



FY11 Performance Plan

Updated March 2011 (with corrected budget table in October 2011)



**Department of
Health and Human Services**

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Overview

Contribution to Montgomery County Results

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

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DHHS At-A-Glance

DHHS ensures delivery of a full array of services to address the somatic and behavioral health, economic and housing security, and other health and human services needs of County residents. DHHS directs, manages, administers, funds and delivers critical supports for the most vulnerable residents. Services provided also include case management and advocacy services, protective services for vulnerable children and adults, and prevention services.

The Department strives to provide services that:

- Build on the strengths of our customers and the community
- Are community-based
- Are accessible
- Are culturally competent
- Are responsive to changing needs of our community
- Are provided in collaboration with our community partners.

| What DHHS Does and for Whom | How Much - FY 11 Budget & Work Years (WY) |
|--|---|
| <p><u>Overall</u> The mission of the Department of Health and Human Services (DHHS) is to promote and ensure the health and safety of the residents of Montgomery County and to build individual and family strength and self-sufficiency.</p> | <p>\$250.97 million 1485.8</p> |
| <p><u>Aging and Disability Services (ADS)</u> The mission of ADS is to affirm the dignity and value of seniors, persons with disabilities, and their families by offering a wide range of information, home and community-based support services, protections, and opportunities which promote choice, independence, and inclusion.</p> | <p>\$37.4 million 156.7 WYs</p> |
| <p><u>Behavioral Health and Crisis Services (BHCS)</u> The mission of BHCS is to foster the development of a comprehensive system of services to assist children, youth, adults, and families in crisis or behavioral health needs.</p> | <p>\$37.7 million 196.2 WYs</p> |
| <p><u>Children, Youth and Family Services (CYFS)</u> The mission of CYFS is to promote opportunities for children to grow up healthy, and ready for school, and for families to be self-sufficient.</p> | <p>\$62.3 million 427.4 WYs</p> |
| <p><u>Public Health Services (PHS)</u> The mission of PHS is to protect and promote the health and safety of County residents.</p> | <p>\$70.1 million 534.5 WYs</p> |

| What DHHS Does and for Whom | How Much - FY 11 Budget & Work Years (WY) |
|--|---|
| <p><u>Special Needs Housing (SNH)</u> The mission of SNH is to provide oversight and leadership to the County's efforts to develop new and innovative housing models to serve special needs and homeless populations and maintain housing stability for vulnerable households.</p> | <p>\$18.0 million 54.4 WYs</p> |
| <p><u>Administration and Support (AS)</u> The mission of AS is to provide overall leadership, administration and direction to the Department, while providing an efficient system of support services to assure effective management and delivery of services.</p> | <p>\$25.5million 116.6 4 WYs</p> |

1. Team-based Case Management

Basic Facts

- ◆ Cross-systems team-based case management of individual or family cases that receive multiple services:
 - Offers a more coordinated, systematic and comprehensive approach to meeting the customer’s needs.
 - Creates efficiencies through communication and coordinated service delivery for customers.
 - Leads to improved outcomes for customers: risk mitigation, greater independence, improved health, better access to services and successful case closure.
- ◆ Based solely on Client Record System (CRS) data, more than 24,500 unique individuals received more than one service (see table below).
- ◆ The apparent decline over the FY09 number of recipients of multiple services is due to a clean up of electronic records from CRS of records of inactive clients that had not been “closed out” and removed from the the Client Record System database.
- ◆ CRS data represent active clients that had a documented encounter with DHHS. The universe of active clients is higher for two reasons:
 - Clients who are active but did not have a documented encounter in FY10 are not reflected in the data
 - There are several other mandatory state or federal databases of DHHS clients (although CRS is the largest). Some individuals in other databases are not in CRS.
- ◆ The actual number of individuals receiving multiple services is unknown due to the lack of interoperable databases.
- ◆ Effective teamwork is determined by a consensus rating of four or more on a six point scale by a team of reviewers after reading case records, conducting client and key informant interviews, and interpreting fact-finding results based on a standardized Quality Service Review (QSR) protocol.

Client Record System Data of Active Cases Receiving Multiple Services

| Number of Services | Number of Clients | | | |
|--------------------|-------------------|---------------|---------------|---------------|
| | FY 07 | FY08 | FY09 | FY10 |
| 2 | 9,485 | 11,412 | 13,011 | 12,653 |
| 3 | 5,362 | 6,298 | 6,905 | 6,283 |
| 4 | 3,078 | 3,668 | 3,739 | 3,152 |
| 5 | 1,528 | 1,738 | 1,738 | 1,372 |
| 6 | 693 | 769 | 742 | 564 |
| 7 | 313 | 365 | 295 | 235 |
| 8 | 151 | 175 | 121 | 81 |
| 9 | 118 | 121 | 76 | 51 |
| Total | 20,728 | 25,456 | 26,627 | 24,391 |

Performance

Percentage of client cases with multiple services for which effective teamwork (aspects of team formation and team functioning) is documented.

| Aspect of Teamwork | FY 08 (n=10) | FY 09 (n=44) | FY10 (n=43) | FY11 Estimate Based on YTD (n=22) | FY 12 Projection | FY13 Projection |
|--------------------|-----------------|-----------------|----------------|---|---------------------|--------------------|
| Team Formation | 50% | 82% | 84% | 91% | 83% | 84% |
| Team Functioning | 30% | 68% | 79% | 82% | 74% | 77% |

Discussion

Projections for FY12 and FY13 are not higher than the current and past years because the results of the QSR qualitative evaluation tool vary from review cycle to review cycle. This is due to the small and non-random sample of cases chosen for review. Therefore, it cannot be assumed that results will be consistently progressive.

Story Behind Performance

Contributing Factors

- ◆ Team-based case management, a key element in the Department's Service Integration (SI) effort, involves staff coordination across programs in which a client is receiving multiple services. Collaboration can be effective to set goals, achieve those goals, and share decision-making authority and accountability. SI continues to evolve both informally and formally throughout DHHS.
- ◆ A confidentiality policy that allows sharing of client information among team members on a need to know basis is now in place.
- ◆ Progress continued toward an information technology solution that standardizes the intake and screening process. The computer-based model will facilitate more comprehensive screening for the range of customer needs, record standard demographic information on all customers, and enable workers to schedule appointments electronically with participating programs.
- ◆ The Department also is engaged in a comprehensive process to assess the current information technology system and make improvements that lead to retrieving complete, unduplicated counts of customer volume.
- ◆ The Department finalized a conceptual case practice model for team-based case management that articulates the values and competencies that undergird the Department's approach to providing integrated services. This foundation work creates a standard approach and expectations for working within and across programs and services in DHHS.

Restricting Factors

- ◆ The lack of a regularly updated, searchable database of services, programs and personnel with contact information remains a key missing infrastructure

- element necessary for staff to operate effectively in an integrated service approach based on knowledge of and connections to the range of programs, services and staff in the Department.
- ◆ The lack of an interoperable information technology system that facilitates a common client index of all services received by an individual and allows high level case planning across programs impedes cross-discipline service coordination.

What We Propose to Improve Performance

- ◆ Implement the integrated services practice model for team-based case management with a target client population on a small scale in the Department.
- ◆ Develop and implement integrated services case management protocols, procedures and training.
- ◆ Develop and implement rollout plan to include staging and a defined organizational structure to support team-based case management.
- ◆ Continue to improve computer supported intake, screening and referral process to support service integration.
- ◆ Use grant funds for two contracted staff specialists to coordinate service integration efforts.
- ◆ Monitor implementation efforts and provide support to staff in the move to a formal team-based case practice approach.

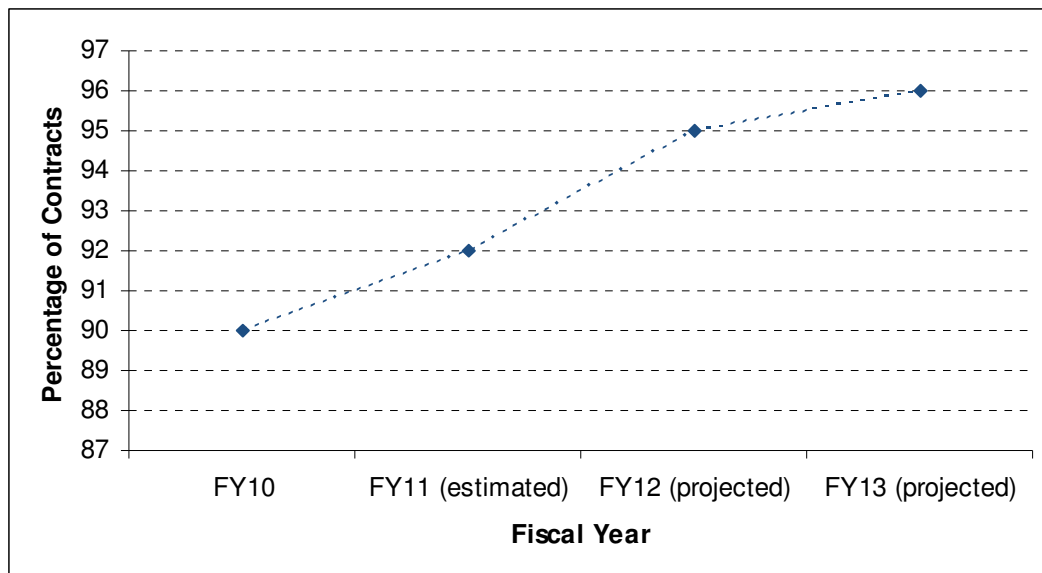
2. Contracted Services Performance Measurement

Basic Facts

- ◆ Performance measures increase accountability and provide a data-driven means for assessing the outcomes of a program or service.
- ◆ Performance measures are a mechanism for continuous quality improvement and therefore are more likely to result in better outcomes for clients.
- ◆ Performance measures provide data for future funding and contracting decisions.
- ◆ Measures focus on three aspects of beneficial Impact: risk mitigation, greater independence and/or improved health for customers.
- ◆ DHHS has over 550 contracts (competitive and non-competitive)
- ◆ Over \$90M of services are procured through contracts (competitive and non-competitive)
- ◆ Beginning in FY09, performance measures were incorporated into new FY09 program-related Requests for Proposals (RFP) and resultant contracts. Beginning in FY10, a count was made of the number of contracts derived from those RFPs in order to calculate the first result under this revised measure.

Performance

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



Discussion

The FY 10 result is derived from dividing the cumulative number of current DHHS “health and human services” contracts derived from RFPs (98) by the total number of current “health and human services” contracts derived from RFPs (109). Each year, the rate should increase as the numerator grows, assuming that the total number of applicable

contracts remains relatively constant. Beneficial impact will be specific to the program and will focus on risk mitigation, greater independence, and/or improved health.

Story Behind Performance

Contributing Factors

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

Restricting Factors

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

What We Propose to Improve Performance

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

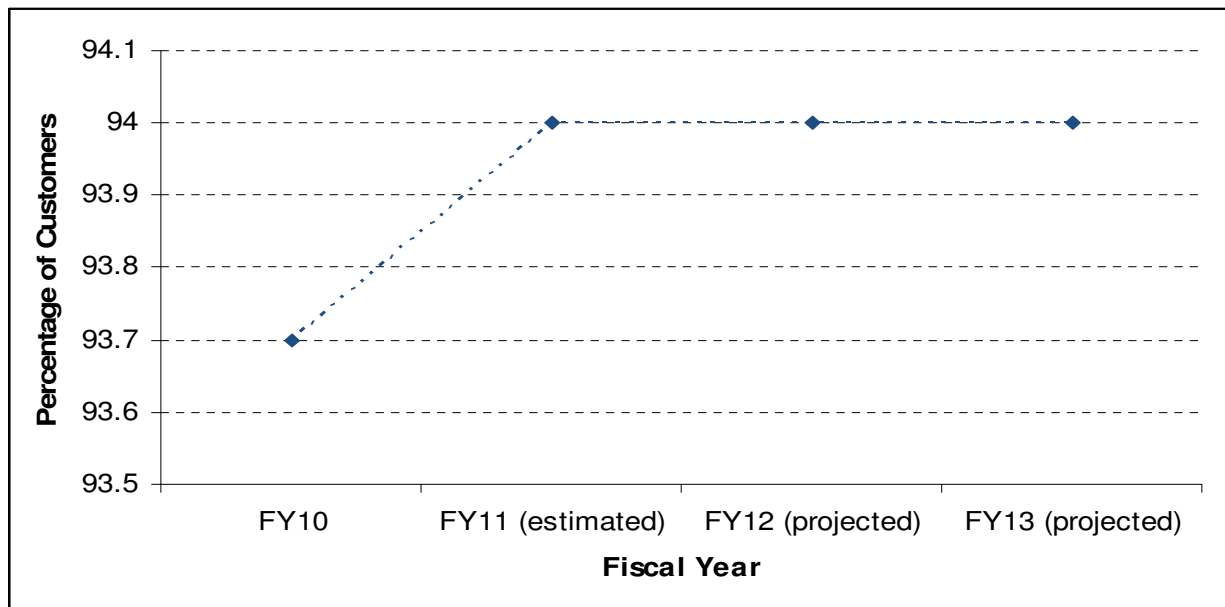
3. Customer Satisfaction

Basic Facts

- ◆ The programs contributing data to the composite result collectively served over 50,000 DHHS clients in FY10.
- ◆ In FY10, DHHS staff encountered Limited English Proficient (LEP) clients 49,000 times and used over 10,000 telephonic interpretations, nearly 300 per diem interpretations, over 5,700 vendor-provided medical interpretations, and 50 translations.
- ◆ While customer satisfaction per se is not the primary intended outcome of human services programs, it is typically used as a proxy outcome that reflects the quality of services provided by an organization. The assumption is that higher quality services are reflected in a greater degree of customer satisfaction.
- ◆ The standardized survey was voluntarily used by seven programs having recipients of services provided directly by DHHS staff. The results for one of the seven were not used in the composite due to the low number of respondents.
- ◆ An additional 16 programs had at least one question on their pre-existing customer satisfaction surveys that crosswalked to the questions on the standardized survey. Results from those questions were used in the composite.

Performance

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



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

The survey also asks whether the respondent required language (or sign language) assistance when contacting DHHS and, if so, whether they received it and their degree of satisfaction with the assistance received. The result for the submeasure (100% for FY10) was not statistically valid due to the low number of respondents to this survey question. Projections of 97% for each of the next three years are based on results achieved with the use of a previous measure of language assistance (based on a survey of pre-311 callers to DHHS Information and Referral phone lines).

Discussion

- ◆ The composite FY10 results for each of the five questions ranged from a low of 87.4% (“my needs were addressed”) to a high of 97.2% (“I was treated politely”). Some programs deviated significantly from the average composite overall satisfaction score of 93.7%. This is largely explained by the fact that some recipients of DHHS staff-provided services are receiving those services involuntarily (e.g., protective services).
- ◆ The empirical literature is replete with the fact that some people will report satisfaction even when they are dissatisfied.
- ◆ Composite indicators (i.e., those in which multiple questions are collapsed into an overall score) are often cited by researchers as providing greater validity in capturing latent constructs such as “satisfaction”, due to the ability to capture different facets of the phenomenon. Also, DHHS applied weights to the raw data so as to better reflect results based on program size. A new standardized customer satisfaction survey asked whether the respondent’s needs were addressed, and whether he or she was served in a timely manner, treated politely, treated with respect, and overall satisfied with services received.

Story Behind Performance

Contributing Factors

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

Restricting Factors

- ◆ Many sources of dissatisfaction are outside of the control of DHHS (e.g., budget reductions which are likely to reduce the availability of many services, and applicants’ ineligibility for program services)
- ◆ Large numbers of LEP residents and large diversity in languages spoken in the County

What We Propose to Improve Performance

- ◆ Work with Contracts Management Team to revise instructions for DHHS contractors' customer satisfaction surveys. DHHS has a goal of requiring that all contracts we originate include a requirement for such a survey. A standardized survey and instructions were developed and provided in new Requests for Proposals beginning in FY10, although the results have not yet been rolled into combined DHHS-staff-provided and contractor-provided customer satisfaction results.
- ◆ Continue to train select groups of DHHS staff in Customer Service, and encourage all staff to take Customer Service training offered by the County
- ◆ Continue to require new front-line staff to take Customer Service Across Cultures training
- ◆ Methodologies for selecting potential survey respondents (to ensure consistent random selection of participants eligible for the survey) and for survey administration (to enhance uniformity and to minimize response bias) are being revised for use in FY11

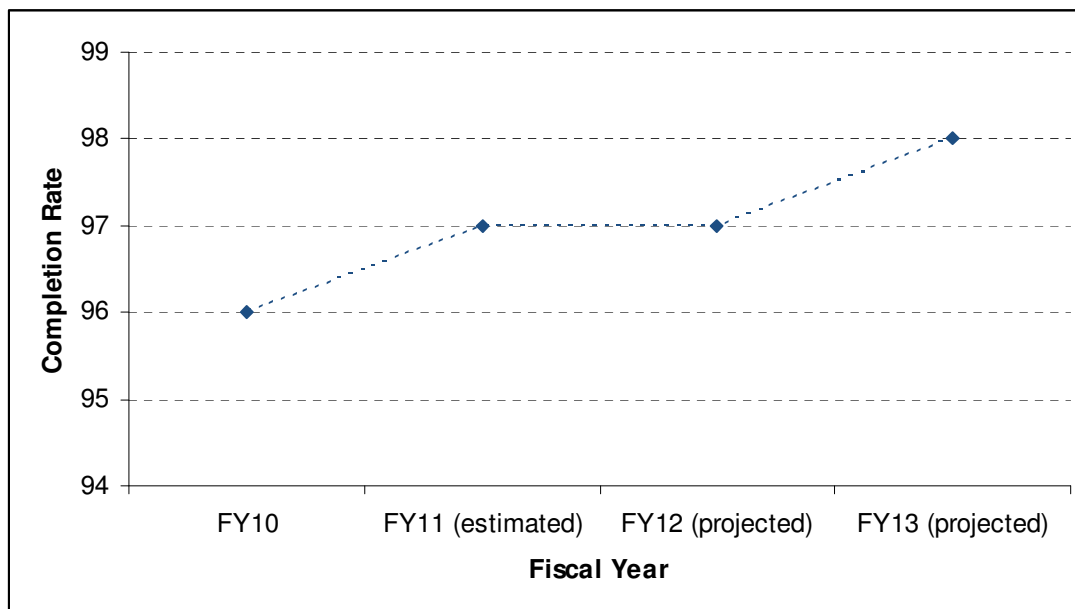
4. Contract Monitoring

Basic Facts

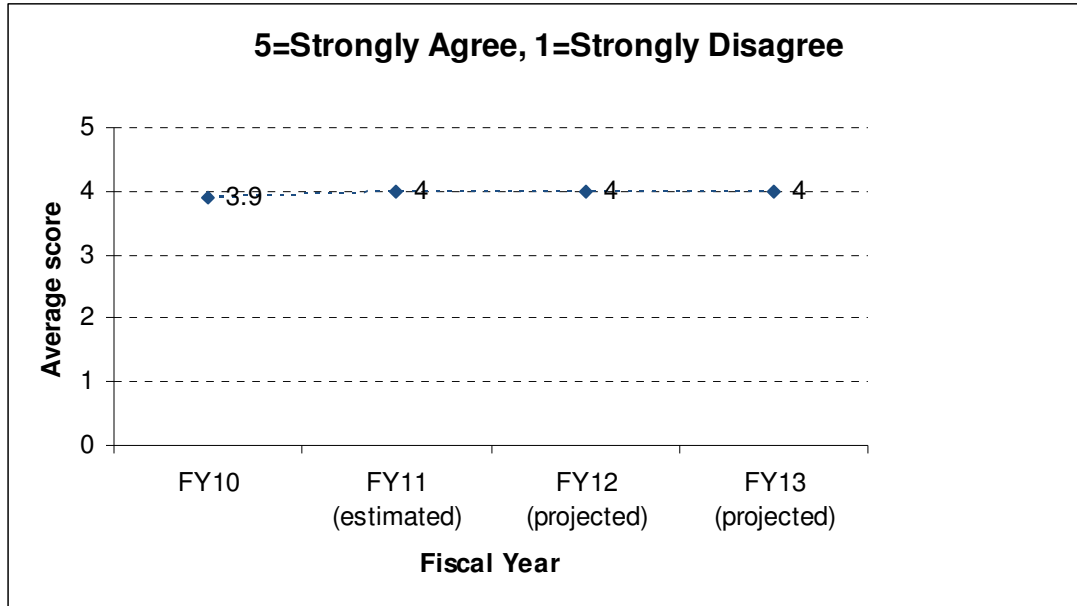
- ◆ Over 550 business, consulting and direct services contracts are administered by the DHHS Contract Management Team (CMT).
- ◆ Over 300 of DHHS' contracts are cost reimbursement contracts.
- ◆ DHHS has strong program based contract monitoring. As a result of several reports issued by the Office of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

Performance

Active contract monitors' training completion rates (County-administered and internally (DHHS)-administered)



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



Discussion

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

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

The statement to which trainees are asked to respond for the Average Response Score measure is "My work quality will improve in efficiency, effectiveness, or accuracy by attending this class." The survey used a five point scale (Strongly Agree = 5; Strongly Disagree = 1). The FY10 results are based on 279 evaluations provided by the Office of Human Resources (OHR).

In another OHR evaluation, 58 trainees were asked whether, because of the class, their work quality would remain the same or improve. Ninety-three percent felt their work quality would improve.

Story Behind Performance

Contributing Factors

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

Restricting Factors

- ◆ Many of the DHHS non-profit vendors lack a strong infrastructure, in terms of financial expertise needed to clearly document items such as indirect and fringe rates.
- ◆ Lack of fiscal background on the part of DHHS contract monitors.
- ◆ Limited resources for enhancing fiscal monitoring, both on the part of DHHS and vendors.
- ◆ Because of staff turnover and training schedules, training completion rates are subject to frequent variation.
- ◆ The volume of contracts monitored is substantial.
- ◆ Numerous staff throughout the Department perform contract monitoring functions that range from very little to 100% of their job responsibilities.
- ◆ Response scores from trainees taking required training tend to skew lower than for those taking discretionary training, per OHR.

What We Propose to Improve Performance

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

5. Juvenile Justice Assessments, Screenings and Referrals

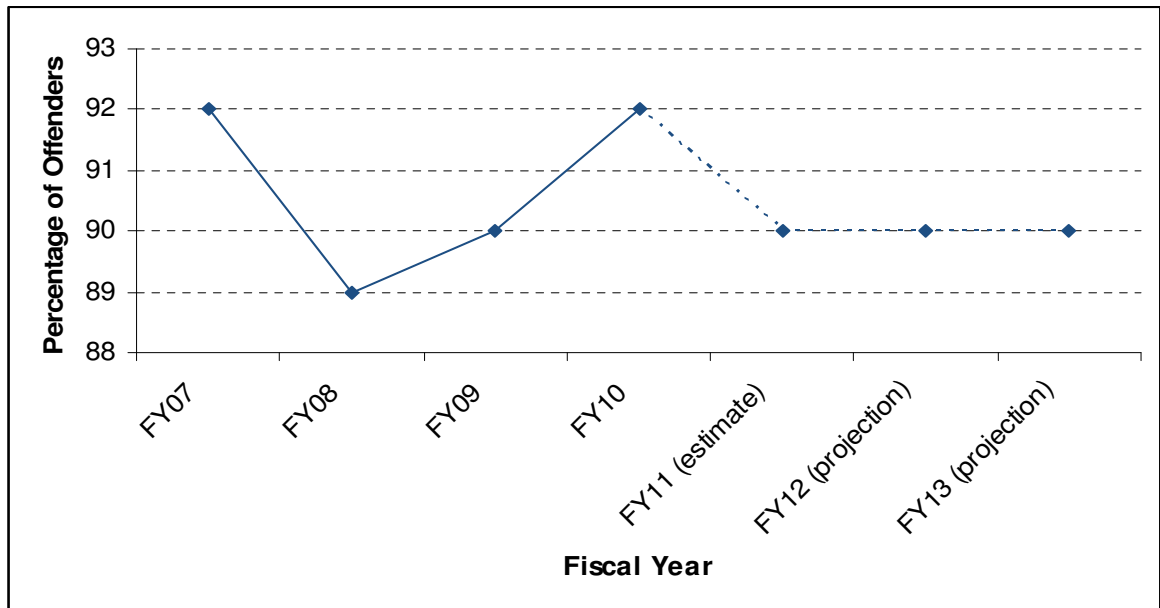
Basic Facts (FY10)*

- ◆ National studies indicate that 50-70% of youth entering juvenile justice systems have substance abuse and/or mental health problems. Providing substance abuse and mental health screening, education and referral to treatment for certain first-time youth offenders and other repeat youth offenders whose offenses are minor will reduce the number of repeat youth offenders and minimize the number of youth referred to the Maryland Department of Juvenile Services (DJS) or the Maryland Department of Corrections.
- ◆ Three hundred forty-five County youth under 18 received an alcohol citation.
- ◆ A total of 3,610 of the youthful offenders under 18 years of age were referred directly to the DJS, while 695 youth who either received an alcohol citation (see previous bullet) or committed certain nonviolent misdemeanors (usually for the first time) were “diverted” from DJS to DHHS where they received substance abuse and mental health screening and referrals, if needed, to a drug and alcohol education program or mental health or substance abuse treatment.
- ◆ Eighty-nine percent of youth diverted to DHHS by the Montgomery County Police Department (MCPD) were assessed “compliant” with the terms of their diversion agreement. Those who were non-compliant were referred to the DJS intake office.
- ◆ The DHHS Juvenile Justice Services unit partners with the DHHS Access to Behavioral Health unit to provide mental health treatment referrals for Medicaid-eligible youth who are diverted.
- ◆ Twenty-five percent of diverted youth entered intensive substance abuse or mental health treatment; an additional 21% received intensive substance abuse education, including urinalysis, and 45% received less intensive substance abuse education. The remaining 9% were not referred to community services based on their assessment. These youth may have had to complete teen court or other requirements through MCPD.
- ◆ 8.2 work years and \$980K were expended for operation of the Screening and Assessment Services for Children and Adolescents (SASCA), the alcohol and substance abuse screening program. This program assessed and referred a total of 1,576 juveniles in FY10.

* This measure is by definition a 12-month follow-up of juvenile justice clients; program completers are followed longitudinally from their completion dates. The reported recidivism rate is the outcome for the year in which the “follow-up” is conducted. Actual FY10 outcome data are based on follow-up conducted on clients who completed the program in FY09. Reporting on this measure occurred differently in past Annual Performance Plans, but is now consistent with all criminal justice behavioral health programs at DHHS.

Performance

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



Discussion

Results reflect youth screened for mental health and substance abuse disorders and diverted from the Juvenile Justice System into community education and treatment services that did not become re-involved in the juvenile justice or adult correction systems within a 12-month follow-up period.

In FY10, eight percent of the mostly first-time youth offenders who were compliant with the SASCA program requirements became re-involved within 12 months. The FY11 estimate is based on the number of successful program completers in FY10. For planning purposes, the out-years are projected to reflect FY11 results.

Story Behind Performance

Contributing Factors

- ◆ An array of community-based substance abuse and mental health education and treatment services are available to youthful offenders.
- ◆ Good cooperation exists among DHHS, Montgomery County Police Department, DJS, the State's Attorney's Office and community substance abuse education and substance abuse and mental health treatment providers.
- ◆ Pre-established diversion eligibility criteria are based upon the severity of the offense, whether or not the youth is a first time offender, and whether the youth admits to the offense.

- ◆ DHHS has an 11-year track record in providing “diversion” services and an experienced substance abuse and mental health screening and assessment staff.

Restricting Factors

- ◆ Underlying individual and family factors that result in criminal behavior are not always easily impacted; as a result, DHHS interventions are not always effective in preventing recidivism.
- ◆ Some criminal cases against youth that are cited again or re-arrested may eventually be dropped by DJS.
- ◆ The SASCA program has only one part-time case manager. Additional case management services could decrease the reoccurrence of offender behavior.

What We Propose to Improve Performance

- ◆ Continue partnership with the Montgomery County Collaboration Council and the State to assure future funding for the case manager position. This position works with families to increase the number of SASCA diversions that become engaged in the diversion process, and increase the retention rate in treatment among diversion program participants.
- ◆ Complete analysis of Juvenile Justice Information System (JJIS) data for diversity trends and outcomes in diversion in FY11.
- ◆ Continue work with the Montgomery County Collaboration Council, the State’s Attorney’s Office for Montgomery County, and Maryland DJS to explore expanding eligibility to diversion in order to serve more youth and families, and divert more youth from DJS.

6. Direct DHHS Services

Basic Facts

- ◆ Determining the impact of receiving DHHS services is central to facilitating a successful outcome for the customer.
- ◆ Determining the impact on customers of receiving DHHS services is a management tool for ongoing quality service improvement.
- ◆ Based solely on Client Record System (CRS) data, 69,921 unique individuals received services from DHHS in FY10.
- ◆ CRS data represent active clients that had a documented encounter with DHHS. The universe of active clients is higher for two reasons:
 - Clients who are active but who did not have a documented encounter in FY10 are not reflected in the data
 - Although CRS is the largest DHHS database, there are several other mandatory state or federal databases of DHHS clients. Some individuals in other databases are not in CRS.
- ◆ The actual number of individuals receiving services is unknown due to the lack of interoperable databases.
- ◆ At the close of FY10, DHHS had 1,254 full-time and 327 part-time staff for a total of 1,581. By mid-FY11, these staff numbers decreased to 1,243 and 320, respectively, for a total of 1,563. Contracted partners are also involved in serving customers within and across Service Areas.

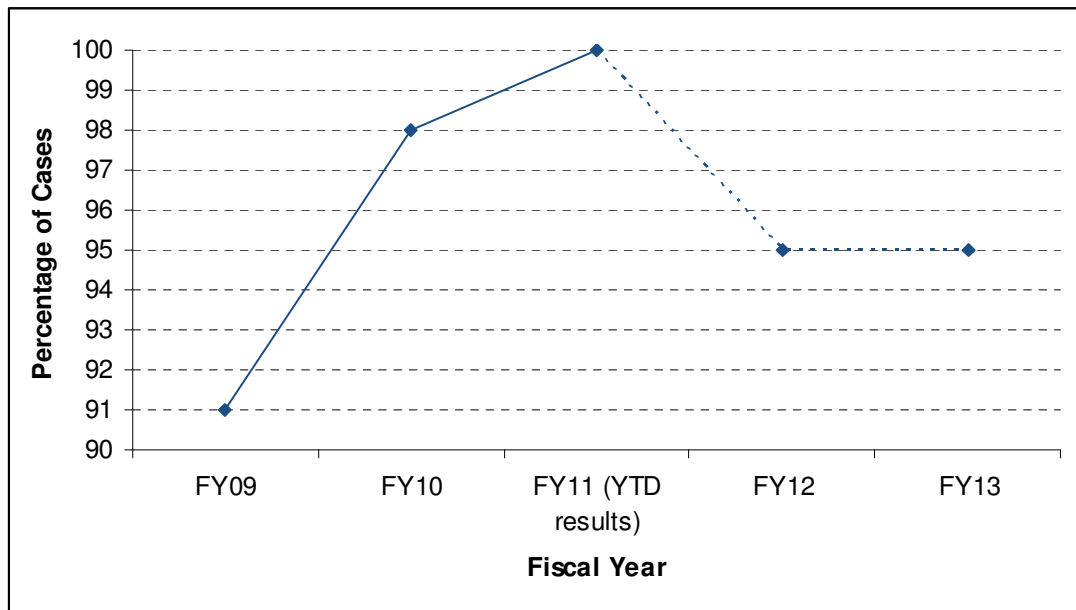
Performance

Weighted composite scores of DHHS client cases that demonstrate (three different aspects of) beneficial impact from received services.

| Aspect of Beneficial Impact | Weighted Composite Scores | | | | | |
|------------------------------|---------------------------|------|------|---------------|-----------------|-----------------|
| | FY08 | FY09 | FY10 | FY11 Estimate | FY12 Projection | FY13 Projection |
| Improved Health and Wellness | 53.4 | 49.1 | 50.8 | 52 | 53 | 53 |
| Greater Independence | 80.0 | 80.2 | 79.7 | 81 | 82 | 82 |
| Risk Mitigation* | 80.4 | 84.0 | 83.0 | 84 | 84 | 84 |

*The selection of programs for calculating this aspect of beneficial impact was slightly revised from FY08 to FY09 and again FY09 to FY10 to better reflect the scope of the Department's impact. Results for FY10 are for the new program selection, so is not strictly comparable to the previous years. Using the FY09 selection, the Risk Mitigation score for FY10 would be 86.1.

Percentage of client cases reviewed that demonstrate beneficial impact from services received*



*This second measure of beneficial impact is determined by a consensus rating of “substantial” or “fair” rather than “marginal”, “no impact”, “adverse”, or “unknown” by a team of reviewers after reading case records, conducting client and key informant interviews, and interpreting fact-finding results by matching them to descriptions in a standardized Quality Service Review (QSR) protocol.

Discussion

Quantification provides the impetus for increasing beneficial impact over time and for analyzing factors that affect the weighted scores. Development, testing and implementation of the QSR protocol for qualitative assessment has led to active planning for the improvement of system performance around team-based case practice.

There was an increase from FY09 to FY10 in the proportion of cases that showed “substantial” versus “fair” beneficial impact, as shown below. FY11 results are based on less than a year’s worth of data:

| | FY09 | FY10 | FY11 (YTD) |
|------------------|------|------|------------|
| % substantial BI | 65.9 | 74.4 | 72.7 |
| % fair BI | 25.0 | 23.3 | 27.3 |
| % other | 9.1 | 2.3 | 0 |

Story Behind Performance

Contributing Factors

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

- ◆ Progress continued toward an information technology solution that standardizes the intake and screening process. The computer-based model will facilitate more comprehensive screening for the range of customer needs,
- ◆ Expectations for case management, including intake and referral, assessment, case planning, service delivery and evaluation are strong and monitored by the Quality Service Review process.
- ◆ Best practice models are used in many programs.
- ◆ Four QSR review cycles were conducted over the year and more reviewers were trained. A process is established to review and use results for continuous improvement.
- ◆ Three Neighborhood Opportunity Network sites now serve geographic areas most impacted by the economic downturn.

Restricting Factors

- ◆ Knowledge about service integration and the team-based case management model is inconsistent throughout the Department.
- ◆ There is a need to continue to enhance data collection and analysis to support continuous improvement in service delivery.
- ◆ The needs of a population adversely affected by economic downturn are increasing in intensity while public resources are more limited. Clients are presenting with more complex needs and for a wider range of services.
- ◆ The capacity of our system is strained to respond to the volume and depth of need, and our infrastructure is weakened by budget cuts.
- ◆ Evidence-based Practices empirically validated as effective in addressing some social problems are limited in number.
- ◆ Resources (staff and funding) from external sources are needed to make substantial progress on interoperability.

What We Propose to Improve Performance

- ◆ Continuously seek efficiencies to deal with pressure on the system to serve more people with ever-decreasing resources.
- ◆ Monitor implementation efforts and provide support to staff in the move to a formal team-based case practice approach.
- ◆ Work to define equity, social justice and institutional racism to better address disparities in (and disproportionality among) residents needing and seeking certain services.

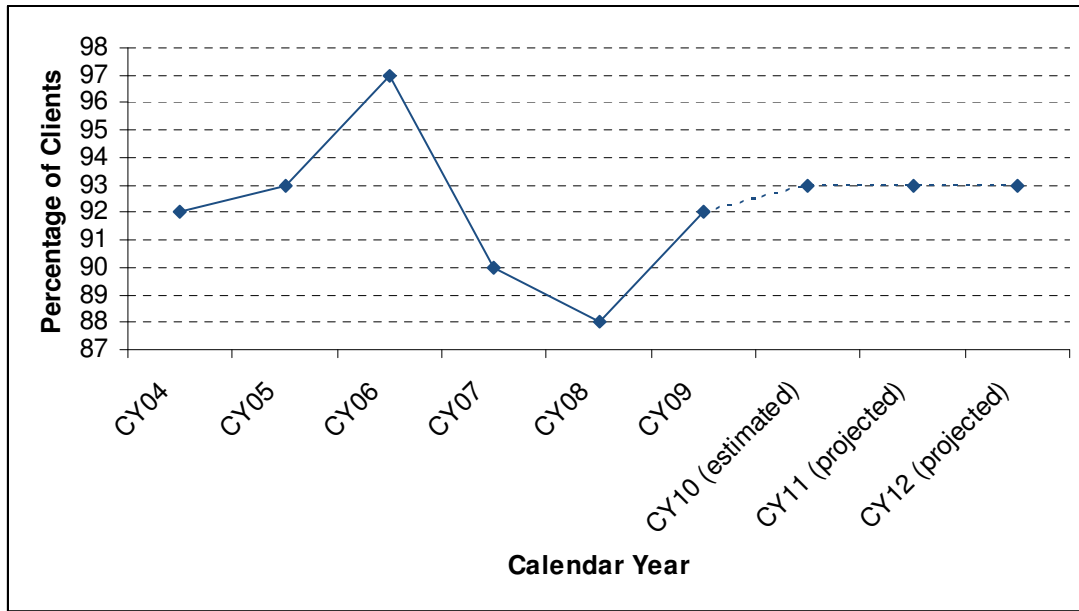
7. Communicable Diseases Control

Basic Facts

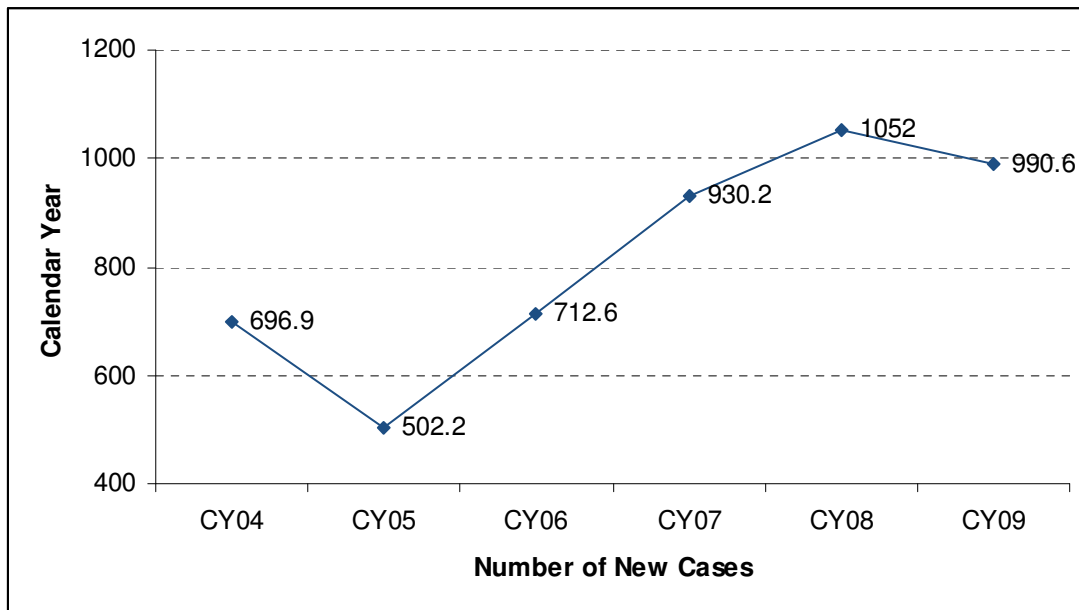
- ◆ The public is protected from communicable diseases by limiting their further spread.
- ◆ DHHS programs provide timely and appropriate response to reports of communicable diseases.
- ◆ DHHS programs provide access to prevention, diagnosis/early intervention and treatment of communicable diseases for at-risk (exposed) individuals.
- ◆ DHHS educates the public on best practices to further limit the spread of disease and protect the health of individuals.
- ◆ Annually, within Public Health Services (PHS), there are over 300 foodborne complaints/investigations (including Campylobacter, E.coli, Hepatitis A, Salmonella or Shigella); 2,600 communicable disease cases (including vaccine-preventable diseases, rabies exposure, Lyme disease, and bacterial meningitis); 75 active tuberculosis (TB) investigations involving approximately 1,000 individuals; and 535 sexually-transmitted diseases (STD) investigations, including Chlamydia, Gonorrhea, HIV and Syphilis.
- ◆ In CY09, there were 215 suspected cases of TB evaluated, with 73 cases requiring and undergoing treatment. There were also seven large scale TB investigations (three in an institutional setting and four in family constellations).
- ◆ The DHHS TB program annually manages approximately one out of every 147 of the national TB cases (approximately 25-30% of Maryland cases).
- ◆ In FY10, the DHHS Immunization Program administered 20,866 vaccines to 13,073 children; 5,022 doses of seasonal flu vaccine and 32,726 doses of H1N1 vaccine were administered to County residents.
- ◆ Timeframes and workload for outbreaks vary based on severity and mode of transmission of the contagion. A single outbreak may be resolved in a few days or three months. Smaller outbreaks are managed by one investigator but larger outbreaks require 8-10 investigators to control.
- ◆ Foodborne diseases and illnesses are being addressed in an integrative approach with Licensure and Regulatory Services.

Performance

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



New Cases of Chlamydia per 100,000 Population among County Residents (Ages 15-24)



Discussion

TB in Montgomery County occurs at dramatically high rates (twice the statewide and national averages). The largest number of cases in the state is found here. This is due to the large number of immigrants who arrive from countries where this disease is prevalent.

In CY09, those 5 (of 66) clients who did not successfully complete the TB treatment regimen died before diagnosis or treatment was completed. There were an additional seven clients who were provided medications to self-administer (i.e., they did not need to be directly observed but were instead monitored regularly).

The Chlamydia result for CY09 represents a 6% decline from the previous year. The number of cases for all those 15 and older experienced a 4.5% decline, but with a slight increase for those ages 35 and older.

DHHS chooses not to estimate future results for new cases of Chlamydia because of uncertainty over whether the decline in case numbers is the result of decreased exposure to the disease or decreases in screening populations at risk. At some point when awareness is elevated to screen all populations at risk, Chlamydia incidences should begin to fall as a result of decreased exposure to the disease resulting from such program activities as community education and partner notification.

Adding to the complexity in interpreting the results in 2009 is that, starting in January 2009 and in accordance with State guidelines, the State laboratory only covered the processing costs of Chlamydia tests for women 25 years and younger. Women 26 and older, and all males who present with symptoms or report contact with a case will be treated following Chlamydia treatment guidelines, but will not be tested (unless the submitting site covers the testing expense). For those untested cases, there will be no trigger to initiate contact tracing or any retesting.

Story Behind Performance

Contributing Factors

- ◆ PHS engages in multiple activities designed to: prevent disease from occurring through immunization, outreach and education programs; identify/diagnose disease through education, screening, and diagnostic evaluations; treat diagnosed diseases using the most effective prescribed protocols; and limit the further spread of disease with education, outreach and partner/contact notification for persons exposed to contagion.
- ◆ Quick response time to outbreaks and emerging diseases is the norm.
- ◆ Education, trust and regulatory authority are used to ensure persons with illness are consistently practicing healthy behavior, with emphasis on completion of treatment and adherence to treatment regimens.
- ◆ Immunizations are offered to county residents of all ages in a variety of settings and after hours.

- ◆ The County operates a strong emergency preparedness program, including exercises and training, recruitment of community volunteers (e.g. Medical Reserve Corps) and development of plans for public health emergencies
- ◆ Intensive medical and nurse case management of diagnosed diseases is provided.
- ◆ Aggressive strategies are in place for contact tracing and partner notification.
- ◆ Public health investigations follow federal and State guidelines for controlling communicable diseases, using sound epidemiological principles.
- ◆ To rule out TB, the TB control program provides screening to contacts of infectious cases of TB, newly arrived refugees, immigrant students prior to admission, County residents per job classification, inmates at the Detention Center, clients entering substance abuse centers, and symptomatic residents who walk into the clinic. The clinic also coordinates TB screening with the homeless shelters and provides treatment for latent TB infection to high risk individuals with the appropriate intervention/follow up.
- ◆ The TB Program successfully manages a number of drug resistant cases as well as some cases of multi-drug resistant tuberculosis (MDR-TB) where treatment can extend to two years.

Restricting Factors

- ◆ Public perception of risk is often inconsistent with actual risk, with the potential of untreated communicable disease presenting high risks to the general public.
- ◆ Funding issues have led to staff shortages in Communicable Disease and Licensure and Regulatory areas, which investigate foodborne disease outbreaks.
- ◆ Adult vaccine clinics were discontinued in FY10 due to lack of space and staff to provide the service.
- ◆ Public health is challenged to find a balance to motivate people to have safe and prudent behavior versus overreaction, restriction and seeking unnecessary treatment.
- ◆ County residents without legal status fear seeking medical care and consequently present with advanced disease.
- ◆ Starting in 2009, in accordance with State guidelines, the State laboratory covered the processing costs of Chlamydia tests for women 25 years and younger. Women 26 and older, and all males who present with symptoms or report contact with a case will be treated following Chlamydia treatment guidelines, but will not be tested (unless the submitting site covers the testing expense). For those untested cases, there will be no trigger to initiate contact tracing or any retesting.
- ◆ While STD clinics see 150 customers weekly to be tested for an STD, the lack of capacity causes an additional 150 callers to be turned away monthly - 65% of callers get an appointment, with 35% of callers asked to call back at a later date.
- ◆ TB program waiting times for clients to commence treatment for latent TB infection could be up to four weeks.
- ◆ Compliance with TB directly observed therapy (DOT) relies heavily upon the client's ability to remain in DHHS service area for the duration of treatment.

- ◆ DHHS continues to provide services to clients in accordance with appropriate protocols; however, revenue from general funds continues to decrease annually. With fewer resources, DHHS will not be able to respond in a timely manner to all presenting cases, nor will it be able to provide the full spectrum of services and delivery of care previously available to meet the needs of the community. Thus, future cases may be identified in more advanced stages of disease and resultant complications. This may potentially lead to increased illness and death.
- ◆ There is an increase in co-morbidity among communicable diseases (e.g. co-infection with HIV and syphilis).

What We Propose to Improve Performance

- ◆ Improve internal process for completing reports on closed cases to DHMH.
- ◆ Provide education/outreach on preventing and limiting the spread of communicable diseases by providing consistent cultural and language appropriate messages on aspects of health topics to improve public awareness and trust in DHHS services.
- ◆ Continue to invest in relationships with key partners, including efforts to implement a community health assessment involving local public health system partners and use information from this assessment to develop a Community Health Improvement Process (Healthy Montgomery).
- ◆ Continue to assess changing needs of the community and develop innovative ways to address those needs, such as increasing access via evening clinic hours.
- ◆ Advocate for additional revenue to compensate for shortfall from grant awards. With less operating revenue for grants, most or all grant funds go toward personnel costs.
- ◆ Advocate for continued clinic staff and space for appropriate screening, treatment, education and counseling/case management, specifically for the STD clinic up-county.
- ◆ Improve internal process for managing patient flow.
- ◆ Advocate for resources to train staff on best screening, counseling and treatment practices.

8. Social Connectedness and Emotional Wellness

Basic Facts

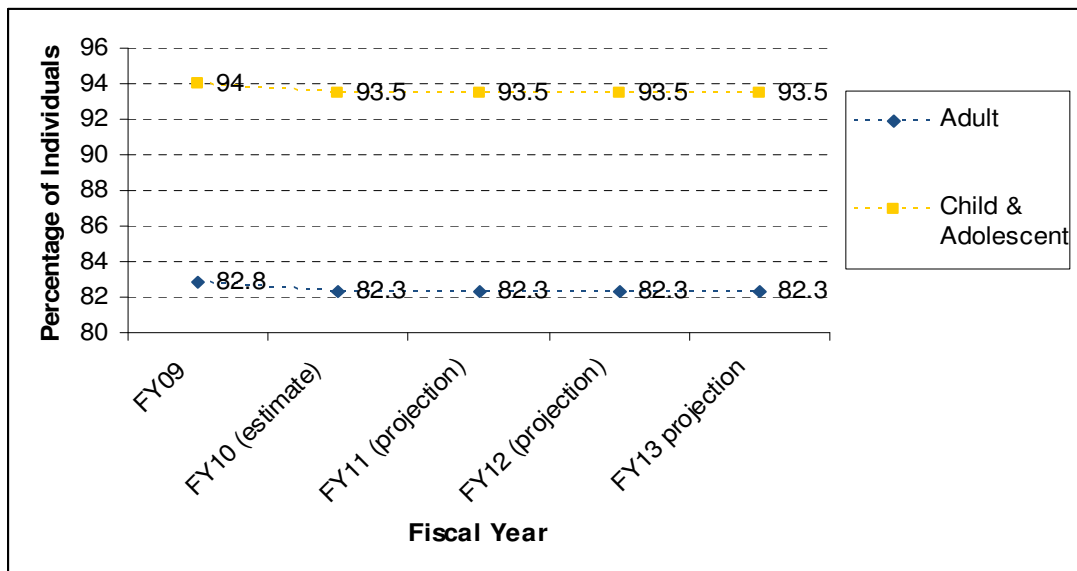
- ◆ DHHS supports a comprehensive system of behavioral health (mental health and substance abuse) treatment services to children, youth, adults, seniors and families through community partnerships, contracting and directly-operated services. Services incorporate evidence-based practices (EBP) and targeted preventive intervention along a continuum of care.
- ◆ Crisis and victim services are available around the clock to clients victimized in schools, homes and in the community.
- ◆ Access to Behavioral Health Services provides information, screening and referrals to appropriate mental health or substance abuse services for consumers, particularly those without commercial medical insurance.
- ◆ Services to clients with public health insurance and priority populations are monitored, including outpatient mental health clinics, senior outreach, homeless outreach, psychiatric rehabilitation and residential rehabilitation programs.
- ◆ In FY10, the Crisis Center served a total of 56,345 contacts including 52,968 phone contacts and 3,377 walk-in contacts. A total of 362 students were referred by their schools to be assessed for level of risk to themselves or their community; 95.6% of these students did not require emergency department services, were stabilized in the community and could return to school.
- ◆ During the five years from 2004-2008, an average of 1,596 individuals in Montgomery County reported an incident of domestic violence to legal authorities annually, accounting for 8% of all domestic violence incidents statewide. A total of 1,867 victims in Montgomery County in FY10 were referred to the Abused Persons Program (APP) for domestic violence services. In FY10, 1731 clients were seen face to face. A total of 834 services in FY10 were delivered in the Abuser Intervention Program which includes men and women in both individual and group sessions.
- ◆ A total of 2,840 sexual assault and general crime victims received services from the Victim Assistance and Sexual Assault Program. Additionally, there were 155 outreaches to sexual assault victims, assisting 288 victims and their loved ones in FY10. All rape victims were offered advocacy and counseling by trained and supervised volunteers who respond directly to police stations or the hospital. The Victim Assistants provided court accompaniment and court advocacy to 1,141 crime victims.
- ◆ In FY10, the Clinical Assessment and Triage Services (CATS), one component of the DHHS Criminal Justice programs, in collaboration with Department of Correction and Rehabilitation (DOCR) staff, oriented and screened 9,966 offenders entering the Montgomery County Detention Center to determine suicide risk.
- ◆ The Child and Adolescent Mental Health Home-Based Team served a total of 144 children in FY10. Of those served, 99% were able to be maintained in the current placement. Only 1% (n=2) of the children had to be referred to out-of-home care. The decrease in numbers for the Home-Based Team in FY 10 is due in part to the transferring of one work year to the Child and Adolescent

Outpatient Clinic to address the Spanish speaking waitlist. The clinic served 328 children in FY 10 with less than 1% needing to be placed out of the home (n=1).

- ◆ From FY09 to FY10, the number of Montgomery County consumers accessing the Public Mental Health System grew by 12.9% from 8,572 to 9,679. This upward trend is expected to continue given the uncertain economic times, increasing Medicaid enrollment and an increasing number of returning veterans needing services.
- ◆ The Adult Behavioral Health (ABH) Program provides a comprehensive range of mental health services including assessment, diagnostic evaluation, psychotropic medication, evaluation and medication monitoring. In FY10, 365 clients accessed services, among which 25% are Vietnamese speaking, 50% Spanish speaking, 12 African dialects speaking, and the remaining are English or other language speaking clients.

Performance

Percentage of individual clients served by the continuum of behavioral health services that demonstrate a higher degree of Social Connectedness and Emotional Wellness as demonstrated by positive outcomes in the domains of housing, quality of life, legal encounter, and employment/education*



* Computation of composite scores focus on Outpatient Mental Health Clinics’ (OMHC) outcome measurement data collected by Maryland’s Department of Health and Mental Hygiene (DHMH) on individuals ages 6-64 receiving outpatient mental health treatment from OMHC, Federally Qualified Health Centers and hospital-based mental health centers. The data release for FY10 is delayed until March 2011. Eight individual measures were chosen from the Maryland Department of Health and Mental Hygiene (DHMH) Outcome Measurement System (OMS) Data Mart to demonstrate consumer self-reported improvement in several domains comprised of housing, employment/education, legal encounter, and quality of life outcomes to represent a full spectrum of consumers’ treatment and recovery experience. The scores for each of these four domains of social connectedness are summarized in the form of a weighted mean of percentages to obtain an overall composite score. The weight used in calculating the weighted mean is the sample size for each of the eight questions in the OMS survey.

Discussion

In FY09, 2,712 adults (54% of all adult outpatients) ages 18-64 years accessed outpatient services at OMHCs and completed an OMS questionnaire. Additionally, outcomes data was collected on 1,984 child and adolescent consumers aged 6-17 years (65% of all child and adolescent consumers). Fiscal Year 10 outcome data will be reported after being released by DHMH to demonstrate the trend in overall social connectedness and emotional wellness and individual domains including housing, employment/education, legal encounter, and quality of life.

Outcome data collected by DHMH from patients served by OMHCs is currently the primary data source supporting this Headline Measure. As planned, in FY10 Behavioral Health Planning and Management program (BHPM) implemented a pilot study of a short version of the OMS questionnaire in county residential rehabilitation programs to evaluate the effectiveness and feasibility of the outcome measurement tool in BHCS programs beyond outpatient settings. A comparative analysis will be completed after release of OMS data by State.

Two separate composite scores were computed for adults and children. The Employment/Education domain measures Staying in School for children and adolescents, and Gained/Retained employment for adults. The difference in the scores for the two groups is attributable to the drastically low employment rate among adult consumers. A much higher rate of child and adolescent outpatients still manage to stay in school despite all the challenges they face.

Story Behind Performance

Contributing Factors

- ◆ A continuum of comprehensive community-based substance abuse and mental health treatment services is available to individuals across the life span.
- ◆ Strong collaborative partnerships exist between DHHS, Montgomery County Public Schools, Montgomery County Police Department, DOCR and community providers to support a comprehensive system of care.
- ◆ DHHS provides well established County-operated crisis services.
- ◆ DHHS has a strong commitment to delivering services that are recognized either as evidence-based or promising practices.
- ◆ In FY10, four staff members of the ABH program participated in the motivational Interviewing sessions offered by the University of Maryland and are using this evidenced based practice.
- ◆ In FY10, APP received certification for the Abuser Intervention Program which also modified delivery of groups so that referrals can be accommodated within two weeks; the waiting list has been eliminated.

Restricting Factors

- ◆ An adequate data system to provide timely and accurate information to effect sound, data-driven decision making is lacking.

- ◆ There can be extensive time delays from the time a service need is identified to actually having a contract in place to provide needed services to our community.
- ◆ Society sometimes criminalizes those with mental illness.
- ◆ Continued budgetary challenges.

What We Propose to Improve Performance

- ◆ Increase number of providers in the community that are trained in EBPs.
- ◆ Continue ongoing data analysis projects of various databases including Public Mental Health System Paid Claims data and Health Services Cost Review Commission Inpatient Admission data to assess notable service utilization pattern/trend and existing comorbidity issue for county's mentally ill population.
- ◆ Increase opportunities for individuals with behavioral health disorders to live successfully in, and remain in, the community.
- ◆ Continue to seek opportunities to integrate somatic health care and behavioral health care services.
- ◆ Continue to partner with the Department of Technology Services for Geographic Information Systems Services as part of ongoing efforts at improved data collection and informed forecasting of service needs.
- ◆ Improve data system for all programs in BHCS which would enable managers to utilize current existing data to improve performance and utilize resources towards maximum efficiency.

9. Providing Health Care Access

Basic Facts

- ◆ Montgomery County had 110,284 uninsured residents in 2009, including 8,130 children. Approximately 38,000 children and 24,500 adults 18-64 years were covered by some public health insurance option (including Medicaid, Medicare, or other government assistance plans).
- ◆ Providing access to health care to all residents has many benefits: healthier, more productive residents; less absenteeism from school or work; more disease prevention, earlier detection and better management of diseases such as asthma, diabetes, cancer and heart disease, and cost savings that arise from prevention and more appropriate use of hospital emergency rooms for true emergencies.
- ◆ Montgomery County has led the way in the State and is probably one of the few jurisdictions nationally to attempt to address the issue of access to health care at the local level.
- ◆ The DHHS Service Eligibility Units (SEUs) process medical assistance applications for the Medicaid for Families program and the Maryland Children's Health Program (MCHP) that are funded and administered through the Maryland Department of Health and Mental Hygiene (DHMH) to cover minor children under the age of 21 and their parents or caretaker relatives and pregnant women. SEUs also process applications for Care for Kids, the Maternity Partnership, and Senior Dental.
- ◆ Additional Medical Assistance coverage groups that fall under the Aged, Blind, and Disabled (ABD) and Families and Children (FAC) categories are administered by the Maryland Department of Human Resources (DHR) and processed by the DHHS Income Support program, along with eligibility for other public assistance programs like Food Stamps, Temporary Assistance for Need Families (TANF), and Temporary Disability Assistance Program (TDAP).
- ◆ In FY09 DHHS processed 70,016 medical assistance applications and 7,335 county healthcare program applications. Of these, 45,487 medical assistance and 7,135 county health care programs applications were approved. Currently, the three SEUs lead the state in the number of enrolled medical assistance cases which averages 38,885 monthly. In the same year, Income Supports offices processed an additional 35,793 applications for other forms of public assistance.
- ◆ DHHS staff enrolled 3,366 uninsured children, who are not eligible for State or federally funded programs, into the County's Care for Kids program in FY10 and enrolled an additional 1,999 pregnant women in the Maternity Partnership to ensure access to prenatal care and delivery services. The Montgomery Cares Program provided access to primary health care and prescriptions plus limited specialty care to 26,268 uninsured adults in FY10.

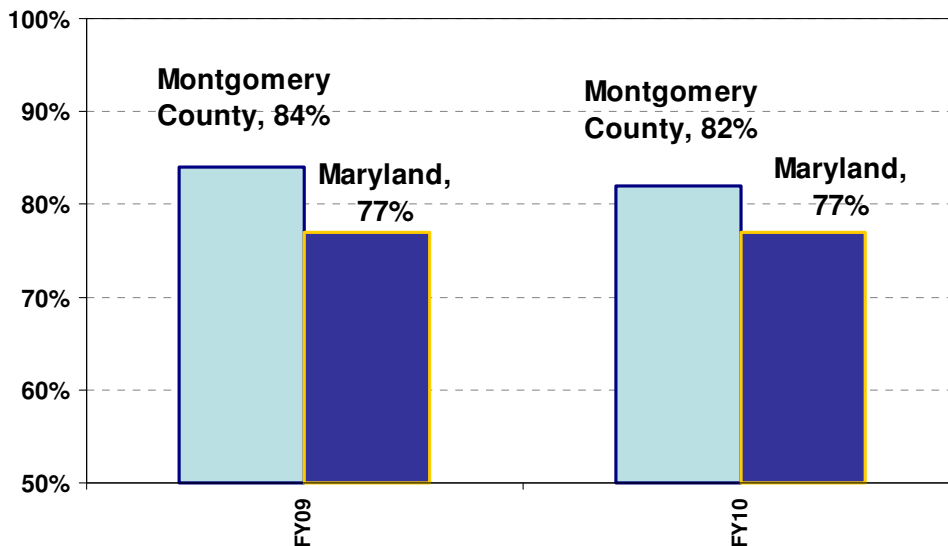
Performance

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

| Populations | FY09 | FY10 | Projections |
|------------------|--------------------|--------------------|--|
| Children | 34.7 | 41.4 | The Department is not projecting results at this time due to the multiple variables related to health care reform. |
| Adults | 21.3 | 25.7 | |
| Pregnant Females | Under Construction | Under Construction | |

Percent of Montgomery County medical assistance applications approved for enrollment.

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



Discussion

While Care for Kids enrollment decreased 6.5%, the estimated population of children without health care coverage declined by 22% from 2008 to 2009. The net result is an overall 7% increase in health care services for children. Similarly, while Montgomery Cares enrollment increased 25%, the number of uninsured adults ages 18 and older increased 3% from 2008 to 2009. The net result is a 4.4% increase in health care services for adults.

The number of pregnant female County residents without health care coverage is not yet available from the Census Bureau’s American Community Survey. DHHS is in the process

of exploring a proxy derived from utilization data kept by the Maryland Healthcare Services Cost Review Commission.

In FY10, 40,331 new applications were submitted for enrollment into Maryland's medical assistance programs (Community Care and Long-Term Care) with 32,339 applications (82%) approved. The FY10 average approval statewide was 77%.

Story Behind Performance

Supporting Factors

Eligibility

- ◆ DHHS enrolls uninsured residents who are not eligible for State or federally funded programs into the County Care for Kids program or refers adults to the County's Montgomery Cares program to ensure access to primary health care and related prescriptions, or to the Maternity Partnership Program for prenatal care.
- ◆ County residents may enroll in specific health care access programs at multiple sites.
- ◆ SEU procedures were streamlined to accommodate the 2008 family Medicaid and the 2009 Children's Health Insurance Program Reauthorization Act (CHIPRA) policy expansions, which also helped the state of Maryland qualify for a \$10.5 million CHIPRA performance bonus in 2010.
- ◆ DHHS provides language interpretation for large numbers of applicants with Limited English Proficiency. In addition, the Department supports residents in using an online application to enroll in medical assistance programs. Health Promoters from the community and other outreach staff also help to link residents to health access programs.

Education

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

Funding

- ◆ County leadership continues to support the current capacity for Montgomery Cares clinics for uninsured adults; a large number of volunteer medical providers contribute time to support Montgomery Cares; additional specialty care providers contribute discounted care; and local clinics and hospitals contribute services and facilities.
- ◆ Enrollment of eligible County residents in State- and federal-funded health insurance programs - including medical assistance and similar programs- leverages County dollars for enrollment workers with State and federal dollars to cover health care administrative costs. Hospitals cover half the cost of County eligibility staff working in the hospitals; and State grants and federal reimbursement cover full or partial costs of many County eligibility staff.

Staffing

- ◆ The FY11 budget included funding for three new eligibility workers for the Medical Assistance eligibility programs. Once these and a fourth current vacancy are filled, it is expected to result in the identification of additional Montgomery Cares patients who are eligible and will enroll in either Medicaid or the State's Primary Adult Care program.

Restricting Factors

Eligibility

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

Education

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

Funding

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

Staffing

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

Information Technology

- ◆ Seamless interoperability and integration of medical assistance and County-specific healthcare programs eligibility screening and processing is needed to improve efficiencies and to provide accurate caseload and client demographic information.
- ◆ DHMH, in coordination with the SEU, is preparing to launch a web based medical assistance pre-screening questionnaire and an electronic application system entitled "Healthy Maryland", that is designed to integrate the eligibility process for county, state, and federal health care programs.

What We Propose to Improve Performance

Eligibility/Information Technology

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

Education

- ◆ Increase individual awareness of eligibility for medical assistance programs through the Montgomery County MC311 information line and updates to the County web site; by continuing to support the online information about resources available to County residents through the Collaboration Council's www.InfoMontgomery.org; and by providing information in multilingual formats like the Montgomery Cares web site (www.MontgomeryCares.org) and brochures.
- ◆ Advocate for and train additional volunteer Health Promoters to assist residents in applying for available publicly-funded health insurance/primary care programs.

Funding

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

Staffing

- ◆ Advocate for hiring and training additional eligibility workers as supported by workload data. The actual number of people enrolled that also require caseload management is far greater than the number of applications processed since applications are typically initiated by the head of household and the average household usually includes two or more minor dependent children.
- ◆ Advocate for resources to increase administrative support and caseworker staffing to provide timely processing of client applications, effective caseload management, adequate case record filing and storage management, and provide dedicated staff to address and resolve client issues.

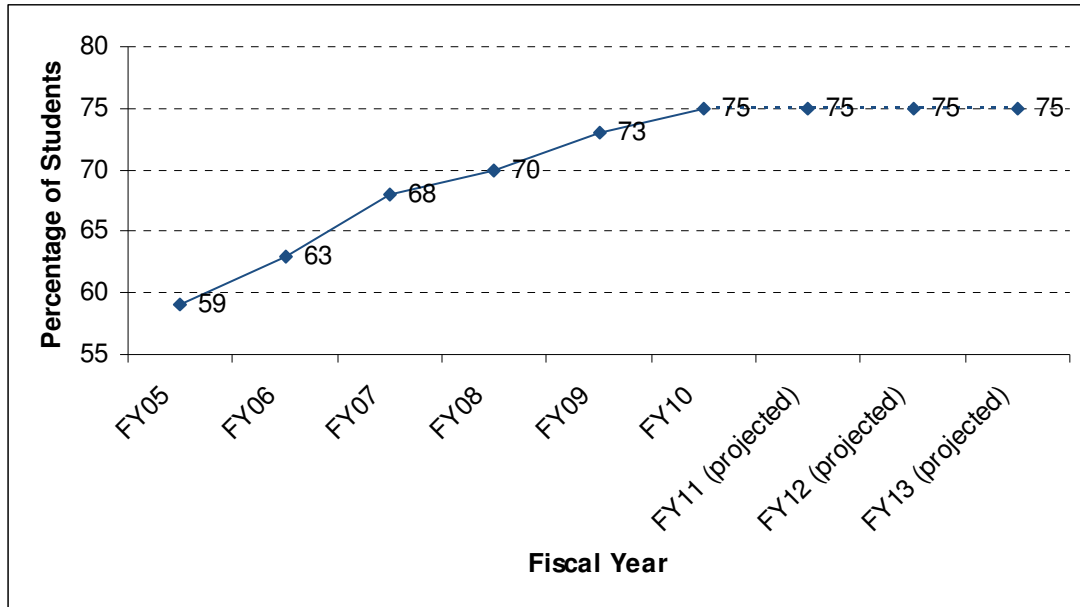
10. Early Childhood Services and Programs

Basic Facts

- ◆ The U.S. Census Bureau in its American Community Survey estimates that, in 2009,:
 - 82,000 children under age six lived in Montgomery County;
 - There were approximately 111,000 families with children; 43% of these families had young children under age six;
 - 56,000 children under age six had both parents in the labor force;
 - Over 22,000 children under age six lived in families with low incomes (less than 200% of poverty level) in 2009, a 73% increase since 2000.
- ◆ There were 13,493 births in 2009, according to the Maryland Vital Statistics Administration.
- ◆ Early Childhood Services documented that 163,229 services were delivered to young children, their families and caregivers in FY10. These services include a wide variety of publicly-funded supports, for example home visiting to at-risk families, workshops for child care providers to enhance the quality of care, health screenings for young children from low income families, Library Story hours, Recreation Department programs, and outreach to help families find the resources they need. Also in FY10:
 - Child care resource and referral information was provided to over 30,000 parents.
 - The Montgomery County Infants and Toddlers Program served 3,952 families, an increase over the previous year's 3,825.
 - 724 children were enrolled in Montgomery County Head Start: with a funded enrollment of 648, 618 were served through the Montgomery County Public Schools (MCPS) Head Start and another 30 were served in community-based Head Start settings.
 - 2,295 four-year-old children were served in the MCPS Pre-Kindergarten program.
 - 4,559 health screens for newborns were conducted in hospitals by the Baby Steps program contract staff.
 - 2,504 program referrals were made to early childhood and family support services by CHILDLINK staff.
 - 884 child care providers received workshop training through the Montgomery County Child Care Resource and Referral Center, and 98 child care providers received scholarships to pursue early childhood coursework at Montgomery College.
 - 12,717 pieces of early childhood public engagement materials were distributed through integrated outreach efforts.
 - Onsite Early Childhood Mental Health Consultation Services were provided to 42 child care programs serving over 3,000 children.
 - Early Childhood Services budget: \$6.7 million includes \$5.2 million in contracts and 24 work years. This includes Montgomery County Infants and Toddlers Program ARRA funding.

Performance

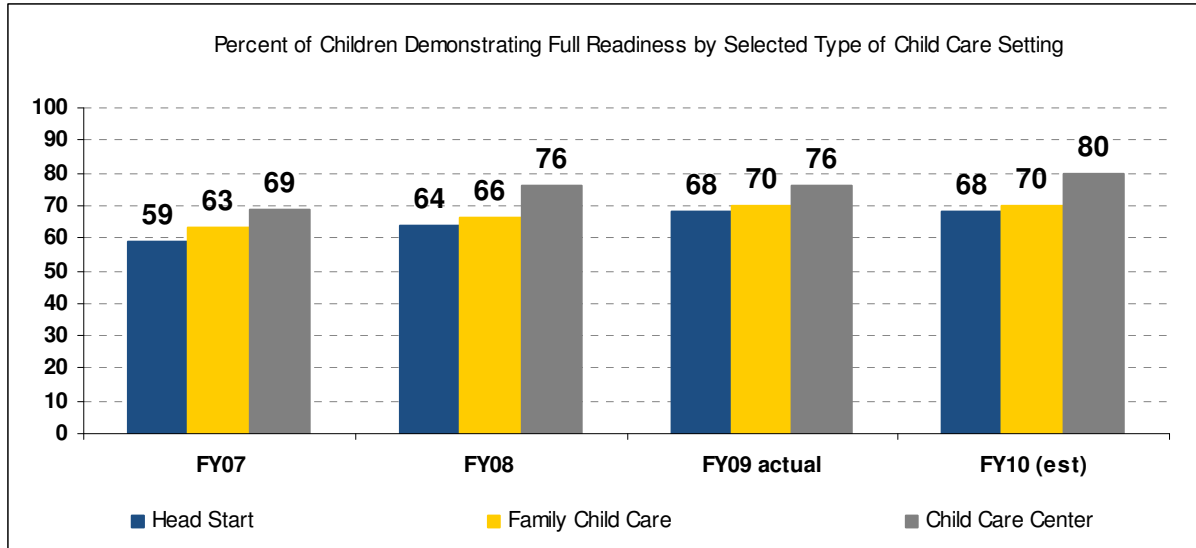
Percentage of Head Start, licensed child care centers and family-based child care students who demonstrate “full readiness” upon entering kindergarten.



Discussion

Measurement takes place after entry into kindergarten. Hence, prior care is assessed in the context of a child’s readiness to learn upon entry to kindergarten. The percentage of county children achieving full kindergarten readiness has increased steadily in recent years. The Maryland Department of Education (MSDE) defines “full readiness” as “students consistently demonstrate skills, behaviors and abilities needed to meet kindergarten expectations successfully.”

The overall composite percentage of children achieving full kindergarten readiness in FY10 was 76, varying by type of prior child care setting as indicated in the chart on the next page.



Those in MCPS pre-kindergarten, a setting which is not included in this measure, demonstrated the highest readiness score, 87%, in FY10. A fifth category, Home/Informal Care, scored the lowest (64%), while a sixth (non-public nursery,) scored 76%. Except for the latter two settings, which declined from FY09 to FY10, kindergarten readiness has consistently improved in every setting in the County since 2002.

Story Behind Performance

Contributing Factors

- ◆ DHHS collaborates with State partners including the Office of the Governor, MSDE, Maryland Department of Health and Mental Hygiene, and County partners including MCPS, private non profit partners and other County agencies, to provide a continuum of comprehensive services to support successful transition of children to kindergarten and to show annual improvement in coordination and service delivery. Increased focus on collaboration among partners led to improvements in kindergarten readiness over the past seven years (FY04-FY10).
- ◆ Effective MCPS Head Start curriculum, teacher and instructional assistant training, and program guidance and training of the family service workers and social workers that work with each Head Start family all contribute to better kindergarten readiness for children enrolled in the Head Start program.

Restricting Factors

- ◆ Fewer early childhood services were documented in FY10 as compared to FY09. With the economic downturn, the majority of programs, public and private, faced reduced budgets, while waiting lists and the eligible population grew. As American Recovery and Reinvestment Act funding runs out in FY11, additional reductions are expected.
- ◆ Children enrolled in Head Start who come from families with incomes below the federal poverty level face several disadvantages compared to their

- counterparts in privately-operated child care programs. According to the Montgomery County Community Action Agency, in FY10:
- 51% came from single parent families
 - 57.6% came from homes where the primary language is not English
 - In 32% of Head Start families, the parents' highest level of education was less than high school; another 31% had only high school or General Equivalency Diplomas.
- ◆ A significant percentage of all immigrants coming into the State of Maryland settle in Montgomery County, creating challenges to providing culturally appropriate early childhood services.
 - ◆ Lack of funding for public engagement educational outreach limits access to appropriate services and constrains progress in kindergarten readiness.

What We Propose to Improve Performance

- ◆ Under the auspices of the Early Care and Education Congress, an Action Agenda was adopted with strategies listed under three main goals: 1) Everyone will understand the need to support school readiness and their role in preparing children for school. 2) All young children will have access to high quality and culturally competent early care and education programs and health services that meet the needs of families, especially low-income families, families with children with disabilities and English language learners. 3) All professionals who work with young children will be appropriately educated in promoting and understanding a comprehensive approach for the development of the whole child, including physical, social-emotional and cognitive well-being as a basis for school readiness.
- ◆ Continue to work with the federal and state government to build coalitions and apply for any new funding that becomes available.
- ◆ In keeping with the State Early Childhood Advisory Council priorities for low income children, children with special needs, and children from families where English is a second language, seek data on Montgomery County's children in those categories and advocate for additional resources.
- ◆ Promote at every opportunity the message developed by the Early Care and Education Congress and featured on the one pager now used as an advocacy piece statewide: During hard times, it is critical that we champion a family-focused early childhood service delivery system and that we maintain funding for the whole system of services that supports these important gains. A loss in any one program jeopardizes the overall design of the system.

11. Employment Services

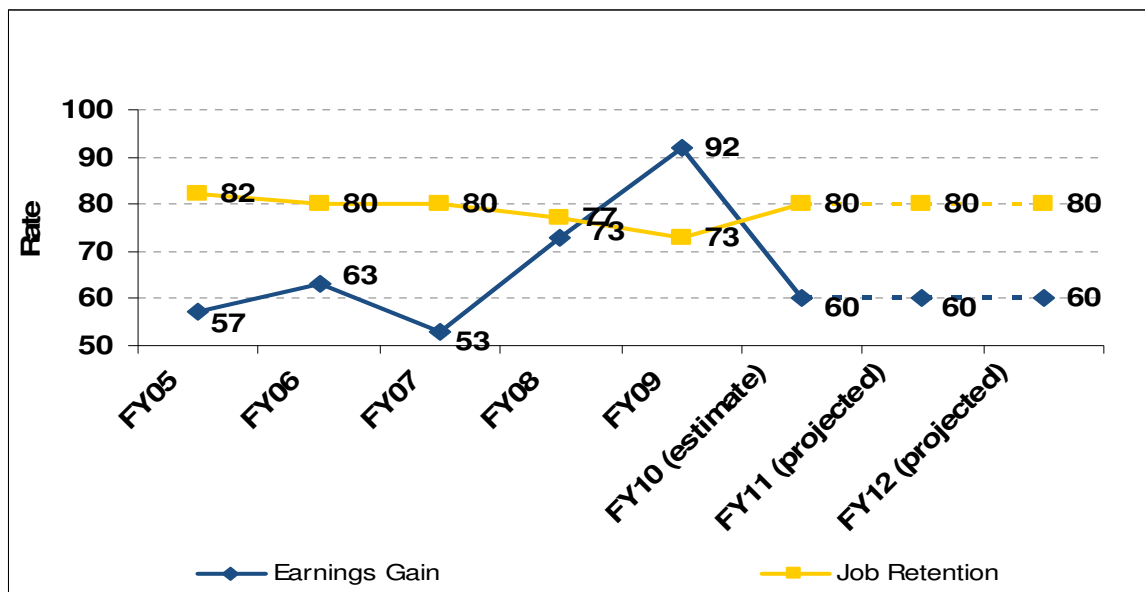
Basic Facts

- ◆ DHHS assists County residents who meet eligibility criteria in obtaining Temporary Cash Assistance (TCA), the federal cash benefit program.
- ◆ DHHS provides TCA recipients assistance in accessing child care, transportation, housing, case management, substance abuse treatment and other medical care services, and employment counseling, training and job placements.
- ◆ Federal law requires that Temporary Cash Assistance (TCA) recipients not exempted from the work program participate in employment activities leading to economic self-sufficiency in order to qualify for and retain TCA. If eligible, they can receive Medicaid and food supplements (formerly known as food stamps) and qualify for child care subsidies and transportation reimbursement while participating in employment activities.
- ◆ The State of Maryland tracks outcomes relevant to increased economic independence for TCA recipients that receive job placements, including job retention rate and earnings gain rate.
- ◆ The County, through its WORKS data management system, tracks hourly wage rate at job placement, and percentage of individuals with full-time employment that are offered health insurance benefits within one year of case closure.

Performance

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

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



Discussion

Fiscal Year 09 is the most recent data available for these measures due to a significant (18 month) time lag. Montgomery County surpassed the State goals of 70% and 40% respectively for both of these measures, and has consistently surpassed these same goals in recent years. The Earnings Gain Rate was the second highest of all Maryland counties. The Department has 10 years of better-than-average performance on all of the State's performance measures.

Additionally, during FY10, Montgomery County's average hourly rate for TCA recipients at job placement was \$10.88. This was the highest hourly wage average amongst all Maryland jurisdictions.

Finally, the percentage of all TCA recipients that found employment and were offered health insurance within one year of employment was 53%. The rate for those employed full-time receiving health insurance was 90%.

Story behind the performance

Contributing Factors

- ◆ DHHS contracts out the Employment Services program to vendors that are subject matter experts in employment support services.
- ◆ A team of DHHS staff with knowledge of Income Support programs, Welfare to Work policies and contract management oversees the daily operations of the Welfare to Work program.
- ◆ There is a strong commitment to facilitate the vendor's operation through a team approach with DHHS and vendor staff that emphasizes goal orientation, seamless processes, excellent customer service, transparency and accountability.
- ◆ Intensive case management and follow-up services provided to TCA applicants and recipients increase the likelihood that those eligible will be able to obtain and retain jobs that will enable them to become more economically independent.
- ◆ Strong partnerships with other public agencies (such as those related to economic development) and with private sector partners (such as job placement resources for internships and permanent employment), support program goals.

Restricting Factors

- ◆ Funding for intensive long-term tracking of client outcomes was cut in the past so that only minimal follow-up of TCA clients' employment status and job earnings now occurs.
- ◆ The significant increase in recent years in the number of TCA applicants and the TCA caseload is correlated with increased unemployment and the decline in the economy.

- ◆ The increase in TCA recipients and caseloads creates significant barriers to serving the most vulnerable customers and those with the most complex cases (i.e., customers with potential or undiagnosed mental health issues).
- ◆ The higher caseload has not been accompanied by an increase in staff; the increased demand for services has not resulted in any additional funding to support technical skills training.
- ◆ Less skilled workers are having a harder time finding permanent employment and are likely to get temporary jobs or contract jobs that end after a few weeks or months.
- ◆ Earned Income data are not available for some time periods for current or former TCA recipients that are federal workers, affecting both the earnings gain and the job retention statistics.

What We Propose to Improve Performance

- ◆ Strengthen the comprehensive employment services program with continuing supports to TCA clients.
- ◆ Develop paid internships/apprenticeships for a cohort of TCA customers.

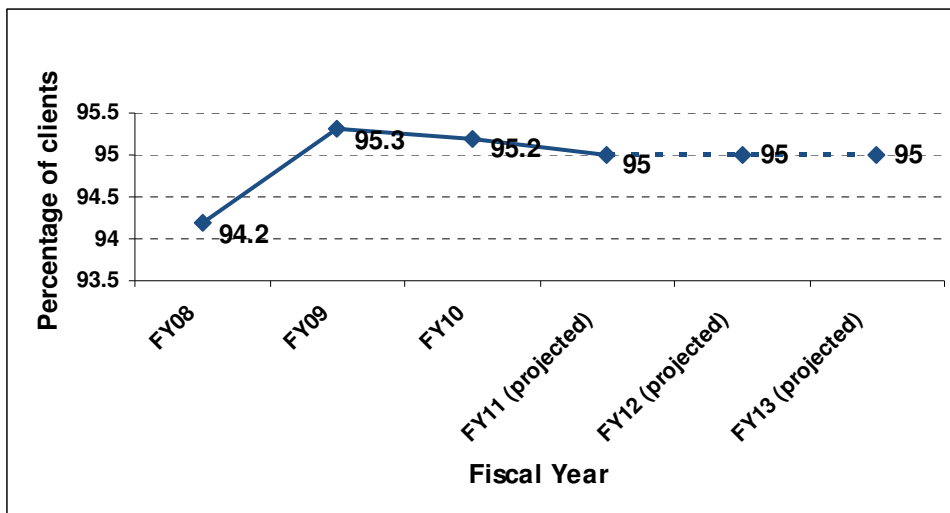
12. Maintaining Independence in the Community

Basic Facts

- ◆ DHHS provides assessment, continuing case management, and an array of services to elderly and disabled county residents, including: nursing assessment, personal care, housing subsidies, structured and supervised daytime activities, respite care, home modifications and assistive devices, and support groups for caregivers.
- ◆ One of the primary desires of senior and/or disabled populations is to remain independent in the community (i.e., 80% of elders express desire to remain living in their current homes for as long as possible).
- ◆ In FY2010 DHHS' Aging and Disability staff provided assessment and continuing case management services to over 2,000 unduplicated individuals.
- ◆ Services were provided by 50 work years of Masters level staff (40 Full-Time Equivalent (FTE) social work staff + 10 FTE Community Health Nurse staff)
- ◆ The DHHS Older Adult Waiver program allows for a more in-depth array of services to prevent premature institutionalization.

Performance

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



Story Behind Performance

Contributing Factors

- ◆ Highly trained and knowledgeable staff provides services.
- ◆ Social support systems and services (critical factors in determining whether or not an individual will need nursing home placement or other institutional care) are available and accessible.
- ◆ An array of services are provided, including case management, nursing assessment, personal care, senior care, adult foster care, adult day care,

respite care, group home subsidies, support groups for caregivers, home modifications and assistive devices.

Restricting Factors

- ◆ Budget constraints have progressively restricted service delivery to individuals at higher levels of functional impairment and risk for institutionalization. While the outcomes for people served have remained consistent, the capacity of HHS to provide services to all vulnerable individuals in need has declined due to staffing and funding limitations.
- ◆ The size of elderly and disabled populations is increasing, particularly among the oldest-old (age 85+) and those with cognitive impairment.
- ◆ The disabled elder population often has multiple and complex health problems (physical and cognitive).
- ◆ The waiting list for Older Adult Waiver (federal program administered through the State) is currently 1,632 and is anticipated to grow.
- ◆ Demographic projections indicate that as the number of disabled elders continues to increase, the number of informal supports (family or friends) available will decrease. This reduction is due to declining birth rates and greater percentages of adults in the work force.

What We Propose to Improve Performance

- ◆ Identify system factors that lead to higher vs. lower quality services through Quality Service Reviews.
- ◆ Examine the feasibility of redirecting internal resources to expand the Better Living at Home program (which provides environmental assessment by occupational therapist, with provision of assistive devices and home modifications as needed). In FY2010 the Better Living at Home program was awarded a national NCOA Innovations in Aging award, as well as a NACo award.
- ◆ Implement strategies from the Senior Agenda to improve quality of life indicators for seniors in the County.
- ◆ Customer Directed Care, available through the In-Home Aide Service program, is an Evidence-based Practice that allows customers to design their own care provision plan, and hire family or friends to provide assistance. This innovation has produced better outcomes at lower costs than traditional service delivery.

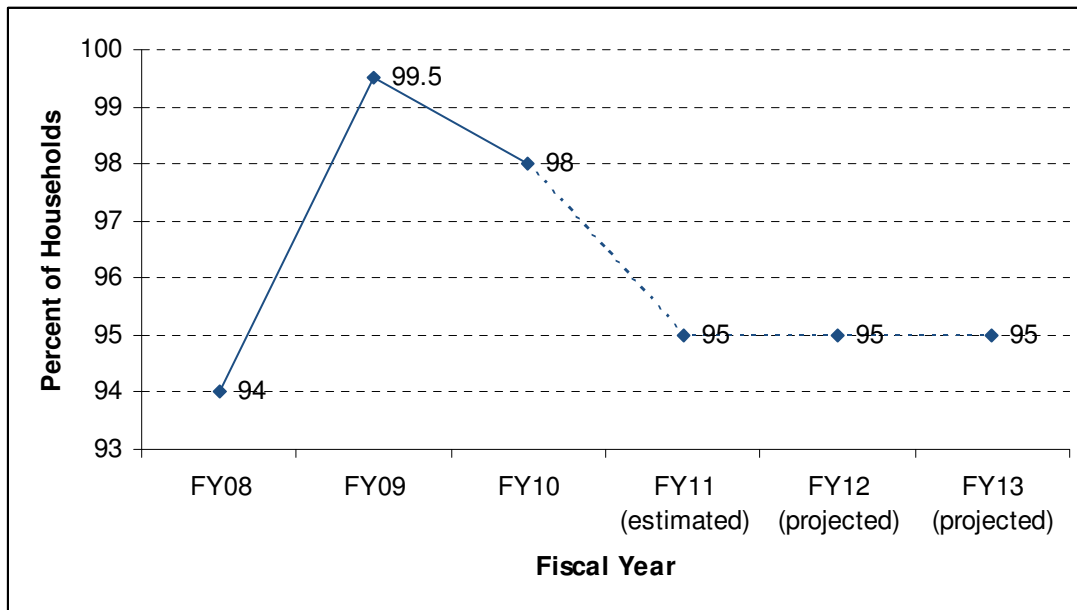
13. Housing Services

Basic Facts

- ◆ DHHS Housing Services work to:
 - Maintain housing stability for vulnerable households.
 - Prevent homelessness and the loss of permanent housing.
 - Promote expansion of affordable housing units for special needs populations.
 - Link housing with essential supportive services for special needs populations.
- ◆ In FY09, the Housing First Initiative began its first year of implementation with a focus on (1) reducing the length of stay in homelessness and providing stable housing for those exiting from homeless programs and (2) preventing homelessness by increasing emergency assistance resources and housing supports to stabilize housing for at risk households.
- ◆ In FY10, 6,313 crisis intervention grants were issued to assist households with preventing evictions, utility cutoffs and other emergency issues. A total of \$1.2 million in Recordation Taxes were targeted to help prevent evictions, and funded 910 of these grants. County Funds of \$1.3 million and State funds of \$1.2 million funded 5,300 grants. In addition, federal American Reinvestment and Recovery Act funding in the amount of \$262,000 supported 103 eviction prevention grants.
- ◆ In FY10, the Home Energy Assistance Program issued grants to help with electricity and heating costs to 9,681 households at or below 150 percent of the Federal Poverty Level.
- ◆ Numbers of people in permanent supportive housing have risen steadily over the past three years: 442 single adults based on the 2010 annual Point in Time Count, a 28% increase from the 2009 count; and 292 families (representing 957 people), a 57% increase from 2009. The numbers served for FY08 were, respectively, 268 and 145.
- ◆ Montgomery County has more than 20% of the region's permanent supportive housing beds. The County increased its beds to 1,339 in 2010 from 964 in 2009. The expansion began in 2007, when there were 576 beds.

Performance

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



Discussion

This measure supports the Department's goal of reducing length of stay in homelessness through increased permanent housing capacity. There was an 18% decline in the average number of days families spent in shelters from FY08 to FY10, and the number of families in permanent supportive housing has increased 46% from FY08 to FY10 during this time. The projected decline is due to increasing need and declining resources. The result for FY10 was calculated by dividing the 217 households that stayed at least 12 months in permanent supportive housing by the 221 households that were placed.

Story Behind Performance

Contributing Factors

- ◆ Specialized case management, mental health and substance abuse counseling and referrals to a range of services, such as mediation, training and employment help, supports the maintenance of housing stability for vulnerable households. DHHS also supports over 20 programs in Housing Stabilization Services, Transitional Housing, and Shelter Services, including 35 contracts that offer shelter, transitional housing and other programs benefiting poor and homeless people.
- ◆ DHHS provided assistance to an average of 1,678 low-income families and disabled and elderly households, whose incomes were below 50 percent of Average Median Income, to pay rent through the County's Rental Assistance Program (RAP) in FY10.

- ◆ DHHS provided assistance to a monthly average of 200 individuals who reside in a group home and have a mental illness, through the County's Handicapped Rental Assistance Program (HRAP) in FY10.

Restricting Factors

- ◆ The economic downturn has greatly increased the demand for eviction prevention services over the past several years.
- ◆ Increasing unemployment has resulted in an increase in the number of families and individuals that are losing their housing and becoming homeless.
- ◆ The Fair Market Rent (\$1,289) for a two bedroom apartment in Montgomery County is high. A household must earn \$51,560 annually (\$24.79 per hour) to afford this level of rent and utilities without paying more than 30 percent of income on housing.
- ◆ High utility costs are placing an increasing financial burden on low-income families.
- ◆ Additional support services and intensive case management beyond rental subsidies are required to ensure special needs populations maintain their housing.
- ◆ Immigration status, poor credit history and criminal records impact rapid exit from homelessness.

What We Propose to Improve Performance

- ◆ Collaborate with DHHS partners to continue to implement the "Housing First" model to expedite the movement of homeless families and single adults into permanent housing.
- ◆ Provide case management services to support vulnerable households that seek financial assistance more than twice in a calendar year.
- ◆ Collaborate with HOC and DHCA to explore opportunities to increase the supply of affordable housing units.
- ◆ Reorganize structure of Continuum of Care in preparation for implementation in 2011 of the McKinney-Vento Amendment, Homeless Emergency and Rapid Transition to Housing (HEARTH) Act.
- ◆ Implement the Housing First Initiative's four primary goals:
 - Provide assistance to at-risk households to prevent homelessness;
 - Move homeless families through the intake/assessment phase of the system as quickly as possible;
 - Place families into suitable housing as quickly as possible;
 - Deliver the necessary services required to keep families in housing to stabilize their situation and prevent a reoccurrence of homelessness.

DHHS Performance Plan

Appendix A Budget Details for Proposed Strategies

All costs for strategies listed under “What We Propose to Improve Performance” for each measure will be absorbed by the Department’s operating budget.

DHHS Performance Plan

Appendix B Implementation Timeline for Proposed Strategies

The timeline for strategies listed under “What We Propose to Improve Performance” for each measure is “ongoing”.

DHHS Performance Plan

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

EQUITY MEASURE

Contribution to Montgomery County Results

GREATER RESPONSIVENESS AND ACCOUNTABILITY

Background

Towards a systematic approach to promoting equity and social justice with customers, staff and community and to reducing disparities and disproportionalities in our vulnerable populations, the Montgomery County Department of Health and Human Services (DHHS) is developing a department-wide Equity and Social Justice Strategic Plan and logic model to:

- Assess, strategize, and implement a plan that ensures fair policies, decisions and actions by DHHS when impacting the lives of people;
- Create a culture of inclusion that promotes fairness and opportunity in the use of resources, decision-making and all departmental interactions;
- Adapt and tailor approaches to achieve the best possible outcomes for the communities and customers DHHS serves; and
- Recognize and honor differences and the diversity of our community.

Performance

To be determined.

Steps for development of Equity measure

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

During FY10, we completed the following:

1. Brought in a consultant to guide the work with grant funding
2. Formed a dedicated workgroup among staff representing all service areas
3. Established an overarching Mission/Purpose/Vision
4. Conducted 23 key informant interviews among internal and external partners
5. Held two community conversations with community members
6. Worked closely with the Community Health Improvement Process to align efforts to include internal/external focus.
7. Aligned efforts with the work to achieve full service integration

During FY11, we will:

1. Engage in peer-to-peer learning with successful initiatives around the country
2. Conduct an Equity Review in alignment with the service integration work plan
 - a. Identify impacts of programs on fairness and opportunity for different groups
 - b. Examine the institutional features that produce these impacts by identifying the sequence of institutional actions that take place in terms of key actors, policies, regulations and guiding practices
3. Create an action agenda to translate value of equity into policy and practice
 - a. Define what success will look like
 - b. Establish a logic model to guide creation of action steps
 - c. Determine what steps can be taken to adjust existing infrastructure in the immediate term to advance the vision of promoting Equity and Social Justice
 - d. Identify what data is needed to move equity forward
4. Engage Senior Leadership and DHHS managerial systems
 - a. Show the benefits of reducing disparities/promoting equitable approaches to promoting positive outcomes and fulfilling DHHS' mission.
 - b. Provide training opportunities and material resource assistance.
5. Work closely with the Community Health Improvement Process to align efforts to include internal/external focus.

During FY12, we will:

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

HOUSING SERVICES MEASURE

Contribution to Montgomery County Results

AFFORDABLE HOUSING IN AN INCLUSIVE COMMUNITY

Background

Special Needs Housing provides a range of services to resolve housing emergencies and prevent homelessness. As part of the Service Area's continuous quality improvement activities, it was determined that a more meaningful measure needed to be identified. The current measure, the number of households who receive financial assistance and request additional assistance within 12 months, did not meet our standards for data reliability and validity. As a result, consensus was reached that the existing measure needed to be revised.

Performance

A measure of the effectiveness of the prevention case management initiative is to be determined.

Steps for development of measure and needed data

Steps for developing this new measure include:

1. Obtain consensus from stakeholders regarding outcome measure
2. Clearly define measure
3. Identify data sources and data collection methodology
4. Pilot data collection and refine measure, as needed
5. Determine if FY11 can be a baseline year
6. Finalize and implement measure