowledge amongst each other and bridged the knowledge gap between individuals and the path to healthier living. These invaluable partnerships enabled AAHI to improve its capability to serve the Asian American community by reaching out to isolated communities while also sharing lessons learned with others.

AAHI has been a recipient of this grant since FY 2005. See the financials page for more information.

Highlights: Komen Community-Assisted Mammogram Program

AAHI continued its work on the Susan G. Komen Community-Assisted Mammogram Program (KCAMP) in collaboration with Holy Cross Hospital, Community Ministries of Rockville, CASA de Maryland, and the African American Health Program. During FY12, AAHI diligently worked to conduct culturally competent community outreach on breast health and provide referrals to community clinics for clinical breast exams or mammograms.

Through this grant, AAHI health promoters provided breast-self exam demonstrations, breast cancer education, and information on local resources for breast health. Health promoters tailored the outreach to be culturally sensitive and reduce stigma and fears associated with breast cancer screening and treatment. By continuing in this program and collaborating with its partners, AAHI has served the Asian American community by removing cultural, linguistic, economic, and accessibility barriers to breast care.

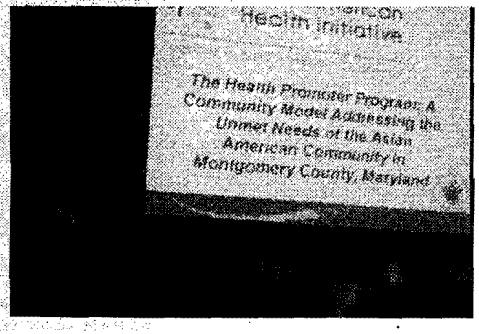
AAHI has been a recipient of this grant since 2009. See the financials page for more information.

Screening rates for breast cancer, cervical cancer, and colorectal cancer were significantly lower among Asians than whites and blacks.

National Health Interview Survey, 2010

8

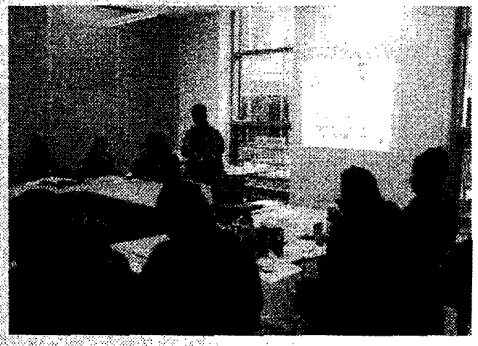
Highlights: Health Disparities Conference

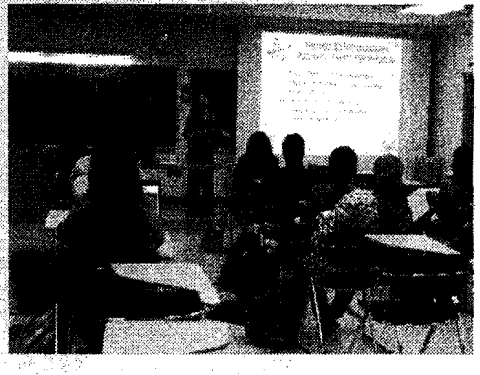


As part of the conference planning committee for The Center on Health Disparities at Adventist HealthCare, AAHI provided assistance and guidance on planning the annual Health Disparities Conference. This event is hosted annually by the Center to raise community awareness about local health disparities, disseminate research findings, and develop solutions to eliminate health disparities and barriers to quality health care. With presentations and panel discussions by nationally recognized leaders from the fields of public health, health care management, and policy, the conference provides important information to stakeholders and presents an avenue for networking with diverse community health professionals.

In FY12, the Center—in partnership with the Montgomery County Department of Health and Human Services, Kaiser Permanente, and Carefirst Blue Cross Blue Shield—successfully hosted its 5th Annual Health Disparities Conference. The theme for this conference was "Partnering towards a Healthier Future: Achieving Health Equity through Health Care Reform." The conference provided a comprehensive overview of the Affordable Care Act and its effect on eliminating health disparities and improving health care for underserved individuals. With heartfelt dedication from its collaborators, the conference was a successful and engaging event.

Highlights: AAHI 101 Presentations





In order to develop a health sector that is knowledgeable about the unique needs of the Asian American population, AAHI continued its AAHI 101 presentations in FY12. AAHI staff presented an up-to-date, comprehensive overview of the Asian American community to various organizations, as well as interested individuals and health care providers. The presentations included information on demographics, barriers to accessing care, health disparities particular to the Asian American community, and the importance of cultural and linguistic competency when working with this population. These presentations also raised awareness about AAHI and its programs and services, paving an avenue for future collaboration with others.

Organizations presented to:

- American University
- US Government Accountability Office
- Housing Opportunities Commission, Elizabeth House
- Housing Opportunities Commission, Waverly House
- Montgomery County DHHS, Aging & Disability
- Montgomery Hospice
- University of Maryland School of Public Health

191

Highlights: Equity & Social Justice Initiative

In FY12, the Asian American Health Initiative continued to serve 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 people. The Equity and Social Justice Initiative's principal workgroup, developed to guide the Department's work, convenes to plan, implement, and evaluate activities that will ultimately assist the Department in integrating a comprehensive equity plan to ensure equitable service delivery. To date, this initiative has made progress in identifying four priority areas and AAHI continues to work with the members of the initiative to create a work plan.

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

"Equity—defined as: fair policies, decisions, and actions—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

- Adventist HealthCare – Center on Health Disparities
- African American Health Program
- African Women's Cancer Awareness Association
- Alpha Kappa Alpha
- American Heart Association
- America-Nepal Women's Association of Greater Washington, DC
- Asian American LEAD
- 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
- Asian Pacific Partners for Empowerment and Leadership
- Bait-ur-Rahman Mosque
- Boat People, SOS
- Burma American Buddhist Association
- Cambodian Buddhist Society
- Cambodian Senior Association
- Casa de Maryland
- CCACC Pan Asian Volunteer Health Clinic
- Child Care & Adult Services, Inc.
- Chinese American Senior Services Association
- Chinese Bible Church of Maryland
- Chinese Culture and Community Service Center, Inc
- Chinese Women's League Washington DC Chapter
- Cigarette Restitution Fund Program
- Community Health Consulting
- Community Ministries of Rockville
- Coordination Council of Chinese American Associations
- Cross Cultural Infotech
- Danya Institute
- DC Japanese Mental Health Network
- DC Muslim Interscholastic Tournament
- East County Citizens Advisory Board
- Family Services, Inc.
- Filipino-American Ministry of Saint Michael the Archangel Catholic Church
- Food & Drug Administration, Women's Group
- Gaithersburg Upcounty Senior Center
- Global Mission Church
- Guru Nanak Foundation of America
- Hepatitis B - Patient Advocacy Liaison Program, Bristol Myers Squibb
- Hepatitis B Initiative-DC
- Hindu American Community Services
- Holy Cross Hospital
- Hopewell Health
- Housing Opportunities Commission of Montgomery County
- Independent Persia Writers
- Indonesian Muslim Association of America
- International Buddhist Center
- International Rescue Committee
- Islamic Center of Maryland
- Jain Society of Metropolitan Washington
- Japanese American Citizens League
- Japanese Christian Community Center of Washington DC
- Johns Hopkins Bayview Medical Center
- Johns Hopkins Bloomberg School of Public Health
- Kaiser Permanente
- Korean Community Services Center of Greater Washington
- Latino Health Initiative
- Maryland Commission on Indian Affairs
- Maryland Department of Health and Mental Hygiene, Center Health Promotion Maryland Department of Health and Mental Hygiene, Office of Minority Health and Health Disparities
- Maryland Insurance Administration
- Maryland Vietnamese Mutual Association
- MedStar Montgomery Medical Center
- Mobile Medical Clinic
- Montgomery College, Germantown Campus
- Montgomery College, Rockville Campus
- Montgomery County Cancer Coalition
- Montgomery County Cancer Crusaders
- Montgomery County Commission on Aging
- Montgomery County Department of Health and Human Services
- Montgomery County Mental Health Advisory Committee
- Montgomery County Office of Human Rights
- Montgomery County Office of Community Partnerships
- Montgomery County Tobacco Coalition
- Muslim Community Center (MCC)
- MCC Medical Clinic
- MCC Montgomery Coalition for Adult English Literacy English Program
- NIH, Asian Pacific American Organization
- NIH, National Cancer Institute
- NIH, National Institute of Arthritis and Musculoskeletal and Skin Diseases
- 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
- Professional Development for the Global Stage
- Recovery Partners Montgomery
- Rockville Senior Center
- Shady Grove Adventist Hospital
- Southern Asian Seventh Day Adventist Church
- St. Rose of Lima Church
- Suburban Hospital
- Sri Lanka Association of Washington DC
- Thai Alliance of America
- U.S. Census Bureau
- United States Department of Agriculture, Office of Public Affairs and Consumer Education
- United States Department of Health and Human Services, Health Resources and Services Administration
- United States Department of Health and Human Services, Substance Abuse and Mental Health Services Administration
- University of Maryland College Park, Office of Multicultural Involvement & Community Advocacy
- University of Maryland College Park, School of Public Health
- Viet Nam Medical Assistance Program
- Vietnamese American Senior Association
- Washington Adventist Hospital
- Washington Japanese Alliance Church
- Wat Thai Washington, DC
- Woman's Cancer Control Program
- Women, Infants & Children
- YMCA

Highlights: Work Group Participation

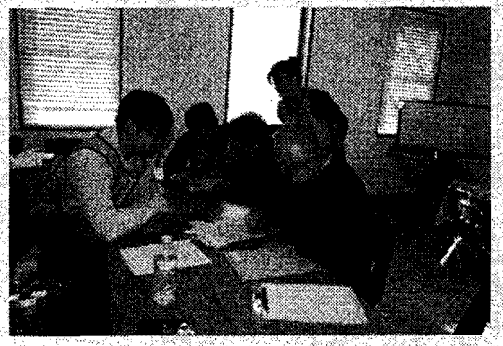
- Adventist HealthCare Center on Health Disparities – Advisory Group
- Asian Pacific Islander Caucus for Public Health in official relations with the American Public Health Association – Executive Committee
- Johns Hopkins University National Children's Study Center – Advisory Board
- Maryland Asian American Cancer Education Program, Johns Hopkins Bloomberg School of Public Health and University of Maryland School of Public Health – Community Advisory Board
- Montgomery County DHHS Cancer Coalition
- Montgomery County DHHS Commission on Aging – Mental Health Summer Study Workgroup
- Montgomery County DHHS Equity & Social Justice Initiative
- Montgomery County DHHS Quality Service Review
- Montgomery County DHHS Tobacco Free Coalition
- National Institutes of Health, National Institute of Arthritis and Musculoskeletal and Skin Disease – Multicultural Outreach Workgroup

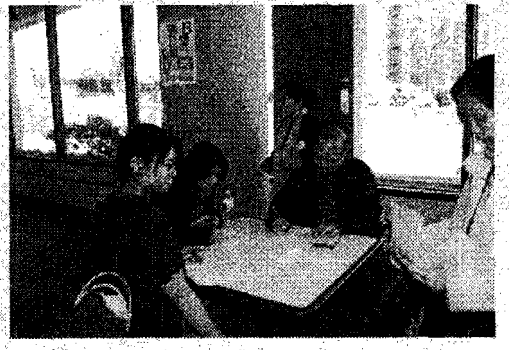
Enhancing Data Collection and Reporting

Data collection is foundational to acquiring meaningful insight, knowledge, and evidential support in order to make critical decisions. It is pivotal in helping organizations understand the health needs of the community and improve programs designed to meet these needs. Given the diversity of the Asian American population, disaggregated data is necessary to prevent the masking of health disparities in each unique Asian subgroup. Lumped data can often lead to the false idea that Asian Americans are a homogenous group with similar needs. As a result, resources may not be properly allocated to effectively meet the needs of the community.

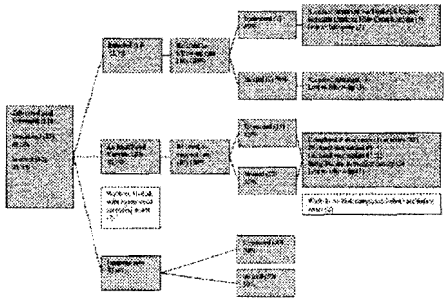
With that in mind, AAHI continued to conduct in-depth data collection to monitor the health status of Asian Americans in Montgomery County. In FY12, the AAHI Steering Committee maintained its efforts to assist in Healthy Montgomery, a collaborative, community-based data surveillance project. AAHI also continued to collect valuable data through comprehensive evaluation of its various programs to determine achievement of objectives and indicate areas where AAHI programming could be improved.

AAHI disseminated the data collected from its projects to stakeholders and partners through various routes — reports, conferences, academic settings, etc — to share the wealth of knowledge and assist in collaborative work towards improving the community's health. AAHI recognizes that distributing data is particularly important to facilitate decisions made by community leaders, government officials, and policymakers pertaining to the needs of County residents.





Highlights: Hepatitis B Project Evaluation Reports



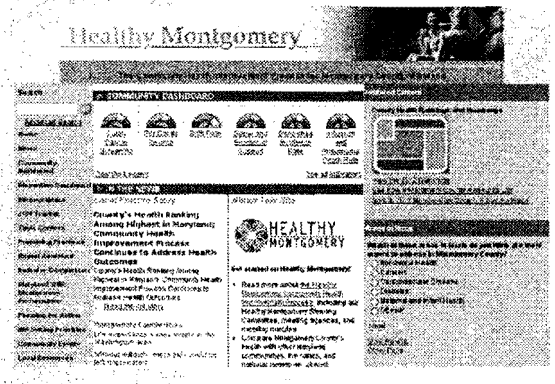
Since AAHI's inception, hepatitis B has been a priority area for AAHI. In order to implement effective hepatitis B services, AAHI ensures that quantitative and qualitative data collection tools are incorporated into the programs to enable analysis and evaluation of the projects.

In FY11, AAHI supported the Viet Nam Medical Assistance Program (VNMAP) with the Screening, Management, Awareness, and Solutions for Hepatitis B (SMASH B) Program, a program targeted to the Vietnamese American community to provide hepatitis B education, screening, and vaccination or referrals for treatment. In FY12, data from the 2011 SMASH B Program was published in an evaluation report produced by AAHI and VNMAP. The report outlines program implementation steps, outcome data, recommendations, and lessons learned. AAHI and VNMAP also collaboratively identified gaps and provided valuable information about eliminating hepatitis B disparities in the Asian American community. This publication can be reviewed on AAHI's website at http://aahiinfo.org/our-work/publications/.

AAHI is currently working with the Korean Community Service Center of Greater Washington and Viet Nam Medical Assistance Program to produce evaluation reports on their respective hepatitis B programs held in FY12. Please look for the evaluation reports on the Active Care & Treatment of Hepatitis B (ACT Hep B) Program and 2012 SMASH B Program in the future.

101

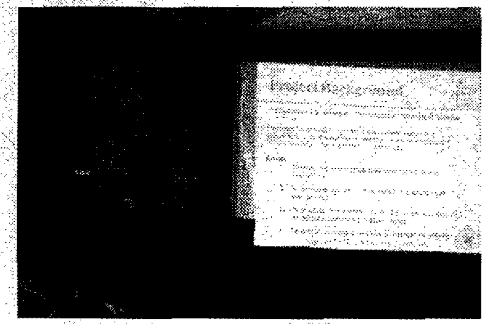
Highlights: Healthy Montgomery

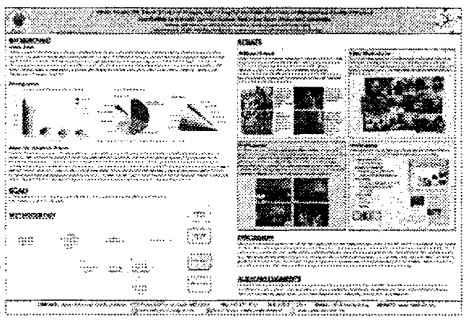


AAHI's Steering Committee continued to participate actively in the Healthy Montgomery community health improvement process during FY12. Based on a community and consensus-driven approach, the Healthy Montgomery process brings together representatives from public and private sectors to identify and address key priority areas that will improve the health status and well-being of the County.

Last fiscal year, the Healthy Montgomery website, a one-stop, online resource for population-based data and information about the County's health, was released. During this fiscal year, further progress was made as Healthy Montgomery staff, Steering Committee, and consultants collected information on the health profile of Montgomery County and published a needs assessment of the community. Using the information collected from the needs assessment, priority setting was completed and efforts will now be directed towards action plan development.

Highlights: Professional Presentations





Please see CSAAH's website (http://asian-health.med.nyu.edu/) for conference resources, including the video streaming of our morning keynote panel with guest speakers: Dr. Rochelle Rollins, Director, Division of Policy and Data, Office of Minority Health, HHS; Sefa Aina, Commission Member, President's Advisory Commission on Asian Americans and Pacific Islanders; Jeff Caballero, Executive Director, Association of Asian Pacific Community Health Organizations; and Kathy Lim Ko, President & CEO, Asian & Pacific Islander American Health Forum, as well as links to panelists' presentations. ■

Clockwise from left: NYU CSAAH Staff and interns help with registration; Dr. Mariano Rey and [illegible] workgroup session; Track 4 Moderator [illegible] (NYU) and speakers Dr. [illegible] Kim (Johns Hopkins School of Nursing), [illegible] (APIAHF), Perry Chan (Montgomery County DHHS), [illegible] (Tongan Community Service Center); Conference Morning Keynote Panel speakers Mary Northridge (APHA), Rochelle Rollins (Office of Minority Health, HHS), Sefa Aina (President's Advisory Commission on Asian Americans and Pacific Islanders), Jeff Caballero (AAPCHO), Kathy Lim Ko (APIAHF)

OCTOBER 2011

Maryland Department of Health and Mental Hygiene Conference

- Oral presentation: *Non-traditional Pathways into Health Professions- Health Promoters Program*

American Public Health Association Annual Meeting and Exposition

- Poster presentation: *Storytelling as a Health Communication Tool in the Asian American Community*
- Oral presentation: *The Health Promoter Program: A Community Model Addressing the Unmet Needs of the Asian American Community in Montgomery County, Maryland*
- Oral panelist: *Reality Check: Opportunities, Challenges and Strategies in Community-Based Public Health Work*
- Oral presentation: *Importance of Community Engagement in the Movement to Eliminate Hepatitis B Disparities*

NOVEMER 2011

Adventist HealthCare Disparities Conference

- Oral presentation: *The Health Promoter Program: A Community Model Addressing the Unmet Needs of the Asian American Community in Montgomery County, Maryland*

DECEMBER 2011

NYU Center for the Study of Asian American Health, Asian American, Native Hawaiian, and Pacific Islander (AA and NHPI) Health Conference

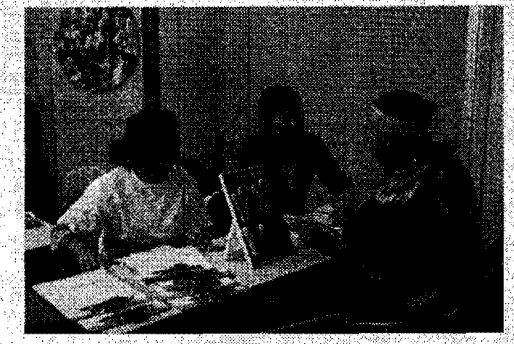
- Oral presentation: *The Health Promoter Program: A Community Model Addressing the Unmet Needs of the Asian American Community in Montgomery County, Maryland*

109

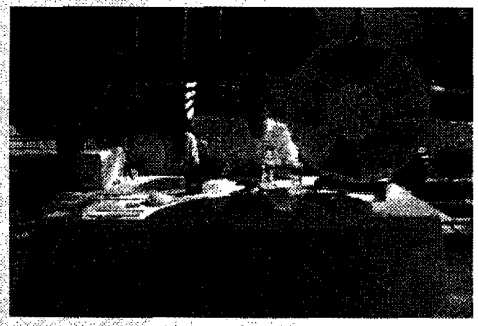
Professional Development

To empower and nurture a future generation of health professionals, the Asian American Health Initiative commits to providing an environment that encourages learning, mentoring, and skill development for its staff and interns. The AAHI Internship Program offers fall, spring and summer internships for students and recent graduates who are interested in the community health field and want to gain firsthand experience and practical skills. Though this program, interns receive the opportunity to be involved in a variety of AAHI projects ranging from research to educational material development to program implementation. AAHI tailors the program to meet the interns' interests so that they are able to grow and enhance their skills according to their needs. Interns learn about public health in a community setting while also building professional relationships across the public and private sectors. AAHI's vision is for interns to leave with an abundant amount of knowledge, skills, and professional connections for their future career development.

In addition to its internship program, AAHI and Montgomery County DHHS supported and provided trainings, seminars, and conferences for its staff throughout the year. These professional development opportunities allowed the staff to share their ideas, knowledge, and insight with other public health professionals and to continuously learn about new developments in the field. These facilitated learning opportunities enriched the staff's capabilities as public health professionals and allowed the programs they create to be successful.



Highlights: FY2012 Interns



SUMMER 2011 INTERNS

Katherine Ip, *University of Maryland, School of Public Health*
Andrew Poo, *Emory University*

Highlights:

- Conducted outreach to small businesses, providing health education and information on health resources and services to several restaurants and cafes
- Researched health equity, particularly in regards to equal access, ties to social justice, and individual change

FALL 2011 INTERNS

Carolyn Ho, *University of Maryland, School of Public Health*
Candace Lee, *University of Maryland, School of Public Health*

Highlights:

- Researched and developed educational presentations on health information technology and mental health among Asian Americans
- Composed news articles on the topics of osteoporosis and heart health, which were published in ethnic newspapers

SPRING 2012 INTERNS

Jennifer Chang, *University of Maryland, School of Public Health*
Yu-Ting Chen, *University of Maryland, School of Public Health*

Highlights:

- Provided health education and information on health resources at outreach events and small businesses
- Researched the impact of the Affordable Care Act in Maryland

Highlights: Staff Development/Trainings

AAHI staff had the opportunity to participate in a variety of professional development conferences and trainings throughout FY12. Highlights include:

JULY 2011

- Peer learning with Seattle King County Health Department on Equity and Social Justice
- Susan G. Komen/National Cancer Institute Community Outreach and Education session and luncheon

SEPTMBER 2011

- Agency for Healthcare Research and Quality Conference: Leading Through Innovation & Collaboration

OCTOBER 2011

- American Public Health Association Annual Meeting & Exposition

MARCH 2012

- 5th Annual National Institute of Health conference on the Science of Dissemination and Implementation: Research at the Crossroads

MAY 2012

- National Council of Asian & Pacific Islander Physicians Conference: Moving Forward on Health Reform: Optimal Health for All

112

Financials

Similar to recent years, FY12 was challenging given the economic downturn and reductions in government funding. AAHI's core budget was reduced from $552,822 in FY11 to $403,209, including $25,000 from the Montgomery County Council to support a one year Hepatitis B prevention project in the Vietnamese community. In spite of the reductions, AAHI continued to make strides in improving the health of the Asian American community.

FY12 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 24.4% of AAHI's core budget expenditures.

2. Contract with Primary Care Coalition: This category accounts for 75.6% of AAHI's core budget expenditures.

Through collaborations with Holy Cross Hospital and other community partners, AAHI also received a $11,514 grant from the Maryland Department of Health and Mental Hygiene's Minority Outreach and Technical Assistance (MOTA) program and a $10,000 grant from the Susan G. Komen Community-Assisted Mammogram Program.

AAHI Steering Committee

The Asian American Health Initiative Steering Committee (AAHI SC) consists of 14 professionally and ethnically 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 community. With expertise and intimate knowledge of various communities, the Steering Committee provides invaluable insight and support to the work of AAHI and MCDHHS. In FY12, the Steering Committee members continued to work diligently with their unwavering motivation and efforts to serve the Asian American community. Some of their efforts include:

- Volunteered over 420 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 MCDHHS Advisory Board assessing the evolving role of the minority health initiatives/program in addressing racial/ethnic health disparities and well-being with leadership of the African American Health Program Executive Committee and Latino Health 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 health education columns for accuracy of content and cultural competency
- Contributed to the development of the Fiscal Year 2011 Annual Report
- Supported planning of two Empowering Community Health Organizations workshops, Grants101 and Grants102
- Presented with a proclamation by the Montgomery County Council in recognition of National Minority Health Month with other minority health initiatives/program
- Offered letters of support for health-related grants to MCDHHS and Holy Cross Hospital

Members

Sam Mukherjee, Chair
Karen Ho Chaves, Vice Chair
Anis Ahmed
Ji-Young Cho
Nerita Estampador
Wilbur Friedman
Harry Kwon
MunSu Kwon
Meng Lee
Sunmin Lee
Michael Lin
Betty Luan
Wendy Shiau
Sovan Tun

34

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 www.AAHIinfo.org 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 for 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.

151

Acknowledgements

AAHI would like to express its deepest appreciation to the County Executive, members of the Montgomery County Council, the Department of Health and Human Services, the AAHI Steering Committee, community partners, staff, and volunteers for their steadfast support during the 2012 fiscal year.

AAHI Staff

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Program Coordinator

Sanjana Quasem
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LNC

County Council Hearing April 11, 2013

TESTIMONY OF ELVA JALDIN, HEALTH PROMOTER AND MEMBER OF THE LATINO HEALTH STEERING COMMITTEE OF MONTGOMERY COUNTY

Good afternoon members of the County Council. My name is Elva Jaldin and I live in Wheaton. I am here today representing the Community Engagement Workgroup of the Latino Health Steering Committee of Montgomery County. Thank you for the opportunity to offer my testimony on the Fiscal Year 2014 budget. I would like to acknowledge the presence of some of my colleagues who are here today.

As you are aware, our County has become more diverse than ever with the increase in the number racial and ethnic minorities. Often minority communities are the ones that face the biggest obstacles to achieve healthy lives. From having problems getting decent jobs with livable wages to being able to get healthy foods, diverse communities, in particular, face increasing needs.

Several years ago, the Department of Health and Human Services (DHHS) established the Latino, Asian American and African American Health Initiatives/Program in an effort to improve the health of these groups. Even though the Minority Initiatives/Program and their community partners have done an incredible job with very limited resources, bigger efforts are needed to address the very large problems our people face. In order to seek comprehensive solutions to these problems, leaders from the Latino, African American, and Asian communities worked together with senior staff from the Department of Health and Human Services for a period of 20 months, which ended this past February. As a result of this unprecedented effort in

Since the inception of the Latino Health Initiative in the year 2000 I have had the pleasure of serving as a volunteer health promoter and community advocate, along with many others like me As a health promoter I can only begin tell you the struggles that our community faces because of health concerns. I am happy to report that we have a lot of successes educating people about ways to improve their health and well-being. Yet we sadly also see situations every day where people are not able to get basic health and human services because of the inability of the current system to assist them to get better and break the barriers that put their lives in disarray. For instance, just recently we assisted a mother, a female construction worker with an injured shoulder that was not able to work because of her injury, as her husband was incapacitated in bed suffering the effects of uncontrolled diabetes. They and their children were having a terrible time because they did not know where to go for help. Fortunately, I and other peers worked together to connect them to a community clinic, apply for social services, and receive legal assistance. Unfortunately many others do not receive the support needed and fall through the cracks.

I am proud of the work of my fellow health promoters and colleagues in the Latino Health Steering Committee and the other Minority Initiatives. With the partial restoration of our funding we will be able to work in a more collaborative and integrated way with DHHS to accomplish our common goal, the goal of a more healthy, fair and productive Montgomery County.

Thank you very much.

AMA TU VIDA

Latino Health INITIATIVE

MONTGOMERY COUNTY, MD

FY12 ANNUAL REPORT

JULY 1, 2011 – JUNE 30, 2012

Creando un Plan de Vida para Nuestra Comunidad

Building a Life Plan for Our Community

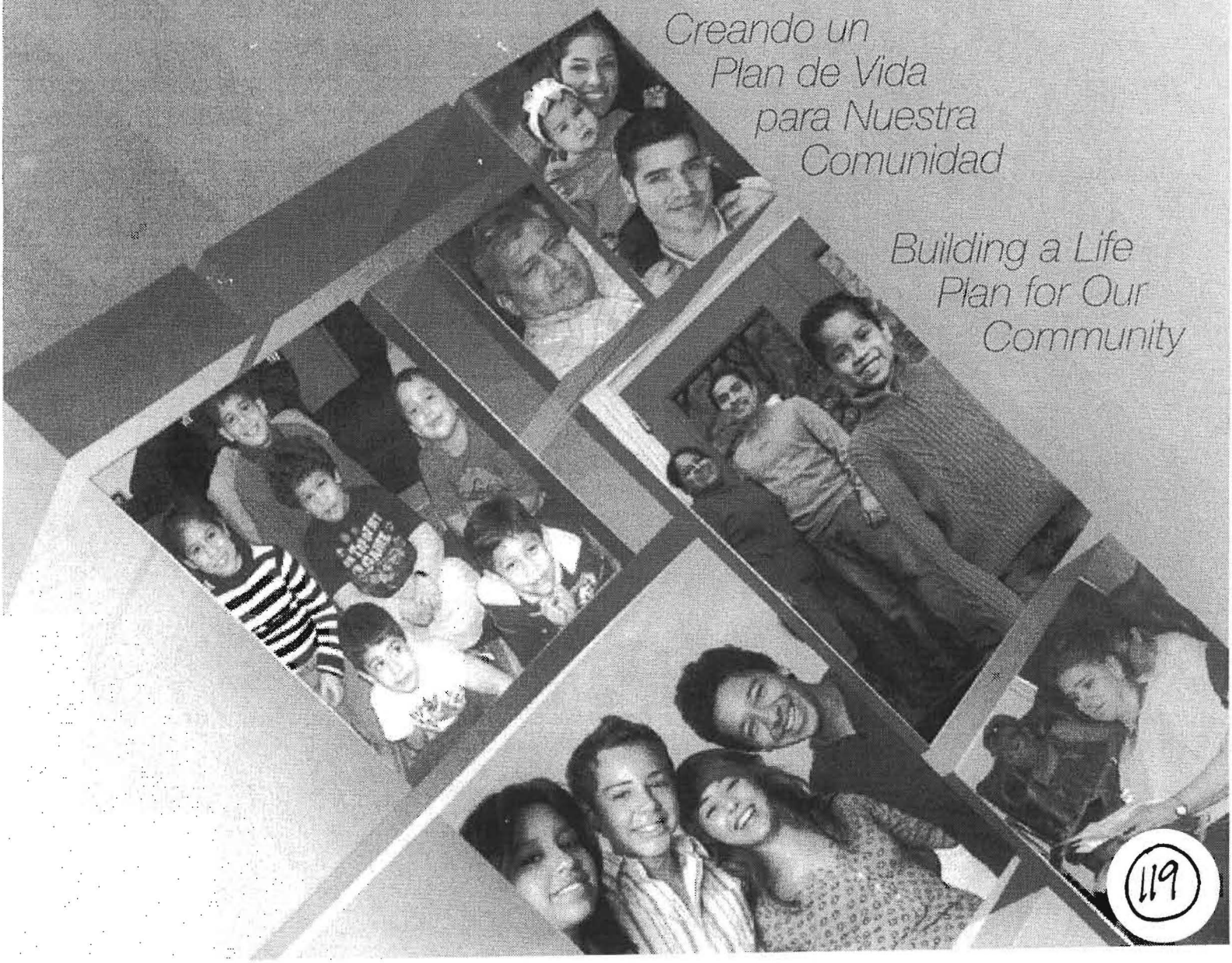


TABLE OF CONTENTS

MESSAGE FROM THE LATINO HEALTH STEERING COMMITTEE (LHSC) CO-CHAIRS AND THE LATINO HEALTH INITIATIVE (LHI) MANAGER

Wake naturally without an alarm clock. Local yogurt, honey, sourdough bread, and coffee for breakfast. Work in homegrown garden till mid-afternoon. Beans, potatoes, greens, and olive oil for late lunch. Nap. Visit neighbors till sunset. Bread, hummus, and goat's milk for family dinner. Dominoes and dance with friends till midnight, accompanied by wine. Share mountain herbal tea before bed. Church on Sundays. Walk up and down hills throughout the day. "Us" trumps "Me."

If you think the above schedule is only a dream, think again. This is what a typical day looks like for residents of a Greek Island, Ikaria. People on Ikaria reach the age of 90 years at 2.5 times the rate Americans do. Ikarian men are nearly 4 times as likely as their American counterparts to reach 90 years. Ikarians also live longer before succumbing to cancers and cardiovascular disease, suffering less depression and about a quarter the rate of dementia.[1]

For a dozen years, the Latino Health Initiative (LHI) has aimed to build an ecosystem for Latino and other residents in Montgomery County where culture, belonging, and purpose are part of the picture. Yes, Ikaria is an outlier. But, the Ikaria model illustrates the power that an environment with natural physically and socially reinforcing checks and balances can have on health. It is difficult to change individual behaviors when community behaviors remain the same. That is why the LHI has directed some of its focus on tackling what can be modified in both the built environment as well as the social milieu. FY12 highlights of such efforts include:

- The Latino Data Group engaged in community conversations on the social determinants of health.
- The Community Engagement Work Group participated in a community workshop on the impact of social and environmental conditions.
- The *Ama Tu Vida* festival provided over 2,500 medical screenings free of charge and assistance in follow-up.
- The Latino Youth Wellness Program created tailored wellness plans for 156 families, engaged in 107 hours of fitness training, and provided 30 hours of parent training, 7 weekend retreats, and 343 hours of group training with middle school youth.
- The Asthma Management Program collaborated with school officials to reduce school-based environmental triggers and engaged parents to deliver school-based asthma control education materials to teachers.
- The *Vías de la Salud* Health Promoter Program reached 7,898 individuals through education interventions at community events and led 5 Caminatas (walks) with 95 adults and children.
- The Smoking Cessation Program developed individual plans to help 10 smokers quit.

1 Adapted from: "Where people forget to die," by Dan Buettner. *New York Times,* October 24, 2012.

In Spanish, the concept named, "*plan de vida,*" describes the map that a person constructs to direct their aspirations and goals. A plan de vida supplies a person with a sense of purpose across their lifetime. We at the LHI are proud to work toward building and reinforcing physical and social buttresses to sustain Latino people's reason for waking up in the morning and dreaming about what is possible for the future. Please join us in working together to make our built and social environments suitable for optimal health so that every individual in Montgomery County is able to achieve their *plan de vida.*

Cesar Palacios, MD, MPH
Grace Rivera-Oven
Co-Chairs, Latino Health Steering Committee (LHSC), Montgomery County

Sonia E. Mora, MPH
Latino Health Initiative (LHI) Manager

LATINO HEALTH STEERING COMMITTEE (LHSC) OF MONTGOMERY COUNTY

"El Comité Directivo de Salud Latina junto a los comités asesores del Programa de Salud Afro-Americano, y de la Iniciativa Asiática-Americana, han estado activamente involucrados en un proceso intenso de planificación con la dirección del Departamento de Salud y Servicios Humanos. El propósito de este proceso de planificación es ayudar a fortalecer la capacidad del departamento para responder a los cambios demográficos de la población en el condado. La sabiduría y experiencia del Comité Directivo de Salud Latina ha proporcionado gran perspicacia y ha contribuido significativamente a este proceso".

"The Latino Health Steering Committee, along with the advisory committees of the African American Health Program and the Asian American Health Initiative, has been actively involved in an intensive planning process with the leadership of the Department of Health and Human Services. The purpose of this planning process is to help strengthen the department's capacity to respond to a changing demographic in the county. The wisdom and experience of the Latino Health Steering Committee has provided great insight and contributed meaningfully to this process."

—Betty H. Lam, Chief, Office of Community Affairs, Montgomery County DHHS

Latino Health Steering Committee members at annual retreat

Over the past dozen years, the Latino Health Steering Committee (LHSC) of Montgomery County has provided expert guidance and technical assistance not only to the Latino Health Initiative (LHI) but also to the County's Department of Health and Human Services (DHHS). As volunteers, LHSC members—professionals and community leaders—have dedicated time and effort to advocating for policies and practices whose ultimate aim is to improve the health of Latinos residing in Montgomery County.

FY12 ACCOMPLISHMENTS

- Volunteered over 1,500 hours to support the Latino Health Initiative's (LHI's) work.
- Recruited one new member to maintain a core group of 18 total members.
- Assisted the County DHHS to secure over $1,100,000 to support FY13 programs and activities.
- Advocated and testified at County forums on behalf of the Latino community regarding important health-related issues in Montgomery County.
- Proceeded to actively chair and collaborate with the Latino Data Workgroup and Community Engagement Workgroup.
- Supported the Minority Health Initiatives reorganization process through the DHHS Advisory Group. Specifically, the LHSC:
    - Coordinated with the Asian American Health Initiative Steering Committee and the African American Health Initiative Steering Committee.
    - Promoted conversations with the DHHS Director.
    - Facilitated internal conversations among Minority Health Initiatives and DHHS staff.
    - Participated actively in the Discovery and Learning Phase (presentations from Service Areas, DHHS-wide projects, and administrative services).
    - Developed the Process for Recommendations Phase.
    - Formulated recommendations and negotiation possibilities.
- Supported the Healthy Montgomery project to accomplish Phase III goals that included the selection of six health and wellbeing focus areas: (1) behavioral health, (2) cancer, (3) cardiovascular disease, (4) diabetes, (5) maternal and infant health, and (6) obesity. Additional areas identified as "lenses" in which to examine all health realms include inequities, lack of access, and unhealthy behaviors.
- Held the annual retreat to strengthen relationships among LHSC members, acknowledge LHI's and LHSC's major accomplishments, discuss the Minority Health Initiatives' reorganization process, and formulate priorities for 2013.

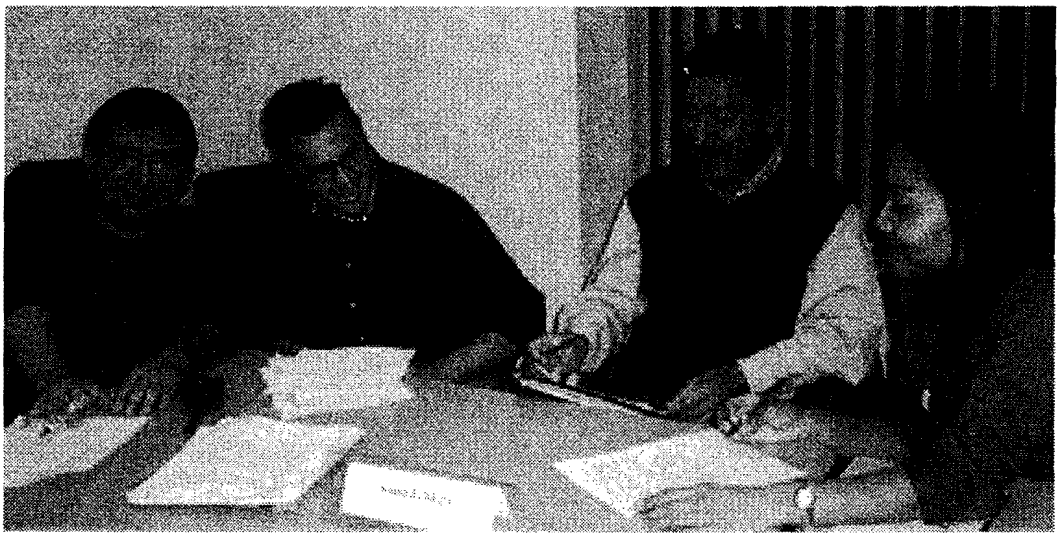
Latino Data Workgroup

"El Grupo de Trabajo de Datos del Comité Directivo de Salud Latina se centra en el análisis de cómo la información sobre la salud que recoge y reporta el condado de Montgomery refleja la realidad multidimensional de esta comunidad y proporciona una base apropiada para las intervenciones destinadas a mejorar el estado de salud y el bienestar de la comunidad latina".

"The Data Workgroup of the Latino Health Steering Committee focuses on analyzing how data on Latino health collected and reported by Montgomery County reflect the multidimensional realities of this community and provides adequate bases for interventions to improve the health status and wellbeing of the Latino community."

—Cesar Palacios, MD, Executive Director, Proyecto Salud, LHSC Co-Chair

Established in 2002, the Latino Data Workgroup (LDW) is composed of professionals who work in the Federal, academic, and private sector. This 10-member body provides technical assistance, advice, and advocacy support for the collection, analysis, and reporting of health-related data on Montgomery County Latino residents.



Members of the Latino Data Workgroup

FY12 ACCOMPLISHMENTS

- Collaborated with the Montgomery County Commission on Health to identify data sources for the Commission's initiative to rally the Latino community around obesity prevention and provide advice on outreach to the Latino community in Montgomery County.
- Supported the update of the Latino Health Initiative (LHI) Web portal with 5,261 visitors July 1, 2011 to June 30, 2012. Almost three-quarters of the visitors (73.35%) were new and over one-quarter (26.65%) returning ones.

- Produced four informational documents on the social determinants of health: (1) data summary to support the Community Engagement Workgroup advocacy efforts, (2) descriptive framework on the social determinants of health, (3) fact sheet on the social determinants of health, and (4) PowerPoint presentation on the social determinants of health.
- Supported the development and implementation of five 2-hour community conversations focusing on the social determinants of health in which 103 Latino community members participated actively.

Community Engagement Workgroup

"Los integrantes del Grupo de Participación Comunitaria de la Iniciativa Latina de Salud trabajaron para crear conciencia sobre diversos problemas de la comunidad de viviendas móviles en Germantown. Mientras que todo el mundo parecía saber sobre las viviendas móviles, el esfuerzo de los miembros de este grupo impulsó a las escuelas públicas del condado de Montgomery, al Gobierno del Condado y a la comunidad para trabajar juntos y abordar una serie de necesidades básicas de esta comunidad".

"The Latino Health Initiative (LHI) Community Engagement Workgroup (CEW) members worked to raise awareness about several issues of the Germantown Mobile Home community. While everyone seemed to know about the mobile home park, CEW members' efforts galvanized Montgomery County Public Schools, County Government, and the community to work together to address a few basic issues."

—Karla Silvestre, Latino Liaison to the County Executive

Community members participating in a Community Workshop on Social Determinants of Health

The Community Engagement Workgroup (CEW) was established October 2008 with the goal to increase community participation in decisions that affect the health of the Latino community.

FY12 ACCOMPLISHMENTS

- Worked in coordination with the County Executive's Latino Liaison, Director of the Up County Regional Office, Community Liaison for the African American and Faith Communities, and Daly Elementary School Principal to create an intervention strategy to reach a Germantown mobile home community.

- Raised awareness of the Germantown Mobile Home Park community. The most urgent issue for residents was whether the property had been sold and they would be displaced. Several community meetings were organized at Daly Elementary School to address this issue and share updated information. The Daly Elementary School principal, in partnership with the County, organized a book giveaway at the end of the school year in the mobile home property parking lot and the English for Speakers of Other Languages (ESOL) department offered classes during the summer to mobile home parents of pre-school children. The Chief of Community Engagement for Montgomery County Public Schools (MCPS), the Collaboration Council, and nonprofits like Identity, Inc. are now planning future intervention activities with this community.
- Participated in a community workshop about the impact social and environmental conditions have on individuals' and communities' health.
- Attended the HHS Community Forum on the FY13 Operating Forum, hosted by the Montgomery County Department of Health and Human Services Director, Uma Ahluwalia. One CEW member provided testimony on the reality that access to care continues to be an enormous need and priority in the Latino population.
- Participated in the FY13 Budget Forums sponsored by the County Executive. Two members provided testimony underscoring the importance of continuously supporting health-related programs that address the needs of the Latino population.

COMMUNITY PROGRAMS AND ACTIVITIES

Ama Tu Vida (Love Your Life) Health Festival

In an effort to facilitate access to preventive and health promotion services, the Latino Health Initiative (LHI) conceptualized and implemented the *Ama Tu Vida* (Love Your Life) Campaign. The *Ama Tu Vida* Health Festival is part of the LHI's ongoing *Ama Tu Vida* Campaign inviting community members to commit to a healthier life.

This fiscal year's *Ama Tu Vida* Health Festival was held October 16, 2011 at Wheaton Triangle in collaboration with the World of Montgomery Festival. About 33 nonprofit and private agencies partnered with the LHI to provide health and social services to festival participants.

For more information about *Ama Tu Vida* visit http://www.lhiinfo.org/en-programs-and-activities/Ama-Tu-Vida-\Campaign.asp

FY12 ACCOMPLISHMENTS

- Coordinated with 33 exhibitors who provided information on disease prevention, health promotion, and ways of accessing services in Montgomery County to approximately 3,000 festival participants.
- Provided over 2,500 medical screenings free of charge by 13 participating healthcare providers.
- Gave festival participants results of their screenings and assistance in scheduling follow-up appointments at community clinics to those without medical insurance. In partnership with community clinics such as Proyecto Salud, Community Clinic, Inc., and Spanish Catholic Center, a total of 26 follow-up appointments were scheduled for uninsured Montgomery County residents with abnormal medical screening results.
- Of the 26 individuals without insurance that were given appointments, 19 were reached to follow up on. Findings revealed that 53% of them showed up for their appointment and obtained the appropriate treatment.

LESSONS LEARNED

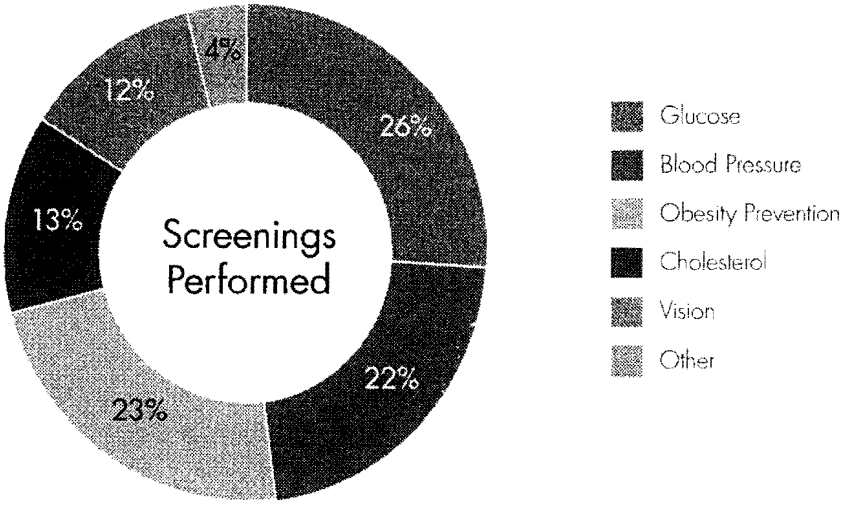
Due to budget constraints, some organizations were unable to participate in this year's *Ama Tu Vida* Health Festival. Specifically, a couple of participating partners were not able to provide certain screenings offered in previous years, such as for hepatitis B and syphilis. During FY11, *Ama Tu Vida* was held at a location whose space did not accommodate the soccer tournament that had been held in conjunction with *Ama Tu Vida* in the past. Nor was this space able to host any other physical activities for youth. The limited space also reduced the number of exhibitors able to be accommodated at the festival. Hence, a new location will be identified for future festivals.

Ama Tu Vida Health Festival Measures and Results

OUTPUT MEASURES	RESULTS
Number of Participants	3,000
# Medical screenings performed*	2,561
# Abnormal results	40
OUTCOME MEASURES	
% Individuals who attended scheduled appointments	53%

*Number and Type of Medical Screenings Performed

SCREENING	NUMBER PERFORMED
Basal metabolic rate	200
Blood pressure	563
Body fat	200
Cholesterol	337
Glaucoma	150
Glucose	662
Grip strength	21
HIV	77
Pregnancy test	1
Total body water	200
Vision	150
Total	**2,561**



Asthma Management Program

"Aprecio mucho lo que está haciendo el Programa de Asma. Todo lo que aprendí lo estoy usando diariamente, tengo más cuidado al dar las medicinas a mi hijo y estoy muy pendiente de cómo evitar los desencadenantes del asma en mi hogar".

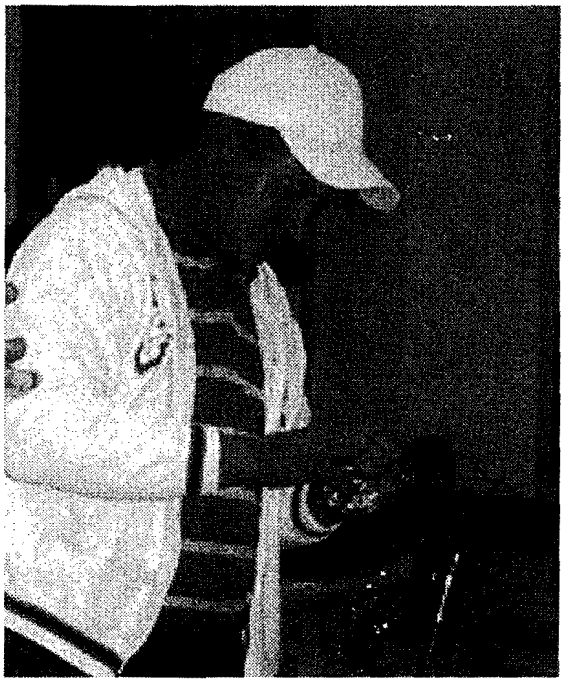
—Adriana, madre de un niño con asma

"I appreciate very much what the Asthma Program is doing. Everything I learned I am using daily. I am more careful with respect to the medicines I give to my child and I am very aware about what I need to do to avoid asthma triggers at home."

—Adriana, mother of a child with asthma

Asthma is the most common pediatric illness that disproportionately affects racial and ethnic minority children living in low socioeconomic urban environments. To address this disparity among the Latino community, the Asthma Management Program helps low-income Latino parents and caregivers better manage their children's asthma through culturally competent and linguistically accurate education interventions.

For more information on the Asthma Management Program visit http://www.lhiinfo.org/en-programs-and-activities/ Asthma-Management-Program.asp



Parent demonstrating the use of nebullizer.

FY12 ACCOMPLISHMENTS

- Reached 36 individuals who completed intensive education and support sessions on asthma management. Education sessions were held at Harmony Hills, Weller Road, and Gaithersburg elementary schools.
- *"Consedus"* (counselors/educators) contributed over 360 volunteer hours (representing 45 full day equivalents) of social support and counseling to overcome barriers faced by families.
- Offered 16-hour training on asthma to 18 volunteer asthma coaches (*Consedus*). The training enabled Consedus to enhance their ability to provide support to Latino parents of children with asthma.
- Engaged 3 Asthma Advisory Board members to serve as guest speakers during the *Consedus* training and as revisers of the Asthma Guide for Latino Parents.
- Reached 432 parents/caregivers and individuals with asthma through school activities and community health fairs.
- The Asthma Program Coordinator served as a member of the Maryland Asthma Control Program Executive Committee.
- Partnered with school officials at Viers Mill Elementary School to establish a parents club for children with asthma. This project empowers parents of children with asthma to work with school officials to reduce school-based environmental triggers. The goal is to convert Viers Mill Elementary School into an asthma-friendly school.
- Engaged 12 individuals in the parents club who delivered education material on school-based asthma control to 92 teachers and staff members.
- Developed the proposal for the Maryland Department of Health and Mental Hygiene (MDHMH) FY13 grant that was awarded $20,000.

FY12 ASTHMA MANAGEMENT PROGRAM MEASURES AND RESULTS

OUTPUT MEASURES	RESULTS
# Asthma outreach and community activities implemented	8
# Participants in outreach and community activities	432
# Education sessions conducted	24

QUALITY OF SERVICE MEASURES	RESULTS
% Participants who completed education interventions	72%
% Parents/caregivers satisfied with the Asthma Management Program	95%
% Participants reporting the Asthma Management Program helped their child's asthma management	100%
% Participants who feel their opinions, experiences, and worries were respected in the group	89%

OUTCOME MEASURES	RESULTS		
	PRE-TEST	POST- TEST	% CHANGE
Asthma management knowledge by parents/caregivers	70.1%	87.3%	24.5% Increase
Participants developing an asthma management plan	61.1%	94.4%	54.5% Increase
Reported use of asthma management plan	50%	94.4%	88.8% Increase
Fairly/very confident in ability to manage children's asthma	27.9%	96.1%	244% Increase
Reported emergency department visits due to asthma	13.9%	5.6%	59.7% Decrease
Reported hospitalization due to asthma	5.6%	0%	100% Decrease
Reported school days missed due to asthma	38.9%	22.2%	42.9% Decrease
Reported restricted activity due to asthma	22.2%	19.4%	12.6% Decrease

LESSONS LEARNED

Though the Asthma Management Program has improved parents' capabilities to better manage their children's asthma, this program cannot reduce morbidity in any substantial way without concurrent modifications in the ecosystem. Improving the school environment to remove asthma triggers requires multi-level participation. The pilot project to convert a school into an asthma-friendly one proved to be challenging. Creating an asthma-friendly school that includes built-in environmental trigger avoidances necessitates a concerted effort among a multitude of diverse players including the community, parents, and school.

Mother of a child with asthma explaining the the lung function.

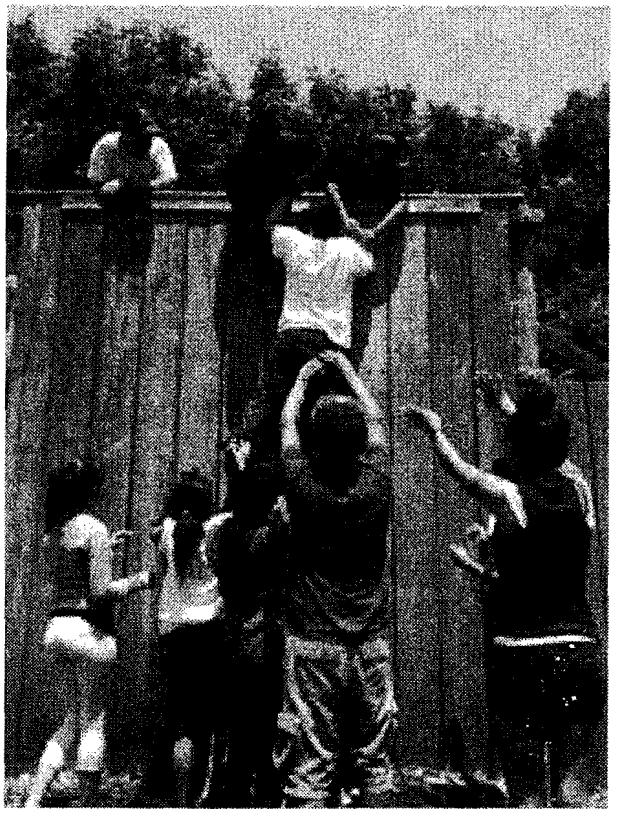
Latino Youth Wellness Program

"La mejor parte de este programa es que se debaten los puntos que más le importan y sobre los que tienen más curiosidad a los jóvenes. El programa ayuda a los estudiantes a tener una orientación positiva sobre habilidades para la vida, como en quién confiar y cómo tomar buenas decisiones por sí mismos. Las personas del programa desarrollaron una dinámica muy buena con los estudiantes, quienes se sintieron muy bien tratados. El programa no estuvo solamente centrado en las necesidades del estudiante sino también en las necesidades de la familia en el hogar".

—Margot, madre de uno de los participantes de la escuela intermedia Forest Oak

"The greatest part about this program is that it discusses the points that youth most care about and are curious about. The program helps participants have a positive orientation toward life skills such as who to trust and how to make good decisions for themselves. Facilitators had a great dynamic in regards to their relationship with students. Students felt they were treated fairly. The program not only focused on student needs but also on family needs at home."

—Margot, the mother of a participant at Forest Oak Middle School



Youth helping and supporting each other during a team building, leadership and fitness activity

The Latino Youth Wellness Program (LYWP), funded by the Latino Health Initiative (LHI) and implemented by Identity, Inc. since 2003, serves low-income and at-risk Latino youth living in Montgomery County. The overall goal of the LYWP is to increase protective factors and decrease risk factors among low-income Latino youth. The program is designed to expand young people's overall wellness knowledge base by promoting positive behaviors within a healthy family and community ecosystem.

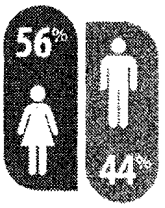
For specific information on the LYWP visit http://www.lhiinfo.org/en-programs-and-activities/Latino-Youth-Wellness-Program.asp

FY12 ACCOMPLISHMENTS

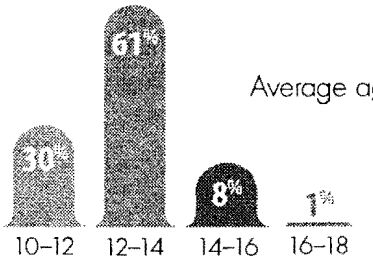
- Implemented the LYWP in 5 schools, including 4 middle schools (Forest Oak, Neelsville, Montgomery Village, Gaithersburg) and 1 high school (Northwood). The LYWP provided its Up County Youth Opportunity Center (Gaithersburg) clients with case management services.
- Developed a new curriculum for middle school students. This curriculum focuses on helping youth establish healthier and longer-lasting relationships with parents, school staff, other adults, and peers. The middle school curriculum includes 15 2½-hour sessions and a weekend retreat comprised of 25 programming hours.
- Served 220 low-income Latino families in Montgomery County.
- Created tailored wellness plans for 156 families to address identified needs (e.g., health insurance, access to affordable and culturally competent medical services, emergency food assistance, housing).
- Made 221 referrals to outside agencies based on the needs identified for each family, completing 161 of these referrals. Referrals related to domestic assistance (e.g., food, clothing), health insurance, other government assistance programs, legal services, and reproductive health services.
- Engaged in 107 hours of fitness training with 74 youth who enjoyed sports tournaments, hikes, and outings to sports facilities.
- Provided 30 hours of parent training to LYWP participants on topics such as communication with children, challenges of adolescence, ways to build a child's self-esteem, education resources in school and the community, Internet security, calculating GPA (grade point average), and interpreting report cards.
- Provided 7 weekend retreats for LYWP clients to practice positive teamwork, leadership, and conflict resolution skills in a fun and comfortable environment away from school and home distractions.
- Provided 139 youth with 343 hours of group training with middle school youth as part of Identity's After-School Program. Key indicators of these youth are summarized on the next page.

KEY INDICATORS OF LYWP YOUTH

Population



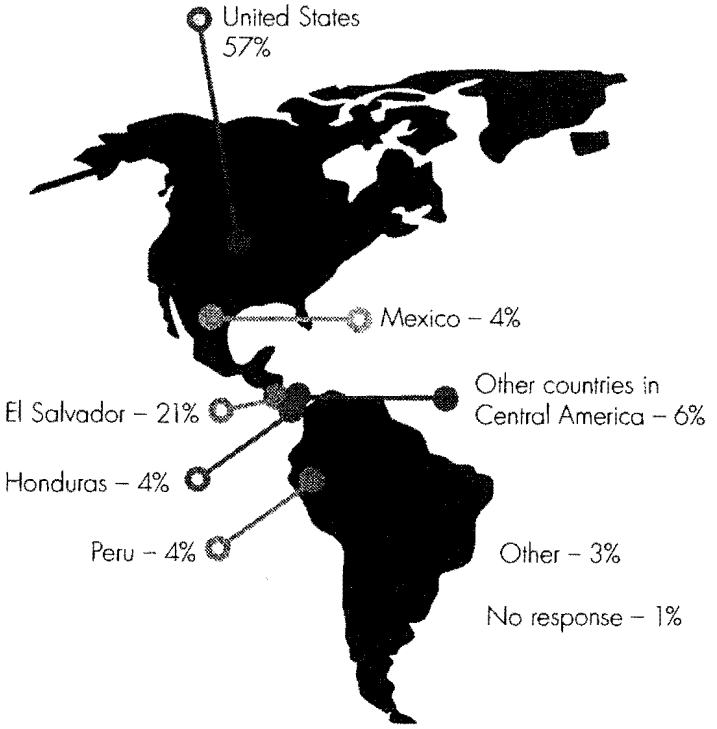
Gender



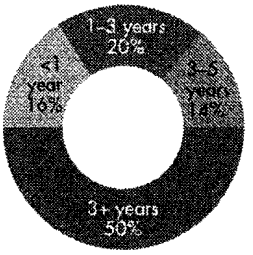
Average age 13 years

Age

Country of birth



Arrival to the U.S.



Socioeconomic indicators

- Receive Free and Reduced-Priced Meals (FARMS), 55%
- No health insurance, 21%
- Work during school year, 12%
- Precarious housing situation (e.g., one single room for entire family), 5%
- Average number of individuals living in same household, 7

Family & social support

- Live in single parent home, 26%
- Live without parents, 7%
- Separated from father at some point in life, 42%
- Separated from father for some length because of immigration issues, 20%
- Never knew father, 8%
- Separated from father because of father's incarceration, 5%
- Separated from mother at some point in life, 13%
- Separated from mother for some length because of immigration issues, 65%
- Never knew mother, 5%

FY12 LATINO YOUTH WELLNESS PROGRAM MEASURES AND RESULTS

The Latino Youth Wellness Program administered baseline and exit surveys with its participants. The following findings were observed regarding risky behaviors and attitudes.

OUTCOME MEASURES FOR PARTICIPANTS IN THE TRAINING PROGRAM

Risk or Protective Factor	Percent change
Self-esteem scale	41% Increase
Future expectations	39% Increase
Physical activity performance	28% Increase
Self-efficacy to refuse joining a gang	60% Increase
Self-efficacy to refuse unsafe sex	21% Increase
Depression scale	26% Decrease
Substance abuse attitudes	40% Decrease

POSITIVE CHANGES IN BEHAVIOR RELATED TO HEALTH AND WELLNESS

Risk or Protective Factor	Percent change
Change in healthy behaviors	32% Increase
Reproductive and HIV healthy behaviors	22% Increase
Relationship with parents	38% Increase
Substance abuse behaviors	40% Decrease
Delinquent behaviors	62% Decrease
Gang-related behaviors	73% Decrease

POSITIVE CHANGES IN LEADERSHIP SKILLS

Protective Factor	Percent change
Listening skills	26% Increase
Self-confidence to express opinions	78% Increase
Self-confidence to make decisions	41% Increase
Attitude towards working in a team	56% Increase

OUTPUT MEASURES	RESULTS
# Families served	220
# Hours of group training with parents	30
# Youth receiving intensive leadership training	74
# Counseling sessions to individuals and families	1,025
# Referrals	221
# Community advisory board group meetings	4
# Retreats	7
# Hours of fitness training	107
QUALITY OF SERVICE MEASURE	**RESULTS**
% Youth who would recommend program to friends	96%
% Youth feeling safe and respected in the program	98%

LESSONS LEARNED

The Latino Youth Wellness Program (LYWP) strives to develop a wellness plan for each participant. Unfortunately, many families have busy schedules and cannot attend a one-on-one meeting. To overcome this hurdle and be accessible, LYWP staff schedule wellness plan development sessions in the evenings and weekends, and even in clients' homes. These extra efforts help, but it is impossible to reach all participants.

The LYWP provides a weekend retreat to all After-School Program clients. This retreat offers a unique opportunity to practice positive teamwork, leadership, and conflict resolution skills in a fun and comfortable environment away from school and home distractions. Regrettably, not all parents are willing to allow their children to attend, despite staff efforts to reach out to parents to allay fears about supervision and safety.

Smoking Cessation Program

"Para mí fue muy importante participar. Tengo un niño de nueve meses y mi esposa es sobreviviente de cáncer cervical. Por ellos sé que no debería fumar. Pero cada vez que intenté de parar de fumar me ponía muy irritable y no podía continuar con el intento. Para mí, compartir nuestras experiencias y venir a las clases de cesación ha sido de gran ayuda. He dejado de fumar desde hace cuatro semanas".

—Alexander, participante del programa de cesación de tabaco

"For me, it was very important to participate. I have a 9-month-old baby son and my wife is a cervical cancer survivor. For them, I know I should not smoke. But each time I tried to quit I became irritable and I could not continue with the intent. For me, sharing our experiences and coming to the cessation classes has been very helpful. I have stopped smoking as of four weeks."

—Alexander, smoking cessation participant

FY12 Smoking Cessation Program Closing Celebration participants with family

Despite drastic funding cuts over the past seven years, the Smoking Cessation Program has demonstrated how culturally and linguistically appropriate interventions can help Latino smokers who want to quit smoking. Individuals who participate in this program understand the importance of their decision to stop using tobacco products, the detrimental effects of using tobacco products, the importance of following a personal quit plan, and ways to avoid relapses.

For more information on the LHI's Smoking Cessation Program visit http://www.lhiinfo.org/en-programs-and-activities/Tobacco-Cessation-Program.asp

FY12 ACCOMPLISHMENTS

- Completed group intervention sessions successfully (14 smokers registered to participate in the classes, and 10 actively participated and completed the course with all 10 smokers quitting at the end of the intervention).
- Offered Nicotine Replacement Therapy (NRT) and used by 9 of 10 participants.
- Developed individual plans to quit smoking (all program participants received group and individual counseling and each participant developed their own plan to quit smoking).

FY12 SMOKING CESSATION PROGRAM MEASURES AND RESULTS

OUTPUT MEASURES	RESULTS
# Smokers invited to participate	63
# Persons registered for the group sessions	14
# Smokers participating in the group sessions	12
% Participants who completed the program	83.3%
QUALITY OF SERVICE MEASURE	**RESULTS**
% Participants satisfied with the program	100%
OUTCOME MEASURES	**RESULTS**
% Change in knowledge about hazards of tobacco use	45.8%
% Smoke-free participants at the end of the 6-week group intervention	90%
% Smoke-free participants at the end of 12 month intervention (Quit rate after a year for smokers who quit during FY11*)	20% (n=5)

*The program twice contacted 9 successfully quitting participants from last year's smoking cessation courses. The program was only able to reach 5 of these 9 participants.

LESSONS LEARNED

The most challenging components of the Smoking Cessation Program intervention is identifying and reaching smokers willing to try the program, preparing them to quit smoking, and actively engaging them in the smoking cessation sessions. Because of limitations in funding, the program is offered only once every fiscal year. The smoking cessation program should be available on an ongoing basis. Offering this service only once a year, furthermore, makes it very difficult for those Latino smokers to access opportune help after relapse.

A very high proportion (80%–90%) of the Latino participants who attended the smoking cessation groups used nicotine replacement therapy (NRT) at some point during their effort to quit. When some participants expressed concerns about NRT at the beginning of the intervention, those concerns evaporated when they received the NRT class that discusses the pros and cons of this treatment, as well as reviews how to use NRT properly and the process necessary for quitting successfully.

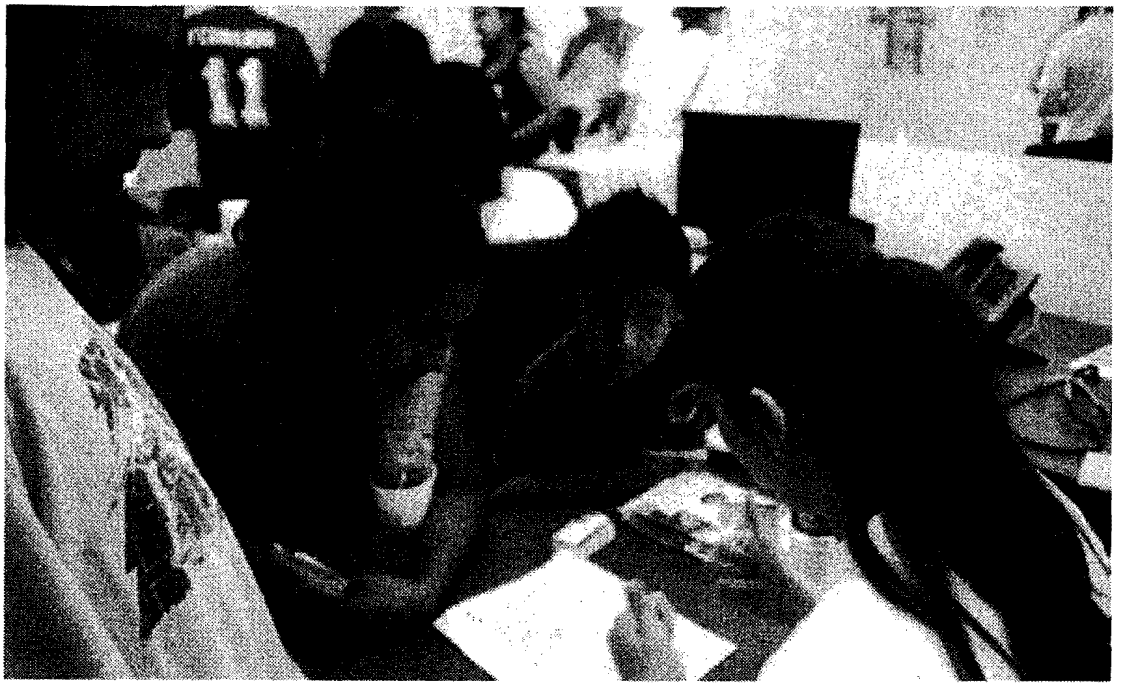
System Navigator and Medical Interpreter Program

"No puedo darle un valor monetario a la habilidad de poder entender a mi doctor. Muchas veces durante mis visitas médicas me sentía frustrado por la barrera del idioma. Puedo hablar un poco de inglés, pero no lo suficiente para entender correctamente las instrucciones que se me daban. El intérprete fue de gran ayuda, me siento que se me quitó un peso de encima".

—Alberto Cuellar, paciente que recibió servicios de interpretación

"I cannot put a price on the ability to understand my doctor. Often during my medical appointments, I felt frustrated by the language barrier. I can speak a little English but not enough to truly understand the instructions that were given to me. The interpreter was of great help. I feel as if a huge weight has been lifted off of me."

—Alberto Cuellar, patient who received interpretation services



An interpreter helps a client to fully understand doctor's indications.

Montgomery County's Latino residents continue to experience a number of health disparities—ones exacerbated by a disproportionate lack of health insurance and preventative care. Further complicating matters, unfamiliarity with the United States healthcare system, confusion over eligibility requirements, and the current political environment have converged to create a climate of distrust among the immigrant community. This distrust is particularly aimed toward mainstream and government-related providers and programs that all too often fall short on culturally and linguistically competent services. The System Navigator and Medical Interpreter Program seeks to help Latinos with Limited English Proficiency (LEP) attain access to health and human services via a bilingual information and navigation hotline. Under contract with the Office of Community Affairs (Department of Health and Human Services), CASA de Maryland delivers this program.

For more information on the System Navigator and Medical Interpreter Program visit http://www.lhiinfo.org/en-programs-and-activities/System-Navigator-and-Interpreter-Program.asp

FY12 ACCOMPLISHMENTS

- Served 2,689 community members with information, referrals, and system navigation through the assistance of the Bilingual Health and Social Services Information Line.
- Provided 4,001 referrals to health and human services. (See the following table on common reasons for calling the system navigator.)
- Conducted 2,106 medical interpretations at Mercy Health Clinic, Mobile Medical Care, Holy Cross Hospital Health Center, Mansfield Kaseman Health Clinic, other Department of Health and Human Services agencies, and specialty care providers in Montgomery County.
- Contracted with 7 certified medical interpreters to provide services, mainly in Spanish and French. (Certification is obtained 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.)

EVALUATION OF THE SYSTEM NAVIGATOR AND MEDICAL INTERPRETER PROGRAM

To obtain information about their experience and evaluate their satisfaction with the System Navigator and Medical Interpreter Program staff surveyed 3% of all community members served by the Bilingual Health Information Hotline, as well as 3% served by the program's medical interpreters. Overall, the program yielded 99% and 97% positive customer satisfaction of the Bilingual Health Information Hotline and medical interpreter program, respectively.

LESSONS LEARNED

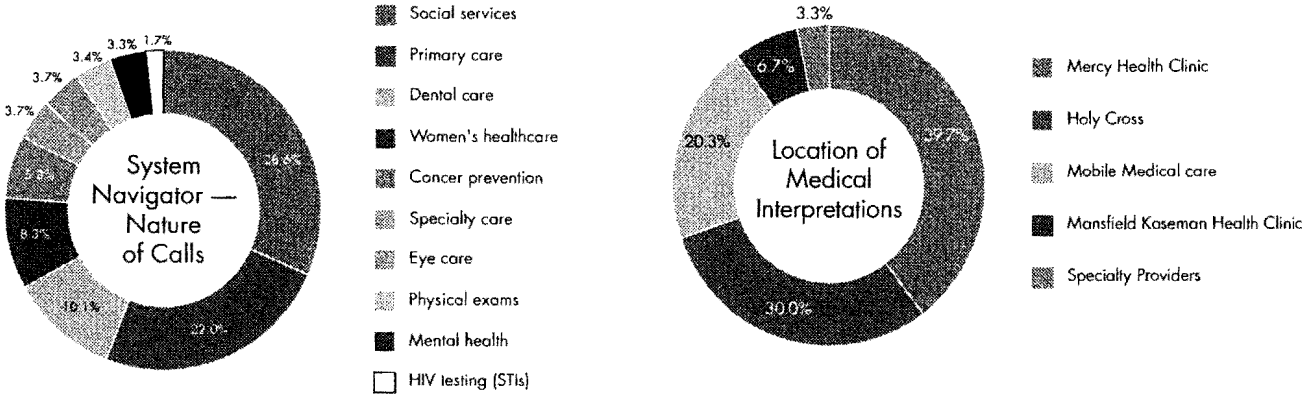
Having too few bilingual and bicultural health professionals in Montgomery County continues to present major barriers to Latinos' ability to access healthcare. Although the System Navigator and Medical Interpreter Program currently dispatches interpreters to at least five safety net clinics and programs across the County, the program receives numerous requests from both community clinics and clients that cannot be addressed because of limited funding. An important way to reduce language barriers during the patient-

provider encounter is to allocate the needed resources so that the program can function at an optimal level. The continued economic slump has further reduced the availability of health and human services in the community. As a result of the reduction or elimination of such services altogether, the program has encountered obstacles to facilitating access to these services. For example, many clients who have called the Bilingual Information Line, particularly for primary care services and mammograms, have only been met with long waiting periods.

FY12 SYSTEM NAVIGATOR AND MEDICAL INTERPRETER PROGRAM MEASURES AND RESULTS

OUTPUT MEASURES	RESULTS
# Bilingual Information Line call assessments	2,689
# Referrals by information specialists	4,001
# Medical interpreter appointments	2,106
OUTCOME MEASURES	**RESULTS**
% Clients accessing services	98.0%
% Medical interpretations completed	98.9%
QUALITY OF SERVICE MEASURES	**RESULTS**
% Satisfaction with Bilingual Information Line[1]	99.0%
% Satisfaction with Medical Interpreter services[2]	97.0%

[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.



143

Vías de la Salud Health Promoter Program

"Me da mucha satisfacción ser promotora de salud. Trabajar con la comunidad latina es mi pasión. Un día mientras distribuía volantes para reclutar participantes para una caminata recluté a una señora salvadoreña de 64 años que sufre de diabetes, presión arterial y colesterol alto. A pesar de todos los obstáculos que enfrenta, ella ha participado en todos los eventos que hemos organizado y muestra interés en lo que le enseñamos para mejorar su salud. Realmente la admiro y me inspira para seguir trabajando como promotora de salud".

—Ana Miriam Cáceres, Promotora de Salud, *Vías de la Salud*

"It gives me great satisfaction being a health promoter. My passion is working with the Latino community. A while ago when I was distributing flyers to recruit walking session participants, I recruited a 64-year-old Salvadoran lady who suffers from diabetes, hypertension, and high cholesterol. Despite all the obstacles she faces, she has participated in all the events we have organized since then and shows interest in what we are teaching to improve her health. I truly admire her and she inspires me to continue working as a health promoter."

—Ana Miriam Cáceres, *Vías de la Salud* Health Promoter

Vías de la Salud Health Promoters, FY12 Annual Retreat

Research indicates that culturally competent and linguistically accurate health promotion efforts contribute to increased access to healthcare and the prevention or reduction of health problems in a cost-effective manner. Through the efforts of lay community health workers, the *Vías de la Salud* Health Promoter Program promotes healthy behaviors and facilitates access to services for low-income Latino people residing in Montgomery County.

Vías de la Salud health promoters are divided into two groups. Those with more than 5 years of training and experience are known as *"Amiga"* or *"Amigo."* Health promoters with less than 5 years of experience known as *"Novel."*

The *"Caminatas"* (walking sessions) are an important activity that *Vías de la Salud* conducts to promote healthy lifestyle behaviors.

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

FY12 ACCOMPLISHMENTS

- Reached 7,898 individuals through education interventions at health fairs, schools, churches, community centers, and neighborhoods.
- 17 *Amiga* health promoters completed their participatory methodology training by successfully passing their theoretical exam and demonstrating the skills they acquired as facilitators during their practical exam. The *Amiga* health promoters were awarded completion certificates.
- 8 *Novel* health promoters completed 10 hours of training on healthy eating (classroom and hands-on practice).
- The cadre of *Novels* met all the *Amiga/Amigo* level requirements over the past four years and thus officially advanced to the *Amiga/Amigo* level.
- 95 adults and children participated in 5 *Caminatas* (held at Millian Memorial Church in Rockville, Twinbrook Elementary School, Wheaton Woods Elementary School, Harmony Hills Elementary School, Gaithersburg Elementary School). Pre-/post-tests showed 81% of the participants reported intending to incorporate physical activity into their daily lives.
- *Vías de la Salud* continued participating with Millian Memorial Church's Coalition of Community Partners of Aspen Hill and Wheaton. Through this partnership, health promoters were able to conduct health education sessions twice a month with families that use the services of the Church's food pantry program. *Vías de la Salud* also supported Millian Memorial Church's Annual Health Festival by promoting the event, recruiting participants, and providing education services the day of the event.
- During the second half of FY12, *Vías de la Salud* received extra funding to implement additional outreach activities aimed to disperse information about the newly created Family Planning State Program. Health promoters were able to invest extra efforts and time to reach out to the community. From February to June 2012, health promoters conducted 241 interventions reaching 2,775 Latino individuals.

FY12 *VÍAS DE LA SALUD* PROGRAM MEASURES AND RESULTS

OUTPUT MEASURES	RESULTS
# Families referred to MCHP, Care for Kids, and other county programs	609
# Volunteer hours from Health Promoters	3,172
# Persons reached by Health Promoters	10,673
QUALITY OF SERVICE MEASURES	**RESULTS**
% Health Promoter satisfaction with the program	96%
% Health Promoters retained in the program	100%
OUTCOME MEASURES	**RESULTS**
% Change in knowledge of physical activity by walking session participants	23%
% Change in behavior intent related to physical activity of walking session participants	81%

LESSONS LEARNED

The departure in the second half of this fiscal year of the Health Promotion Specialist altered the *Vías de la Salud* program's work plan and posed significant challenges to the achievement of scheduled programmatic activities. During the first semester of the fiscal year, the program put into effect some changes that negatively affected the health promoter community work. One of the changes mandated by the HHS County Financial Office related to the procedures on how the incentive was to be given to health promoters. Another major change was the reduction in the number of regular group meetings. We learned that a group of Health Promoter volunteers has an important need to feel connected and valued, as well as encouraged continuously.

Welcome Back Center of Suburban Maryland

"The Welcome Back Center helped me start the credentialing evaluation process. Once I completed this and passed the English exam, I was able to apply for a position as a nurse-in-training in a hospital, and this year, 2012, I was able to make my dream of becoming a Registered Nurse in the state of Maryland a reality. I am working happily as a full-time RN at Holy Cross Hospital. I thank the Welcome Back Center for its support and guidance. Together we can do it. Thank you so much!"

—Luciana Castro, RN, Welcome Back Center participant

Welcome Back Center participants at welcome and orientation session

The Welcome Back Center of Suburban Maryland(WBC) is an innovative model that builds on the personal and professional assets of internationally trained healthcare professionals by helping them re-enter the healthcare workforce in the United States.

The Latino Health Initiative (LHI) spearheads the WBC, working in collaboration with academic and private sectors, as well as local and State government, partners. For more information on the WBC visit http://www.lhiinfo.org/en-programs-and-activities/Welcome-Back-Center.asp

FY12 ACCOMPLISHMENTS

- Guided 8 WBC participants in successfully passing the Registered Nurse (RN) Licensure Exam, 9 WBC participants in successfully securing RN positions, and 1 WBC participant in successfully securing a phlebotomist position.
- Provided services to 261 internationally trained healthcare professionals.
- Provided full services (case management, financial assistance, English instruction, and internships at local hospitals) to 95 internationally trained nurses working towards their RN licensure.
- Selected 27 additional internationally trained nurses and began recruiting behavioral health professionals and physicians (to be completed FY13).
- Maintained a cadre of 12 WBC nurses participating in on-the-job practical exposure to the United States healthcare system working as nurses-in-training at local hospitals.
- Offered nearly $44,000 in financial assistance for training and support expenses to eligible WBC participants.
- Provided pre-employment services for healthcare-related jobs, career development support, and job readiness training.
    - Offered job seekers a seminar at the WBC and made referrals to the Upwardly Global webinars on resume writing for healthcare jobs and other relevant topics.
- Provided support to over 50 internationally trained physicians participating in the Welcome-Back-Physicians Google Group to promote: professional networking in the healthcare field; the process for obtaining licensure in the United States; and ways of exploring other career opportunities in the healthcare field.
    - At least one participating physician secured a job in the healthcare field.
- Supplied 36 hours of telephone and email communication with approximately 157 individuals (including 104 foreign-trained health professionals: 73 nurses, 19 physicians, 8 psychologists, 2 dentists, and 2 obstetricians) who contacted the WBC inquiring about services and participation requirements.
- Revised and updated the WBC website to include friendly and succinct content. The "Guide to Complete the Steps for Foreign-Trained Nurses to Obtain the Maryland Registered Nurse (RN) License" is now available in English, Spanish, and French.
- Secured $87,000 in funding, to be received in FY13 and FY14. This funding is part of an award to the national Welcome Back Initiative through the Kaiser Foundation's Community Health Initiatives Grants Program.

FY12 WBC MEASURES AND RESULTS

OUTPUT MEASURES	RESULTS	OVERALL CUMULATIVE RESULTS FY07—FY12 NUMBER	HOURS
Participants	95 nurses	129 nurses	----
Hours of individual case management with participants	86 hours	----	831 hours
Hours of group guidance and support	17.5 hours	----	184 hours
QUALITY OF SERVICE MEASURES	**NUMBER/PERCENT**	**NUMBER**	**PERCENT**
Participants retained	91 nurses	122 nurses	95%
Participants satisfied	93%	----	-----
OUTCOME MEASURES	**NUMBER/PERCENT**	**NUMBER**	**PERCENT**
Participants completing credentials evaluation	11 nurses	68 nurses	53%
Participants passing English oral proficiency exam	12 nurses	66 nurses	51%
Participants passing Nursing Licensure Exam as RN	8 nurses	38 nurses	29%
Participants working as Nurses-in-Training in Maryland	8 nurses	43 nurses	33%
Participants who began working in their profession as RNs in Maryland	9 nurses	31 nurses	24%
Participants who began working in the healthcare field in Maryland other than as RNs	2 nurses	2 nurses	2%
Participants obtaining alternative license:			
Licensed Practical Nurse – LPN	-----	1 nurse	1%
Certified Nursing Assistant – CNA	9 nurses	47 nurses	36%
Phlebotomist	1 nurse	1 nurse	1%
Average time to complete the WBC program (from entering program until passing RN licensure exam)	25 months	38 nurses	20 months
Average increase in wages (from entering the WBC program until hired as RNs)	216%	31 nurses	181%

LESSONS LEARNED

Although the Health Resources and Services Administration-earmarked funds, through the Maryland Hospital Association and American Recovery and Reinvestment Act/Workforce Investment Act grant that ended FY11, were slashed from the FY12 WBC budget, we secured additional FY12 funding from the Annie E. Casey Foundation and the Healthcare Initiative Foundation. Availability of Nurse-in-Training jobs at partner hospitals to provide WBC participants on-the-job practical exposure to the United States healthcare system, furthermore, decreased from 17 to 12 job positions during FY12. Budget and position reductions limited the WBC's ability to expand services to additional nurses and other healthcare professionals. Given the trend in the last three fiscal years of diminished funding to expand services, we worked with the WBC's Advisory Council to institutionalize key WBC functions and prepare for a small-scale expansion to serve professions other than nursing. Advisory Council recommendations helped the WBC make critical decisions related to next steps. We will simultaneously maintain current services to nurses and initiate a FY13 expansion with two small pilot programs, one with internationally trained behavioral health professionals and the other with physicians.

WBC participants at welcome and orientation session

OTHER FY12 LATINO HEALTH INITIATIVE (LHI) ACTIVITIES

In FY12, the Latino Health Initiative (LHI) showcased its diverse assets by:

- Engaging as active participant of the coordinating team that coalesced senior DHHS 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. Efforts focused on assessing existing services and practices at all DHHS levels and identifying challenges and gaps as well as opportunities for enhancement. Specific recommendations will be crafted in FY13.
- Providing technical guidance to the Maryland Department of Health and Mental Hygiene (MDHMH) in its efforts to identify opportunities for the DHMH to improve the service landscape for Latinos and to develop a work plan addressing four priority areas: (1) data collection, analysis, and reporting, (2) communications and outreach, (3) limited English proficiency and cultural competence, and (4) workforce diversity.
- Delivering a presentation on the Welcome Back Center during the panel, "Non-Traditional Pathways into the Health Professions," at Maryland's 8th Annual Statewide Minority Health Disparities Conference, *Maryland's Health Workforce: Promoting Diversity and Strengthening the Pipeline* (Hyattsville, Maryland, October 4, 2011).
- Presenting at the 139th annual American Public Health Association meeting's session, "Diverse Communities Working to Achieve Better Health" (October 31, 2011).
- Presenting the Asthma Management Program model and its accomplishments to the IMPACT DC Asthma Clinic staff, Children's National Medical Center.
- Presenting on the Welcome Back Center work and engaging in dialogue to identify ways to strengthen collaboration with the Montgomery County Workforce Investment Board (November 16, 2011).
- Presenting on the Welcome Back Center work during the "Success Strategies: Education" panel at the "Redefining Social Capital: Attracting and Supporting New Immigrants" meeting (Baltimore, Maryland, June 7, 2012).
- Dedicating hundreds of hours of time to support critical initiatives and DHHS projects (e.g., Healthy Montgomery, Equity and Social Justice Project, Quality of Service Review, revamp of DHHS website, Business Process Re-engineering).
- Landing an interview with a Welcome Back Center participant that was featured in the article, "Initiatives Are Bringing More Latinos into Healthcare," by Rosa D. Talavera in the on-line publication, *All Healthcare Jobs*, November 8, 2011. Available at http://career-news.allhealthcarejobs.com/2011/11/07/initiatives-are-bringing-more-latinos-into-healthcare/

FY12 FUNDS RECEIVED AND INVESTED

During FY12, the Latino Health Initiative (LHI) received a total of $1,151,964 from Montgomery County general funds.

Expenses for FY12 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, *Ama Tu Vida* Campaign).* This category accounts for 97% of the LHI's core budget expenditures.
- **Administrative:** This includes operational expenses such as for Latino Health Steering Committee (LHSC) support, interpretation services, office equipment, supplies, printing, parking permits for staff, and mileage reimbursement. This category accounts for 3% of LHI's core budget expenditures.

Despite heavy workloads, LHI staff worked hard during FY12 to leverage $188,500 in additional funds from public and private sources. These monies helped offset the impact of previous cuts and increased demand for services.

FY12 LEVERAGED FUNDS

FUNDING SOURCE	AMOUNT
Vías de la Salud Health Promoter Program (Maryland Department of Health and Mental Hygiene via Public Health Services, DHHS)	$10,500
Smoking Cessation Program (Cigarette Restitution Funds)	$10,000
Asthma Management Program	$20,000
Welcome Back Center of Suburban Maryland (Maryland Department of Labor, Licensing and Regulations; Annie E. Casey Foundation; Montgomery County Health)	$148,000
TOTAL	$188,500

The total budget for the Latino Health Initiative (LHI) for FY12 was **$1,340,464**.

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

FY12 PARTNERS AND COLLABORATORS

Adventist Healthcare
American Cancer Society
Annie E. Casey Foundation
Asthma Control Program, Maryland Department of Health and Mental Hygiene
Baltimore Alliance for Careers in Health
Care for Your Health, Inc.
CASA de Maryland
Community Clinic, Inc.
Community Ministries of Rockville
George Washington University
Governor's Commission on Hispanic Affairs
Governor's Workforce Investment Board
GUIDE Program, Inc.
Holy Cross Hospital
Holy Cross Lung Cancer Prevention Program
Identity, Inc.
IMPACT DC Asthma Clinic of the Children's National Medical Center
Institute for Public Health Innovation
Maryland Department of Labor, Licensing and Regulations
Maryland Hospital Association
Maryland Multicultural Youth Center
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 Healthcare Initiative Foundation
Montgomery County Workforce Investment Board
Montgomery County Latino Lions Club
Montgomery Medstar Medical Center
Montgomery Works One-Stop Workforce Center
Primary Care Coalition
Prince Georges County Economic Development Corporation
Priority Partners MCO
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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Montgomery Cares Program Report
Mid-Year FY2013

Sharon Zalewski, Director, Center for Health Care Access
Barbara Raskin, Montgomery Cares Program Manager
December 2012

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151

YTD Patients and Encounters – December 2012

Year to Date	FY13 Unduplicated Patients			FY13 Encounters			Reimbursement
Clinic	FY 2013 Projected Patients	FY13 Unduplicated Patients	FY13 % of Projection	FY13 Projected Encounters	FY13 YTD Encounters	FY13 % of Target Met	Mcares Payment $62/visit *,**
CCACC-PAVHC	600	291	49%	1,200	445	37%	$27,590
Community Clinic, Inc.	3,585	2,039	57%	11,998	4,260	36%	$264,120
CMR - Kaseman Clinic	2,250	1,129	50%	5,200	2,129	41%	$131,998
Holy Cross Hospital Health Centers	6,131	4,113	67%	18,180	8,295	46%	$514,290
Mary's Center	888	608	68%	2,344	1,152	49%	$71,424
Mercy Health Clinic	2,128	1,431	67%	6,057	3,574	59%	$221,588
Mobile Med	6,000	3,613	60%	15,000	6,875	46%	$426,250
Muslim Community Center Clinic	2,500	1,728	69%	7,500	3,520	47%	$218,240
Proyecto Salud - Wheaton & Olney	5,000	3,439	69%	13,675	7,363	54%	$456,506
Spanish Catholic Center	1,100	684	62%	3,000	1,543	51%	$95,666
The People's Community Wellness Center	875	522	60%	2,050	943	46%	$58,466
General Medical Clinic Sub-totals	31,057	19,597	63%	86,204	40,099	47%	$2,486,138
Montgomery Cares FY13 Budget	32,250		61%	85,625		47%	$5,308,750
CCI - Homeless**	535	105	20%	600	226	38%	$32,318
CMR - Kaseman Clinic - Homeless**	273	68	25%	300	139	46%	$19,877
Homeless Medical Clinic Sub-totals	**808**	**173**	**21%**	**900**	**365**	**41%**	**$52,195**
Medical Clinic Totals	**31,865**	**19,770**	**62%**	**87,104**	**40,464**	**46%**	**$2,538,333**
Homeless encounters are reimbursed at $143 per visit. Homeless Medical Clinic reimbursements are a separate budget line item.							

Clinic - Pilot Program	Patient Panel	Number of Encounters	Payments
Care For Your Health	29	47 Primary Care 29 Telemedicine 18	$2,100

***Care for Your Health is a pilot program paid on a capitation basis. Provider is reimbursed $16.67 per person per month.**

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Montgomery Cares Mid-Year Performance

Encounters

- 7 Clinics are between 46-54 % of their projected encounters.
- 1 Clinic is at 59% of its projected encounters.
- 3 Clinics are between 36-41% of their projected encounters.

Unduplicated Patients

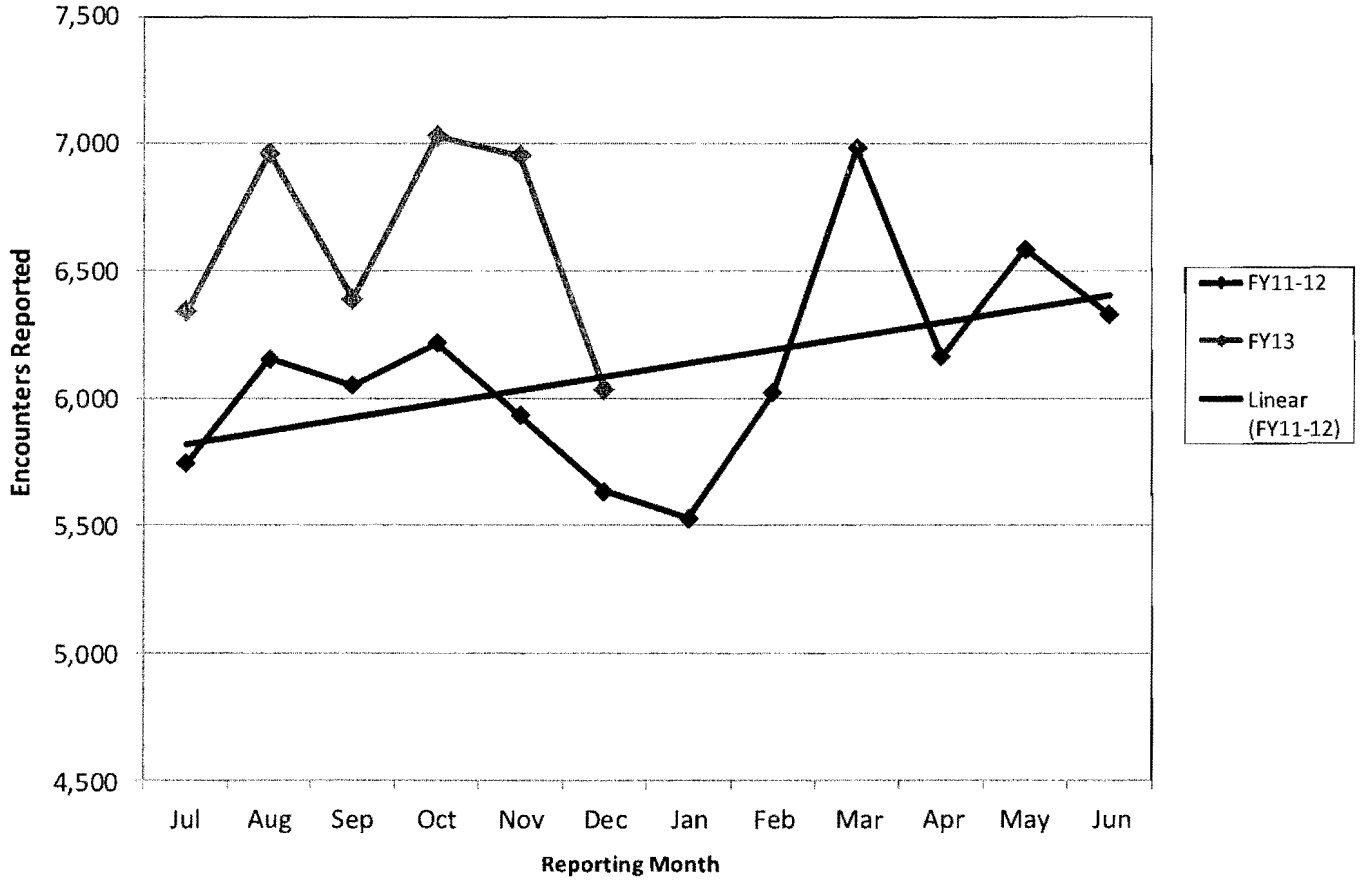
- Eleven of 12 clinics reached 49% or more of their projected number of unduplicated patients; five are between 67-69%.
- Care for Your Health reached 10% of its target panel.

Length of Appointment Wait Time

- New Patient Appointments
  - 3 clinics can see patients immediately; 1 of these clinics can provide same day appointments based upon triage.
  - 7 clinics can provide new patients with appointments within 1 week;
  - 2 clinics have a 2 week wait;
  - 3 clinics have a 3 – 4 week wait.

151

Growth Trends
FY11/12 Compared to FY13



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191

YTD Patients and Encounters – January 2013

Year to Date	FY13 Unduplicated Patients			FY13 Encounters			Reimbursement
Clinic	FY 2013 Projected Patients	FY13 Unduplicated Patients	FY13 % of Projection	FY13 Projected Encounters	FY13 YTD Encounters	FY13 % of Target Met	Mcares Payment $62/visit *,**
CCACC-PAVHC	600	322	54%	1,200	522	44%	$32,364
Community Clinic, Inc.	3,585	2,264	63%	11,998	5,110	43%	$316,820
CMR - Kaseman Clinic	2,250	1,257	56%	5,200	2,561	49%	$158,782
Holy Cross Hospital Health Centers	6,131	4,607	75%	18,180	10,023	55%	$621,426
Mary's Center	888	803	90%	2,344	1,646	70%	$102,052
Mercy Health Clinic	2,128	1,503	71%	6,057	4,234	70%	$262,508
Mobile Med	6,000	3,901	65%	15,000	8,246	55%	$511,252
Muslim Community Center Clinic	2,500	1,922	77%	7,500	4,116	55%	$255,192
Proyecto Salud - Wheaton & Olney	5,000	3,752	75%	13,675	8,637	63%	$535,494
Spanish Catholic Center	1,100	684	62%	3,000	1,822	61%	$112,964
The People's Community Wellness Center	875	570	65%	2,050	1,126	55%	$69,812
General Medical Clinic Sub-totals	31,057	21,585	70%	86,204	48,043	56%	$2,978,666
Montgomery Cares FY13 Budget	32,250		67%	85,625		56%	$5,308,750
CCI - Homeless**	535	NA		600	NA		
CMR - Kaseman Clinic - Homeless**	273	NA		300	NA		
Homeless Medical Clinic Sub-totals	**808**			**900**			
Medical Clinic Totals	**31,865**	**21,585**	**68%**	**87,104**	**48,043**	**55%**	

**Homeless encounters are reimbursed at $143 per visit. Homeless Medical Clinic reimbursements are a separate budget line item.

Year to Date Clinic	Patient Panel	Number of Encounters	Payments Year to Date
Care For Your Health	36	63 Primary Care 44 Telemedicine 19	$2,701

*Care for Your Health is a pilot program paid on a capitation basis. Provider is reimbursed $16.67 per person per month.

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101

Montgomery Cares January 2013

The benchmark for January is 58% of target.

Encounters

- 6 Clinics are between 55-63 % of their projected encounters.
- 2 Clinics are at 70% of their projected encounters.
- 3 Clinics are between 43-49% of their projected encounters.

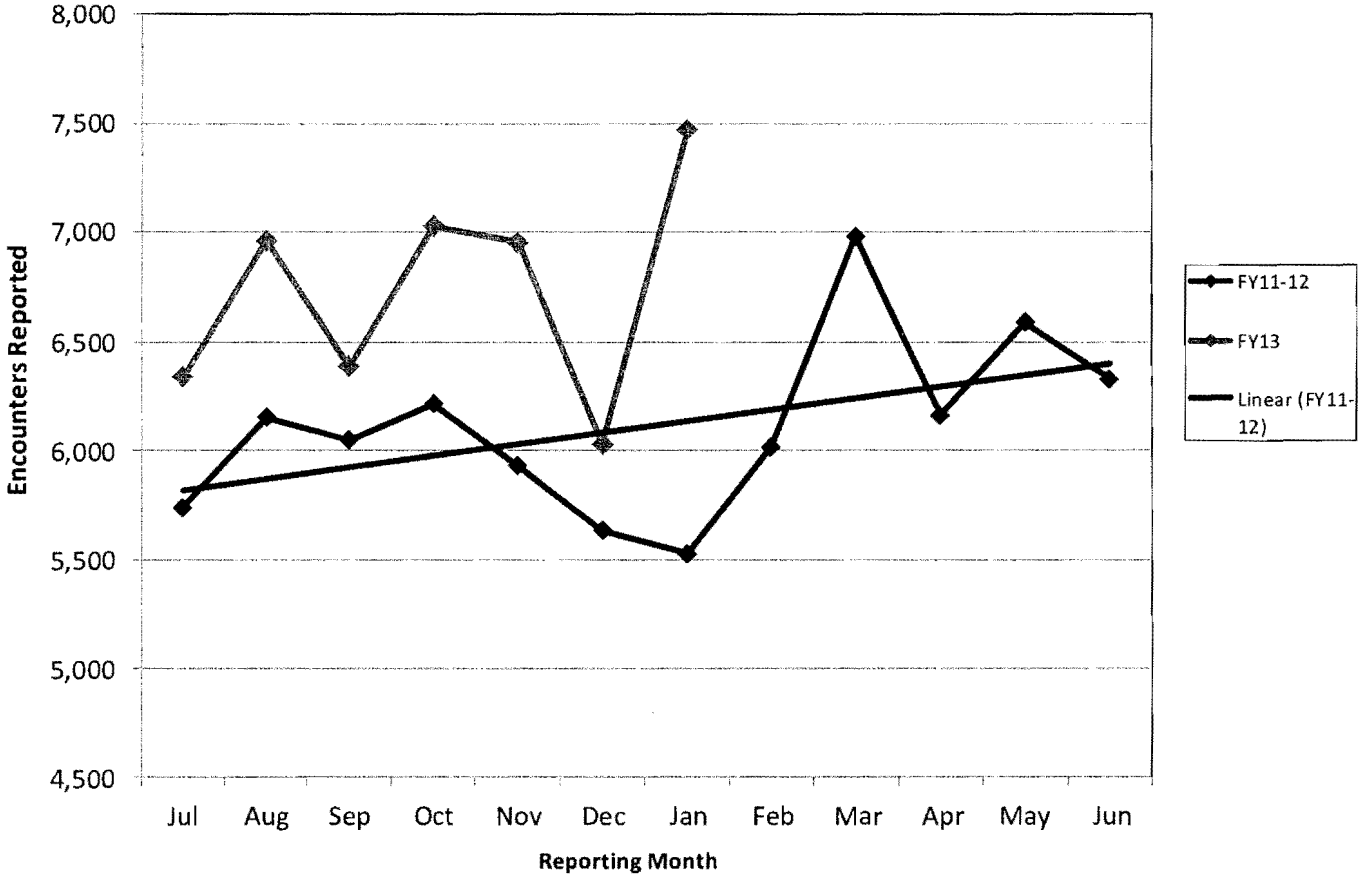
Unduplicated Patients

- 2 Clinics are between 54-56% of their projected targets.
- 9 of 12 clinics have surpassed the 58% benchmark for their projected number of unduplicated patients.
  - 4 Clinics have reached between 62-65% of their projected targets.
  - 4 Clinics have reached between 71-77% of their projected targets.
  - 1 Clinic has reached 90% of its projected target.
- Care for Your Health reached 12% of its target panel adding 7 new patients in a one month period.

Length of Appointment Wait Time remained unchanged from the mid-year report.

191

Growth Trends
FY11/12 Compared to FY13



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163

Community Pharmacy Expenditures
FY13 Q2

Category	FY13 Budget Allocation	Q1	Q2	Total Expenditure	% Expenditure	Budget Remaining	% Remaining
General Formulary	$873,644	$246,613	$234,390	$481,003	55%	$392,641	45%
Diabetic Supplies/ H. Pylori	$262,936	$41,617	$90,176	$131,793	50%	$131,143	50%
Behavioral Health	$60,622	$18,352	$12,183	$30,535	50%	$30,087	50%
Vaccine	$60,622	$40,154	$6,025	$46,179	76%	$14,443	24%
Bradley	$3,000	$419	$592	$1,011	33%	$1,989	67%
Total	$1,260,824	$347,155	$343,366	$690,521	55%	$570,303	45%

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191

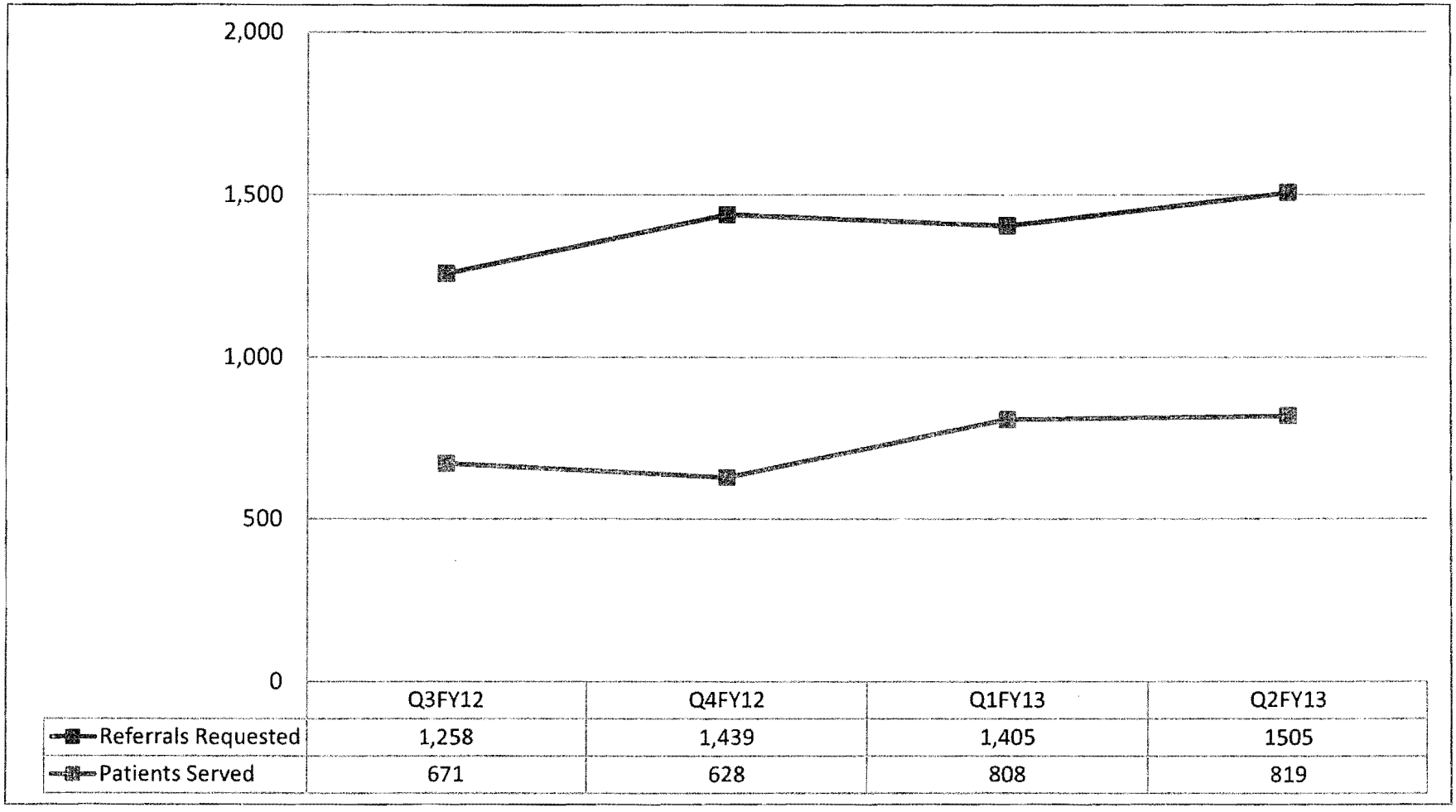
Montgomery County Medbank
FY13 Q2

Category	Q1	Q2	Total
Value of Medications Received	$745,356	$724,848	$1,470,204
Number of Prescriptions Requested	1,884	1,643	3,527
Number of Prescriptions Received from Pharmaceutical Companies	1,266	1,041	2,307
Medication Received Success Rate	67%	64%	65.50%
Total Patient Volume (Average)	1,562	1,624	1,593
• Active Patients (Average)	1,450	1,529	1,489
• Inactive Patients (Actual)	112	95	207
New Enrollees (Quarterly) (captured in the total patient volume)	146	122	268

Specialty Care Appointments by Source FY13

Appointment Source	1st Q	2nd Q	3rd Q	4th Q	Cumulative Totals	FY12 Totals
Clinic On-Site Specialty Care	1,207	1,163			2,370	5,211
AHCN	312	369			681	1,300
Project Access	699	613			1,312	2,256
MM Heart Clinic	119	136			255	570
Total	**2,337**	**2,281**			**4,618**	**9,337**

Specialty Network Referral Requests vs. Patients Served
Third Quarter FY12 – Second Quarter FY13



	Q3FY12	Q4FY12	Q1FY13	Q2FY13
Referrals Requested	1,258	1,439	1,405	1505
Patients Served	671	628	808	819

Note: Data for Montgomery Cares eligible patients referred to PA or AHCN

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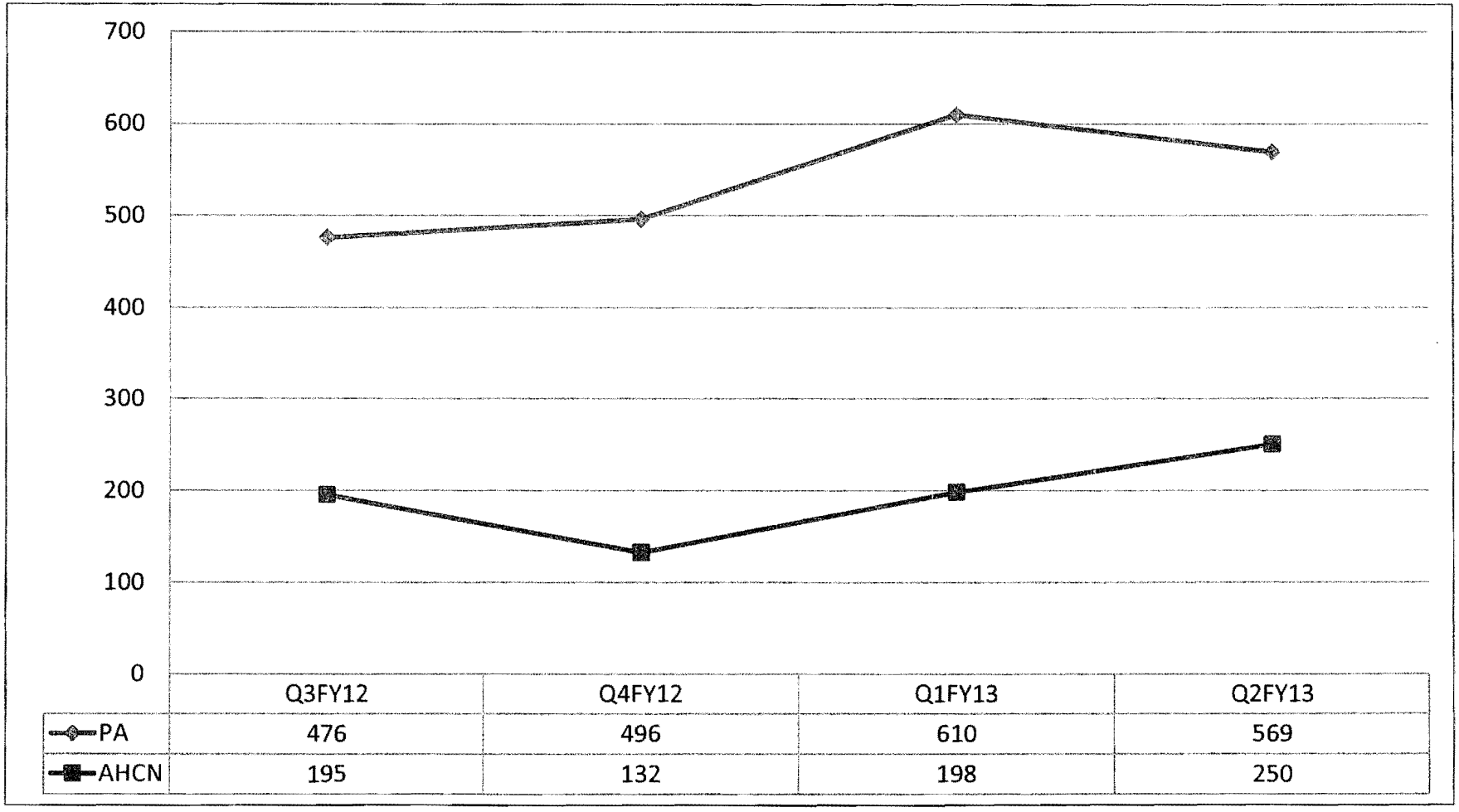
191

Project Access and AHCN: Unduplicated Patients Served Third Quarter FY12 – Second Quarter FY13



	Q3FY12	Q4FY12	Q1FY13	Q2FY13
PA	476	496	610	569
AHCN	195	132	198	250

Note: Data for Montgomery Cares eligible patients referred to PA or AHCN

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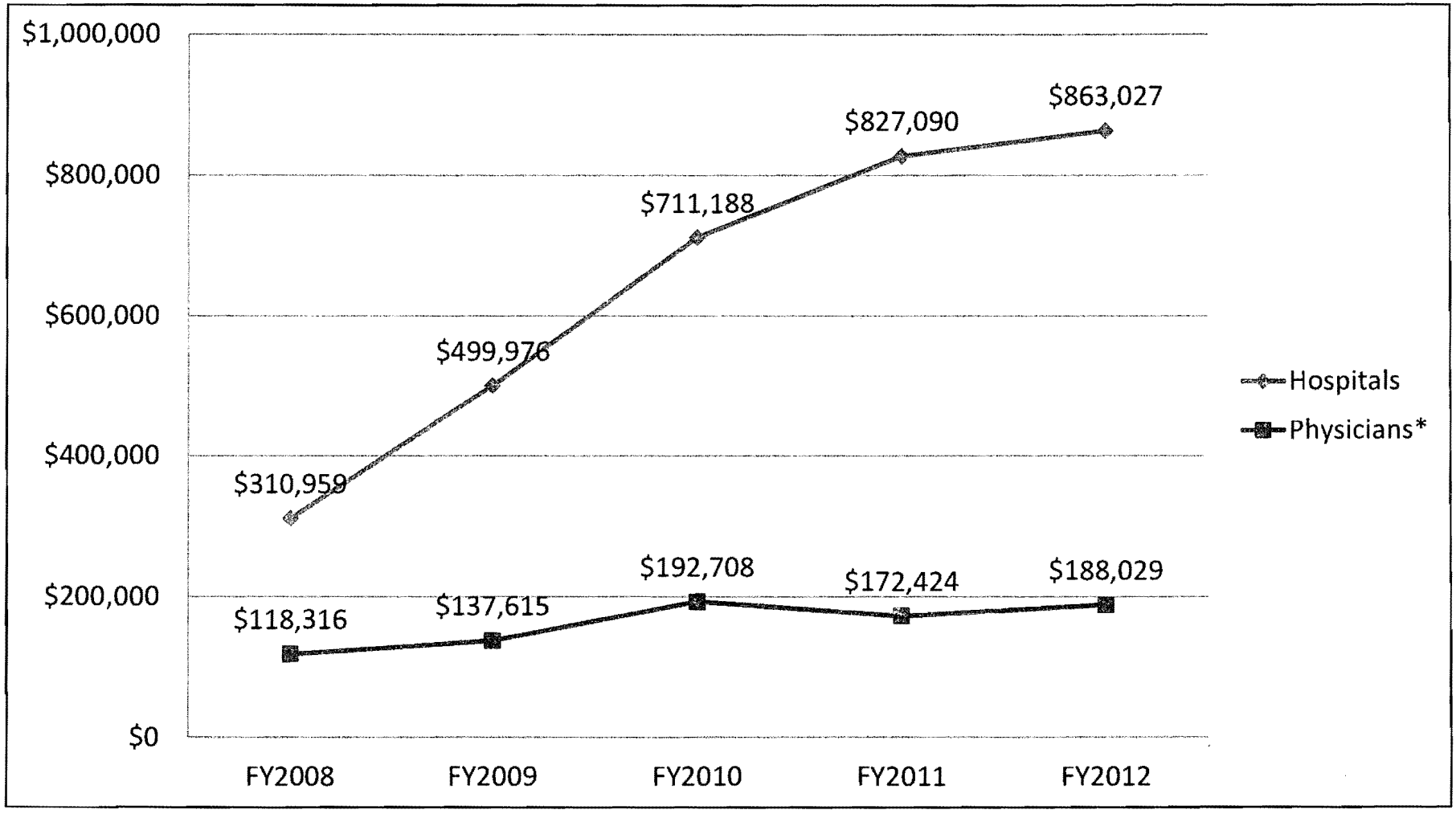
Charitable Care Provided To Project Access (FY2008 – FY2012)



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* Based on reports submitted by volunteer providers.

191

Specialty Care Updates Second Quarter FY13

Project Access

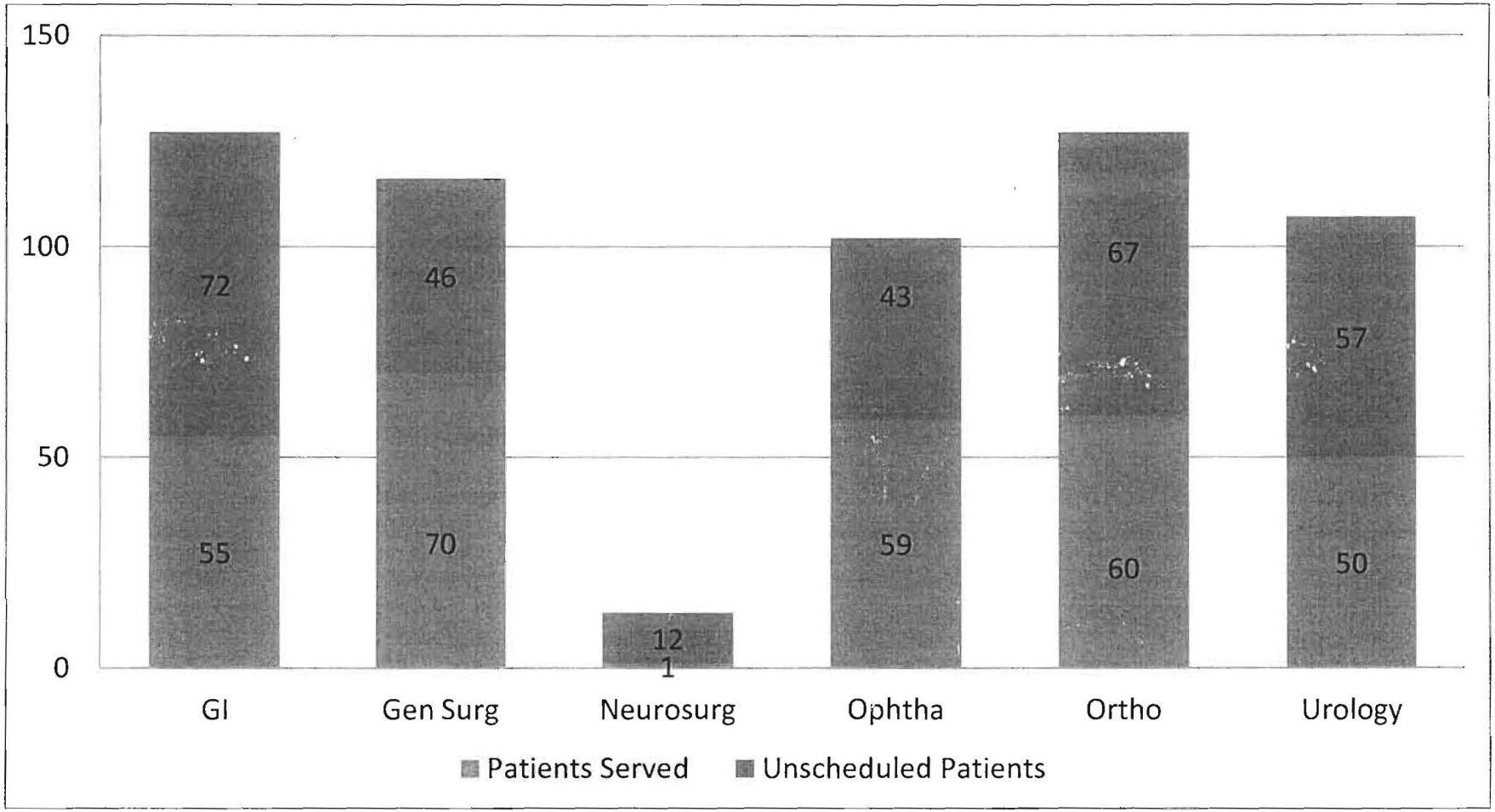
- There have been significant increases in pro bono services/surgeries through MedStar Montgomery and Suburban Hospital over the past 6 months.
- Increased utilization has resulted in limitation on services.
  - Surgeries at Medstar Montgomery Hospital are on hold as of January 1, 2013.
  - Surgeries at Suburban Hospital are limited to acute cases only.
- More referrals are being directed to other County hospitals.
- Efforts to recruit specialty providers with privileges at Holy Cross, Shady Grove and WAH have increased.

AHCN

- Continued progress with increasing the number of Montgomery Cares patients served.
- The ability to accommodate major surgeries remains limited.

(10)

Project Access Patients Served vs. Unscheduled Requests Second Quarter FY13 – Procedure Based Specialties



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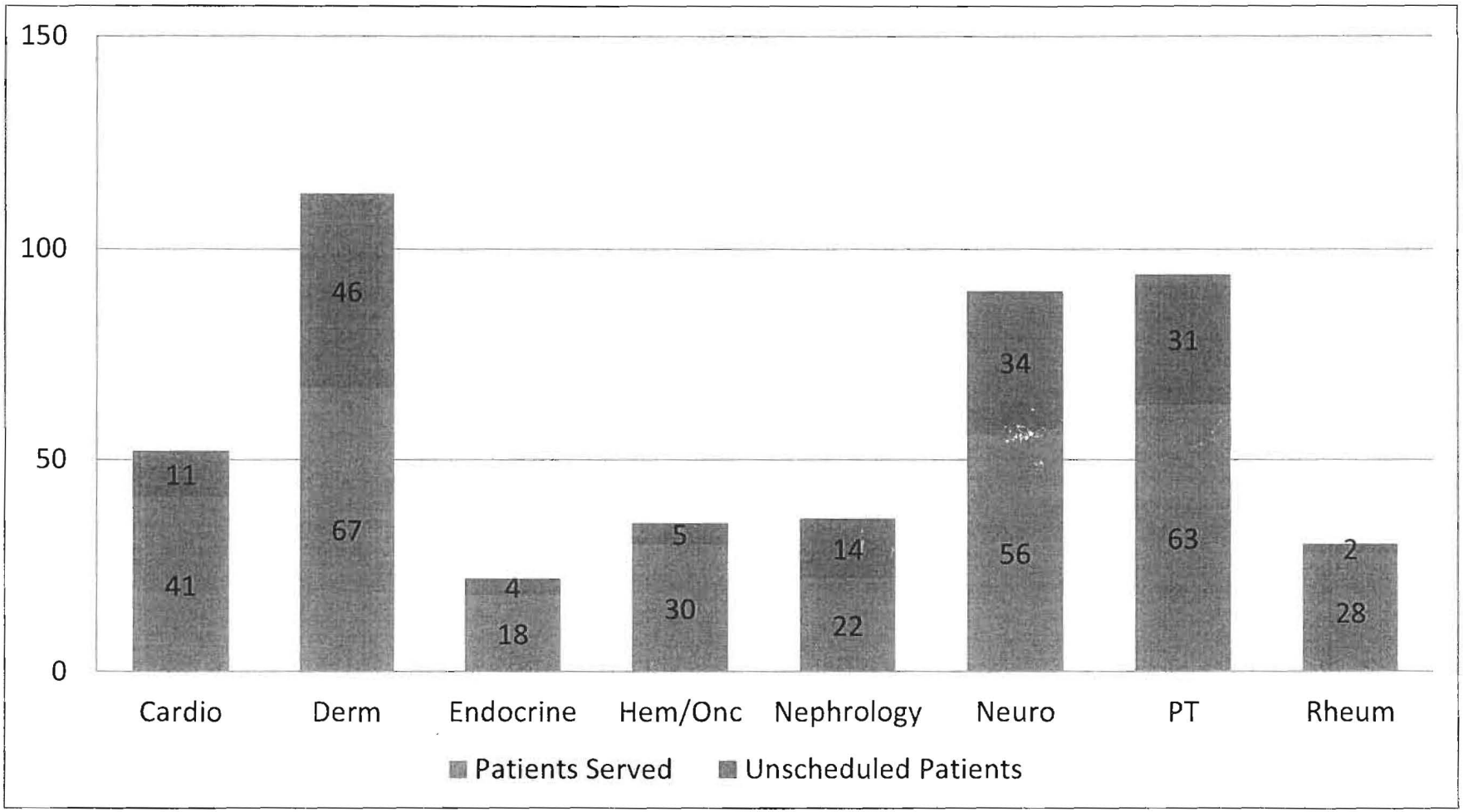
Project Access Patients Served vs. Unscheduled Requests Second Quarter FY13 – Office Based Specialties



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112

Behavioral Health Program
Number of Unique Patients

Program Site	Unduplicated Patients Receiving Clinical Services		
	Q1	Q2	YTD
Holy Cross - SS	109	104	171
Holy Cross - G	104	102	151
Holy Cross - AH	12	56	59
Mercy Clinic	80	71	106
Proyecto Salud	156	126	213
TOTAL	461	459	700

1,045 patients have received services through the behavioral health program. 700 received clinical services; an additional 345 patients received supportive services.

Behavioral Health Program
Number of Services Provided

Program Site	Number of Service Units		
	Q1	Q2	Total
Holy Cross – SS	327	427	754
Holy Cross - G	282	223	505
Holy Cross - AH	35	175	210
Mercy Clinic	171	194	365
Proyecto Salud	465	379	844
TOTAL	1280	1398	2679

Services include evaluation, reassessment, medication management referrals to specialty behavioral health services and referrals to social services.

Program Highlights

- **MC Behavioral Health Program** continues to be available to 46% of the Montgomery Cares population. The program is serving 12% of the 9,000 patients receiving primary care at partner clinics.
- **Behavioral Health-Primary Care Working Group**: SBIRT trainings took place on October 23 and November 13, 2012. The trainings were a collaboration between the University of Maryland School of Medicine SBIRT Medical Residency Training Program and SAMHSA. 40 people attended Part I and 20 people attended Part II of the training.
- **Montgomery County DHHS – MC Clinic Psychiatry Consultation Pilot**: DHHS and Mary's Center are executing an MOU to begin psychiatric consultation at Mary's Center with expected start date of February 2013. DHHS and MCC will also execute an MOU.
- **PCC, Family Services Inc. and CCI** are participating in the Maryland Integration Learning Community sponsored by the Maryland Addictions Directors Council.

Oral Health Program: Mid-Year FY13

Spanish Catholic Center

- 748 Patients Served YTD
- 1,586 Encounters YTD
- 180 - 210 day wait time for new patient appointments; 28-30 day wait time for established patient appointments.

DHHS Adult Dental Services – Metropolitan Court

- 384 Patients Served YTD
- 736 Encounters YTD
- 21 day wait time for new and established patient appointments.

Committed to Quality

- Medical Directors/Quality Health Improvement Committee (quarterly)
  - Guideline-concordant care, process improvement, clinical measures

- Quality Assurance Reviews
  - Bi-annual on-site Quality Assurance Reviews of administrative and clinical standards. Clinic specific and aggregate reports published.

- Quality Improvement Projects and Collaboratives (publication)
  - Office Practice Redesign
  - Diabetes
  - Cardiovascular Risk
  - Cancer Screening
  - Emergency Department Utilization
  - Patient-Centered Medical Home

- Technical Assistance and Resources
  - Individualized Consultation
  - Yahoo! Group

- Clinical Measures
  - Clinical data collected since 2003
  - 18 measures tracked quarterly and benchmarked against HEDIS Medicaid.
    - 10 measures published annually.

Annual Clinical Measures FY12

Measure	FY 08	FY 09	FY 10	FY 11	FY 12	Target Range HEDIS 2011 Medicaid (Reported in 2012) (mean-90th percentile)
* **Diabetes: Annual HgA1c Testing**	54%	74%	77%	83%	84%	82-91%
* **Diabetes: Annual LDL Testing**	47%	65%	70%	77%	75%	75-82%
* **Diabetes: Good HgA1c Control**	26%	35%	37%	41%	42%	35-44%
• **Diabetes: Poor HgA1c Control**	57%	44%	37%	36%	42%	43-29% (Note: Lower numbers demonstrate improvement)
* **Diabetes: LDL Control**	22%	32%	35%	38%	38%	35-46%
* **Hypertension: BP Control**	52%	60%	65%	64%	62%	57-69%
Breast Cancer Screening	12%	26%	29%	32%	34%	50-63%
Cervical Cancer Screening	7%	15%	29%	39%	50%	67-78%
Colorectal Cancer Screening	1%	2%	2%	3%	4%	N/A

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Montgomery Cares Quality Measures

- Performance is benchmarked against HEDIS Medicaid.
- Montgomery Cares clinics have demonstrated significant and continuous improvement in measures of diabetes and hypertension care.
  - Performance meets or exceeds HEDIS benchmarks
- But performance in measures of cancer screening are well below HEDIS benchmarks.
- And performance varies among clinics.
- Most, but not all, clinics participate in the Montgomery Cares Quality Improvement process.

QA Reviews

- On-site reviews conducted by an independent contractor from September through December 2012.
- All clinics received their individual draft narrative report for review and revision.
- Final individual and aggregate reports distributed to clinics and Montgomery County DHHS in February.
- All clinics provide written plans/action steps to address recommendations.
- PCC provides consultation and technical assistance.
- Formal Corrective Action Plans (CAPs) may be recommended.
- PCC provides structured, focused support to clinics implementing CAPs.

Montgomery Cares Findings FY13

IMPROVEMENTS

- BOD Quality Oversight
- Clinic Organization and Appearance
- Human Resources
  - Documentation
  - Orientation and Annual Training
  - Position Descriptions
  - Credentialing and Privileging
- Pharmacy Safety
- Policies and Procedures
- Behavioral Health Integration

OPPORTUNITIES

- Formal QI Plan/Process
- Medical and Environmental Emergency Drills
- Clinical Guideline Dissemination and Peer Review
- Immunization History
- Specialty Care
- Oral Health

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181

Montgomery Cares Advisory Board
Position Statement
Fiscal Year 2014

Overview

The Montgomery Cares (MCares) network has grown in capacity and capability each year since the program's inception in 2006. In Fiscal Year (FY) 2012, the MCares provider network served 27,814 County residents, and is funded to serve 32,250 patients in FY13, thanks to support from the County Executive and County Council.

With the full implementation of the Affordable Care Act in January 2014, additional low-income County residents will have access to health insurance coverage for the first time, either through the new State exchange or as a result of Medicaid expansion. Several of the Montgomery County safety-net providers are expanding capacity to meet the growing demand for services by becoming Medicaid providers while maintaining their capacity to serve those who will continue to require Montgomery Cares services.

The Montgomery Cares Advisory Board (MCAB) welcomes these new ventures, but feels strongly that ***the County needs to sustain and strengthen the Montgomery Cares program for the 65,000 County residents who will remain uninsured after full implementation of the Affordable Care Act.*** For this reason, the MCAB has identified the following budget priorities for Fiscal Year 2014:

Budget Priorities

The MCAB requests an increase to the MCares budget of **$871,875** in FY14. These funds would be allocated as follows:

1. **Primary Care:** The MCAB seeks an increase of **$256,875** in the MCares primary care budget. Consistent with a similar request from the Health Centers Leadership Council, the MCAB recommends a $3 (just under 5%) increase in the per-visit encounter rate, from $62 per visit to $65 per visit. This represents the first increase in payments to participating provider organizations since the per-visit reimbursement strategy was implemented in 2009, and is needed to respond to increases in the cost of care. The $65 per-visit rate is still well below the estimated cost of $100-$150 for a typical primary care visit. On a base of 32,250 patients and 85,625 patient encounters, a $3 per visit increase would require $256,875 in additional funds.

2. **Performance Improvement:** The MCAB is requesting an increase of **$140,000** to pilot a MCares Performance Improvement Program beginning in January 2014. The MCAB is working closely with the MCares participating provider organizations, the Primary Care Coalition, and other community partners in developing the Performance Improvement Program. It would provide incentive payments to those providers that demonstrate improved outcomes of care for their MCares patients, as measured by a select set of quality metrics.

3. **Preventive Care Services:** To ensure that the MCares program more adequately meets national preventive care standards, additional resources of **$400,000** are requested to ensure access to evidence-based breast and colorectal cancer screening services. Of this amount, an increase of $179,500 is requested to supplement the $38,500 grant contained in the County Executive's FY14 budget to expand access to mammography for more than 2500 female MCares patients age 50 and above. Additionally, an increase of $220,500 is requested to implement a colorectal cancer screening protocol for 2100 patients and also provide colonoscopies for 84 MCares patients with positive results.

4. **Behavioral Health Services:** The MCAB is requesting an increase of **$75,000** to expand the reach of the Montgomery Cares Behavioral Health program and offer access to Behavioral Health services to an additional 3,000 patients.

(over)

Budget Summary

A summary of the FY14 budget request from the Montgomery Cares Advisory Board is as follows, and is shown in priority order:

MCAB BUDGET PRIORITIES	AMOUNT
Priority #1: Increase the per-visit encounter rate for primary care services from $62 to $65	$256,875
Priority #2: Performance Improvement Program Pilot	$140,000
Priority #3: Add Preventive Care Services • Mammography • Colorectal cancer screening	 $179,500 $220,500
Priority #4: Expand Behavioral Health Services	$75,000
TOTAL REQUEST	**$871,875**

Value Statement

Access

- Health Care home for 30K adults in 25 locations throughout Montgomery County
- Open to ALL eligible County residents:
  - Adults, 18 years and older
  - Uninsured
  - At or below 250% Federal Poverty Level, or $ 55,875/year for a family of four.
- Provides access to primary care, medications, specialty care, behavioral health, and oral health services.

Quality

- MCares/Health Center participants are 38% less likely to use emergency departments, and 57% less likely to be hospitalized for ambulatory care-sensitive conditions than those who do not have access to primary care.
- MCares providers offer quality medical care: for example diabetes and hypertension care are found to be achieving national target benchmarks for quality.

Cost Control

- Saves at least $500 per patient annually in total health care costs.
- Drives $15M in annual savings from reduced emergency, hospital and specialty care costs.

Economic Engine

- Generated over $33.7M in total economic benefits in 2012 with a County investment of $9.3M.
- The MCares program provides jobs for approximately 350 people.
- MCares program supported 70FTE clinical providers to the uninsured.
- The MCares program saw fourteen capital projects between the years of 2007 and 2012 that resulted in new or expanded facilities for the participating provider organizations.

Collaboration

- Engages 12 community-based nonprofit providers
- Involves five hospitals in the County in direct service provision. In the past two years, the five hospitals have provided $1.5M in uncompensated care to MCares patients.
- Utilizes over 370 County residents as volunteers including 17 dedicated Montgomery Cares Advisory Board members.
- Leverages at least $2.40 in private resources for every $1.00 in County funds.
- Utilizes 100 private physicians providing over $172,500 in pro-bono specialty care through the MCares Project Access program.

Montgomery Cares Advisory Board
2013
FACT SHEET

- **OUR PAST AND FUTURE:** In 2006, Montgomery County DHHS, with the help of the Primary Care Coalition and area hospitals, initiated the Montgomery Cares Program to provide access to health care services for low-income, adult uninsured County residents.

Fiscal Year	MCares Budget*	MCares Patients Served*	MCares Patient Visits* (each patient has approximately 2.7 visits per year)
FY06	$ 4,961,000	11,459	35,269
FY07	$ 9,461,000	12,539	38,140
FY08	$ 9,866,010	16,017	43,275
FY09	$ 9,941,545	20,282	54,144
FY10	$ 9,954,029	25,415	69,159
FY11	$ 9,210,988	26,544	72,504
FY12	$ 9,312,758	27,465	76,354
FY13	$10,642,280	32,250 (budgeted)	85,625 (budgeted)

*Does not include Health Care for the Homeless budget or patients

- **OUR PROVIDERS:** Twelve community-based non-profit organizations participate in the Montgomery Cares Program, serving patients in twenty-five locations across the County.

Care for Your Health
Community Clinic, Inc.
CCACC Pan Asian Volunteer Health Clinic
Holy Cross Health Centers
Mansfield Kaseman Health Center
Mary's Center for Maternal and Child Care
Mercy Health Clinic
Mobile Medical Care, Inc.
Muslim Community Center Medical Clinic
Proyecto Salud
People's Community Wellness Center
Spanish Catholic Center Medical Clinic

- **OUR PATIENTS:** Age 18 years or older, low income, uninsured Montgomery County residents

- **OUR SERVICES:** Montgomery Cares providers offer access to primary medical care, medications, lab tests, x-rays, specialty care, and behavioral and oral health services. In 2012, several of the Montgomery Cares providers began the process of becoming Medicaid providers to better serve newly enrolled Medicaid recipients and state exchange members following full implementation of the Affordable Care Act.

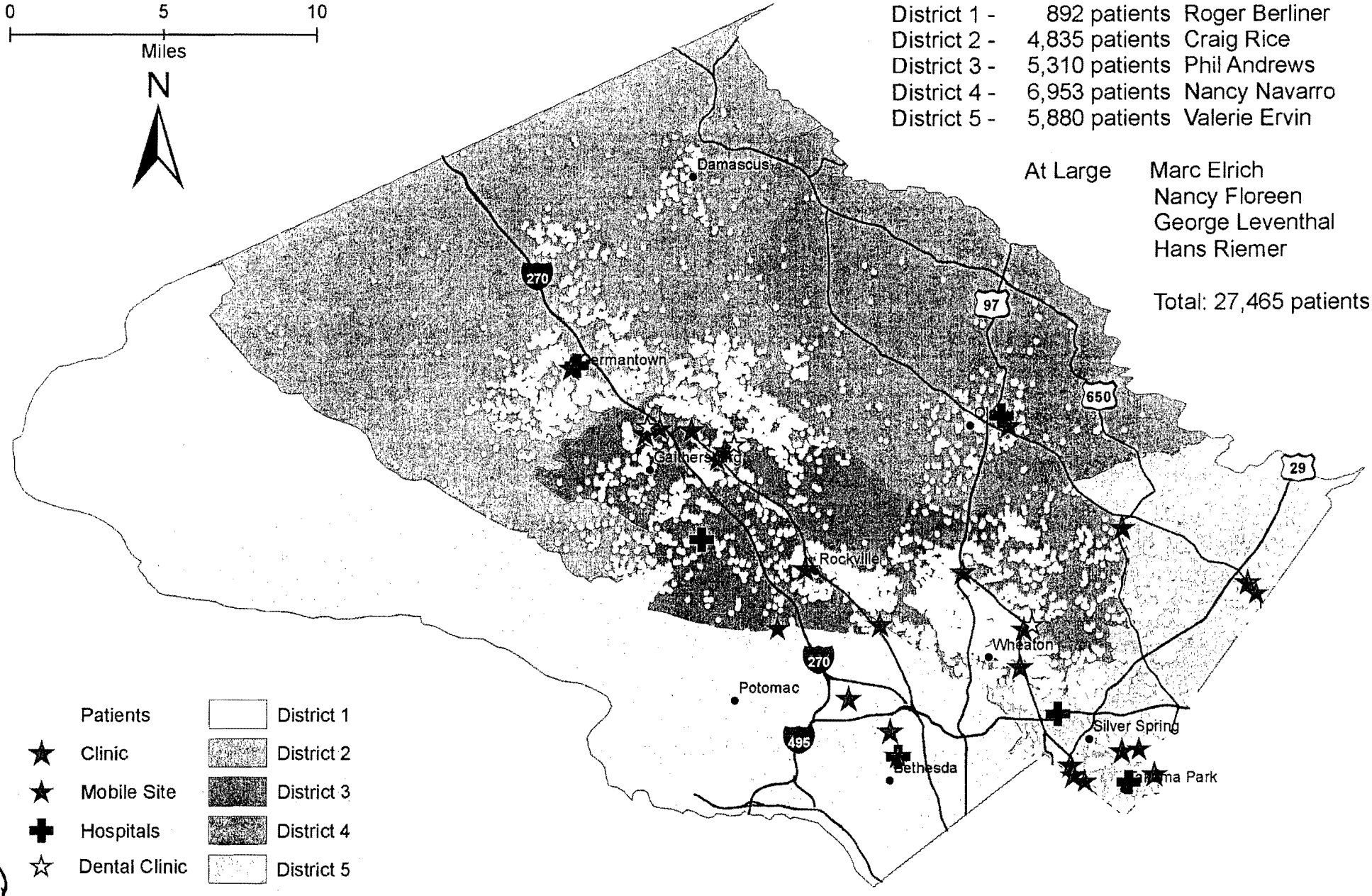
- **OUR QUALITY OF CARE:** Montgomery Cares providers offers consistently high quality medical care, as evidenced below. Diabetes and hypertension indicators are approaching and/or achieving national target benchmarks.

Disease	Measure	Target Range	FY11	FY12
Diabetes	% of diabetes patients who had annual HgA1c (blood glucose level) testing	82%-90%	83%	84%
	% of diabetes patients who had annual LDL Testing	75% 84%	77%	75%
	% of diabetes patients who had good HgA1c (blood glucose level) control	35%-44%	41%	42%
	% of diabetes patients who had LDL control	35%-46%	38%	38%
Hypertension	% of hypertension patients who had good blood pressure control	57%-69%	64%	62%

- **OUR SAVINGS TO THE COMMUNITY:** With the help of its public-private partnership, the MCares program generates at least $2.40 in private resources for every $1.00 committed by the County for MCares services. Further, by addressing health care issues before they become acute and require hospitalization, MCares impacts total health care costs.

Montgomery Cares FY12 Patient Population by County Council District

primary care coalition



* Map includes data from 10 Montgomery Cares-participating clinics. Addresses for 73 patient could not be mapped.

Montgomery Cares Program

Proposal: Evaluate a Performance Incentive Program (PIP)

Proposal: To consider methodology for incentive-based payment in the context of current Montgomery Cares reimbursement and quality metrics structures and process for facilitating further discussion.

Background and Environment

The concept of incentive-based payment was introduced at the Montgomery Cares Advisory Board meeting on January 9th in the context of a discussion of MCAB's advocacy position related to increased reimbursement for Montgomery Cares services. There was some discussion and interest in learning more about how this might work.

A follow-up discussion was conducted with PCC staff in order to determine the viability of developing an incentive-based reimbursement pool and methodology within the context of current Montgomery Cares billing/reimbursement, date collection and quality improvement processes. It was determined that this is possible within current MC processes and desirable based on current trends in Medicaid and commercial insurance carriers.

Incentive – based payments are becoming increasingly common among commercial insurers and will likely be adopted for Medicaid to promote and reward quality. In Montgomery County's safety-net system, all stakeholders have an investment in efficient and effective use of Montgomery Cares funds, high quality health services for people served and alignment with standards and practices being implemented under the Affordable Care Act.

Recommendation:

Montgomery County consider an incentive-based payment strategy. This would be accomplished through in-put and buy-in by all stakeholders through a transparent and inclusive dialogue led by the Montgomery Cares Advisory Board. To reach this objective, the following steps would be taken.

1. The Quality/Outcomes Work Group evaluate and consider incentive-based payment as a means to reward and recognize high performing organizations serving Montgomery Cares patients.

2. A PIP Work Group be formed of interested MCAB members, Clinic Executives, DHHS and PCC staff to learn about and consider the risks and benefits to adopting an incentive-based payment strategy that is both supplemental and complimentary to the existing fee-for-service payment structure. Representatives from this work group would provide information to respective stakeholder groups including provider organizations (staff and leadership), DHHS (staff and leadership), PCC (staff and leadership) and consumers.

3. PCC support this initiative by exploring incentive payment methodologies and how they may be adapted for use by Montgomery Cares. PCC staff will also explore current data and analysis methodology and resources to determine if there is an adequate framework and resources for this purpose.

4. If the PIP workgroup finds value in an incentive based program, PCC and DHHS staff, in consultation with clinic medical directors and staff, will develop a model that is objective and easily implemented within current structures and processes.

5. The PIP Work Group provides a go forward recommendation to the Quality Outcomes Workgroup by April, 2013. As appropriate, they will present a recommended model to the Quality/Outcomes work group for further refinement and presentation to the full MCAB for approval.

6. If approved, MCAB makes a recommendation to DHHS and County Council HHS Committee related to incentive-based payment and time frame for implementation or reconsideration.

Key Stakeholders:

Montgomery Cares Advisory Board (MCAB): The Montgomery Cares Advisory Board advises DHHS and County Council on policy and practice related to Montgomery Cares.

Quality/Outcomes Work Group: MCAB recently established a work group that will align Montgomery Cares with health care reform and extend the primary health care safety-net to cover vulnerable people who are eligible for Medicaid and other publicly subsidized health care programs by establishing and monitoring performance goals in the following areas: Access, Health Outcomes, Patient Experience, Organizational Excellence and Cost/Efficiency.

Montgomery County DHHS: Montgomery County DHHS Montgomery Cares staff is responsible for establishing MC policies, standards and oversight of Montgomery Cares implementation and fiscal accountability.

Primary Care Coalition: The Primary Care Coalition is responsible for implementing and managing Montgomery Cares. As such, it subcontracts with service providers, provides network services (health information management and quality assurance/improvement), provides some direct services (Oral and Behavioral Health) and facilitates processes that support operations and quality improvement activities. PCC maintains the staffing and infrastructure to conduct program billing, payment and reporting. PCC Montgomery Cares program staff serves as staff to the MCAB and its committees conducting research, data analysis and providing information as requested.

Montgomery Cares Provider Participants: There are 12 organizations subcontracted by PCC to provide primary health care services to low-income, uninsured adults eligible for Montgomery Cares services. Community service providers include: 2 Federal Qualified Health Centers, 1 hospital-based clinic, 2 larger (5,000 + patients) mixed practice (volunteer and paid staff) organizations, 4 smaller faith-based clinics, 2 all-volunteer "free" clinics and 1 pilot micro-practice.

Montgomery Cares Patients: There are an estimated 100,000 uninsured adults with almost 28,000 served by Montgomery Cares participating clinics.

Appendix I: Annual Clinical Quality Measures
Primary Care Coalition of Montgomery County

Measure Name	HEDIS 2012 Denominator	Montgomery Cares Denominator	Montgomery Cares Numerator
Diabetes Measures			
Hemoglobin A1c (HgA1c)Testing	Patients aged 18-75 with diabetes	Patients aged 18 or older with a diagnosis of diabetes who had two face-to-face encounters with different dates of service - one visit during the measurement period and the other visit in the measurement period or within two years prior to the end of the measurement period	Denominator patients who had at least one HgA1c test within one year prior to their most recent encounter
Good control of HgA1c	Patients aged 18-75 with diabetes	Patients aged 18 or older with a diagnosis of diabetes who had two face-to-face encounters with different dates of service - one visit during the measurement period and the other visit in the measurement period or within two years prior to the end of the measurement period	Denominator patients who had at least one HgA1c test within one year prior to their post recent encounter and whose last HgA1c test was ≤ 7%
Poor control of HgA1c (≥ 9%)	Patients aged 18-75 with diabetes	Patients aged 18 or older with a diagnosis of diabetes who had two face-to-face encounters with different dates of service - one visit during the measurement period and the other visit in the measurement period or within two years prior to the end of the measurement period	Denominator patients who did not have at least one HgA1c test within one year prior to their most recent encounter or whose last HgA1c test was ≥ 9%
LDL Cholesterol Testing	Patients aged 18-75 with diabetes	Patients aged 18 or older with a diagnosis of diabetes who had two face-to-face encounters with different dates of service - one visit during the measurement period and the other visit in the measurement period or within two years prior to the end of the measurement period	Denominator patients who had at least one LDL cholesterol test within one year prior to their most recent encounter
Good Control LDL cholesterol (≤ 100 mg/dL)	Patients aged 18-75 with diabetes	Patients aged 18 or older with a diagnosis of diabetes who had two face-to-face encounters with different dates of service - one visit during the measurement period and the other visit in the measurement period or within two years prior to the end of the measurement period	Denominator patients who had at least one LDL cholesterol test within one year prior to their most recent encounter and whose last LDL cholesterol was ≤ 130 mg/dL
Diabetes Blood Pressure	Patients aged	Patients aged 18 or older with a diagnosis of diabetes who had two	Denominator patients whose most recent blood pressure was ≤140/90

Control	18-75 with diabetes	face-to-face encounters with different dates of service - one visit during the measurement period and the other visit in the measurement period or within two years prior to the end of the measurement period	
Hypertension Measures			
Blood pressure control (BP ≤140/90)	Patients 18-85 with hypertension	Patients aged 18 or older with a diagnosis of hypertension who had two face-to-face encounters with different dates of service - one visit during the measurement period and the other visit in the measurement period or within two years prior to the end of the measurement period	Denominator patients whose most recent blood pressure was ≤140/90
Preventative Measures – Cancer Screening			
Breast Cancer Screening	40-69 years old	Women aged 40 or older who had two face-to-face encounters with different dates of service - one visit during the measurement period and the other visit in the measurement period or within two years prior to the end of the measurement period	Denominator patients who received a mammogram within two years prior to their most recent encounter
Cervical Cancer Screening	21-64 years old	Women aged 21 to 64 who had two face-to-face encounters with different dates of service – one visit during the measurement period and the other visit in the measurement period or within two year prior to the end of the measurement period.	Denominator patients who received cervical cancer screening in the past three years.
Colorectal Cancer Screening	50-80 years old No Medicaid Benchmark	Patients aged 50 or older who had two face-to-face encounters with different dates of service - one visit during the measurement period and the other visit in the measurement period or within two years prior to the end of the measurement period	Denominator patients who received one of the following tests: • Colonoscopy within ten years prior to their most recent encounter • Flexible sigmoidoscopy within five years prior to their most recent encounter • Double contrast barium enema within five years prior to their most recent encounter • Fecal occult blood test within one year prior to their most recent encounter

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Isiah Leggett
County Executive

Uma S. Ahluwalia
Director

April 3, 2013

The Honorable Nancy Navarro
President, Montgomery County Council
100 Maryland Avenue, 6th Floor
Rockville, Maryland 20850

Dear Ms. Navarro:

Thank you for the opportunity to review the health care safety-net related grant proposals for the FY14 Council Grants. The Montgomery Cares Advisory Board (MCAB) appreciates your respect for our Board and its advisory function.

The MCAB underwent the same formal review process for the proposals as we have in the past. We assigned two board members to each proposal, to review, score, and make a recommendation to the full Board. At the March 27, 2013 MCAB meeting, the full Board discussed these recommendations and reached funding consensus. You will find the recommendations for each proposal in the attached document. Because we found merit in the majority of the proposals, we have prioritized them for you based on the scores they received, to help you in your decision making.

Thank you again for this opportunity and we hope you find our recommendations helpful. Please contact our staff member, Becky Smith, at 240-777-1278 or rebecca.smith@montgomerycountymd.gov with questions or for additional information.

Sincerely,

Joan Planell

Joan Planell
Chair, Montgomery Cares Advisory Board

Attachments:
MCAB Review and Recommendation, FY14 County Grants

cc: Peggy Fitzgerald-Bare, Montgomery County Council
Linda McMillan, Montgomery County Council
Uma S. Ahluwalia, Director, Department of Health and Human Services
Ulder J. Tillman, Chief of Public Health Services, Department of Health and Human Services
Jean Hochron, Sr. Administrator, Montgomery Cares Program, Department of Health and Human Services

FY14 County Council Grants
Montgomery Cares Advisory Board
Review and Recommendations

1. **Organization:** Care for Your Health *(virtual case management)*

Amount Requested $32,037

MCAB Recommendation: **MCAB does not recommend this project for funding.**

The reviewers noted that the applicant did not describe the expected number of patients to be served, how the project fits within the County's priorities, how the outcomes will be measures or how the program will be sustained.

2. **Organization:** Chinese Culture and Community Services Center, Inc (CCACC) *(Hep B Program)*

Amount Requested: $38,000

MCAB Recommendation: **MCAB recommends this project for funding**

The reviewers were pleased with the proposal and reported that "no one else is providing this service free of charge in the County. Hepatitis B is a serious problem in the Asian population and CCACC is a trusted and respected organization across the Asian community. The only problem we found is sustainability for the future, but given the economic market , we did not deduct many points" .

3. **Organization:** Community Ministries of Rockville/Mansfield Kaseman *(Behavioral Health and Podiatry)*

Amount Requested: $85,000

MCAB Recommendation: **MCAB recommends this project for funding.**

In the comments section, the reviewers noted, "if funds are available, this is a worthy project to fund."

4. **Organization:** **Mary's Center for Maternal and Child Care** *(staff and emergency assistance funds)*

Amount Requested: $100,702

MCAB Recommendation: **MCAB recommends this project for funding.**

The reviewers found this to be a worthy project that received the maximum 25 out of 25 available points.

5. **Organization:** Mercy Health Clinic #1 *(Health Education)*

Amount Requested: $20,000

MCAB Recommendation: **MCAB recommends this project for funding**

This is a continuation of a health education effort that began this current fiscal year.

6. **Organization:** Mercy Health Clinic #2 *(Pharmacy Program support)*

Amount Requested: $30,000

MCAB Recommendation: **MCAB recommends this project for funding**

This is an ongoing project that the clinic has had for several years, although the reviewers thought this was the first year that Council support has been requested.

7. **Organization:** Mercy Health Clinic #3 *(Clinical Director)*

Amount Requested: $75,000

MCAB Recommendation: **MCAB recommends this project for funding**

The reviewers noted, "This grant proposal is very thorough and addresses Montgomery Cares priorities. Sustainably will be a challenge, but the clinic appears to have alternative funding identified"

8. **Organization:** Mobile Medical Care, Inc *(Diabetes Care Program)*

Amount Requested: $47,900

MCAB Recommendation: **MCAB recommends this project for funding**

The reviewers reported the proposal was strong with clear measurable goals and a reasonable budget.

9. **Organization:** Primary Care Coalition *(Tech. Assistance- Medicaid)*

Amount Requested: $75,000

MCAB Recommendation: **MCAB recommends this project for funding**

The reviewers found the proposal to be mission appropriate and purposeful. They were impressed with the way it anticipates the changes in reimbursement in health care and was able to impact the services across the clinics.

10. **Organization:** The Muslim Community Medical Center, Inc #1 *(Domestic Violence Prevention)*

Amount Requested: $25,000

MCAB Recommendation: **MCAB recommends this project for funding.**

This is a repeat project from last year. The reviewers felt it was successful and should see an additional year.

11. **Organization:** The Muslim Community Medical Center, Inc #2 *(Handicapped Accessible Van)*

Amount Requested: $50,000

MCAB Recommendation: **MCAB does not recommend this project for funding.**

The reviewers commented that there needs to be a better justification for the service including an analysis of alternatives to a van such as Metro Access or transportation vouchers. The proposal does not provide the number of patient in need of special transportation arrangements. Sustainability is very uncertain.

12. **Organization:** The Muslim Community Medical Center, Inc #3 *(2-Chair Dental Facility)*

Amount Requested: $100,000

MCAB Recommendation: **MCAB recommends this project for partial funding ($50,000)**

The County Executive also recommended this project for $50,000 in his 2014 Recommended Budget.

Considering that the CE has recommended the project for $50,000, and the full project is $100,000, the reviewers, recommend the Council fund the remaining $50,000 to make the project whole at $100,000. The Board also requested that if funded that the clinic be open to all Montgomery Cares patients.

13. **Organization:** Primary Care Coalition (late addition add on) *(Mammogram Access)*

Amount Requested: $77,000

MCAB Recommendation: **MCAB recommends this project for funding**

The reviewers noted that this was a very strong proposal and that all the grant dollars go directly to patient services.

FY13 County Council Grants
Montgomery Cares Advisory Board
Priority List of Recommended Proposals

Based on Reviewers Scores (out of 25 possible points)

	Clinic Name	Recommended Award	Project Description	Reviewers Score
#1a(tied)	Mary's Center	$100,702	Health Educators, Navigator, Family Service Worker, Emergency Assistance Funds	25
#1b(tied)	Muslim Community Medical Center #3	$50,000	In-House two chair dental facility	25
#1c(tied)	Primary Care Coalition (add-on from CE Recommended Budget)	$77,000	Funds to increase capacity for screening mammograms.	25
#2	Mobile Medical Care	47,900	Diabetes Care Program	23
#3a(tied)	Mercy Health Clinic #1	$20,000	Health Education	22.5
#3b(tied)	Mercy Health Clinic #3	75,000	Clinical Director	22.5
#4a(tied)	Chinese Culture and Community services Center	$38,000	Hepatitis B Program	22
#4b(tied)	Primary Care Coalition	$75,000	Technical Assistance to clinics in becoming Medicaid providers	22
#5	Muslim Community Medical Center #1	$25,000	Domestic Violence Prevention	21
#6	Community Ministries of Rockville/Kaseman	$85,000	Behavioral Health and Podiatry	17.5
#7	Mercy Health Clinic #2	$30,000	Pharmacy Program	16

Not Recommended:

Clinic Name	Recommended Award	Project Description	Reviewers Score
Care for Your Health	$32,037	Virtual Case Management	8
Muslim Community Medical Center #2	$50,000	Handicap Equipped Van	11