Tara H. Jackson
Acting County Executive

THE PRINCE GEORGE'S COUNTY GOVERNMENT
OFFICE OF MANAGEMENT AND BUDGET

Office of MANAGEMENT & BUDGET

MEMORANDUM

DATE: December 16, 2024

TO: Josh Hamlin
Director of Budget and Policy Analysis Division

THRU: Stanley A. Earley Director SAE
Office of Management and Budget

FROM: Dr. Matthew D. Levy, Health Officer
Health Department

RE: End-of-FY 2024 Operating/Programmatic Responses

In an effort to facilitate an efficient and effective budget review and reporting process, we are submitting a separate request for operational and programmatic information. Please respond to the questions and complete any tables with the applicable data. In some cases, we have populated the tables with available known data. Please note that some of these questions were previously embedded in the overall first-round budget question document. We are working to streamline that process and highlight the agency's operations outside of the routine budget process.

Staffing

1. Please complete the following table detailing Department staff through the end of FY 2024:

   See Attachment A.

2. In the FY 2024 First Round Responses, there were 23 Counselors, 15 Assistants, 14 Community Health Nurses, 11 Community Developers, nine (9) Disease Control Specialists, and six (6) Social Workers positions vacant. How many of these positions were successfully filled by the end of FY 2024?

   The table below shows the requested position classifications that were filled in FY 2024, which were but a subset of the recruitment efforts for the Health Department. In FY 2024, 78 positions were filled through new hires, transfers from other county agencies and internal promotions. Additionally, the Health Department went through an intensive process to transition 41 Limited Term Grant Funded (LTGF) positions to Merit positions, resulting in a total of 119 employees processed as newly hired throughout FY 2024.

Classification Categories	Follow Up Requested	Total Hired /Promoted
Counselors	23	1 o Counselor IV
Assistants	15	15 o 3 Administrative Aide Assistant I o 4 Administrative Aide Assistant II o 7 Community Development Assistant I o 1 Community Development Assistant III
Community Health Nurses	14	7 o 3 Community Health Nurse I o 3 Community Health Nurse III o 1 Community Health Nurse IV
Community Developers	11	10 o 6 Community Health Developer I o 1 Community Health Developer II o 1 Community Health Developer III o 2 Community Health Developer IV
Disease Control Specialists	9	2 o 1 Disease Control Specialist IV o 1 Disease Control Specialist V
Social Workers	6	2 o 1 Social Workers I o Social Worker IV
Total	78	37

3. Please compare the salaries of LTGF Counselors, Assistants, Community Health Nurses, Community Developers, Disease Control Specialists, and Social Workers to surrounding counties and jurisdictions.

   The Health Department does not have access to the salaries of other surrounding counties and jurisdictions. The Department requested that OHRM complete a classification study for specific classifications within the Health Department.

Program Management

4. Please describe what factors positively affected the Department's performance in FY 2024.

   The Department's performance was positively impacted by:
   - **Quality improvement projects aimed at decreasing the number of days required to fill a vacant position resulted in higher rates of recruitment. The Health Department was able to fill several critical vacancies, including our Health Officer and two Division Director positions.**

- **Agency-wide efforts aimed at improving workplace culture significantly impacted performance. The Health Department initiated several workplace culture initiatives including developing new mission, vision, and values statements; conducting an employee engagement survey; implementing agency-level and divisional-level employee engagement improvement plans; and improving agency-wide communication practices and transparency.**

5. Please describe what factors negatively affected the Department's performance in FY 2024.

- **Administrative delays at the Maryland Department of Health, resulted in delays in loading grant budgets. Without a loaded budget, the business of government generally comes to a halt. These delays create a domino effect that adversely impacts hiring, procurement processes, and, ultimately, program execution.**
- **The Health Department continues to work with OIT to enhance functionality of Momentum, the County's permitting and licensing electronic system. Until the system is fully functional, inspections, permits, and statistical reports on the number of inspections will continue to be inaccurate. System issues cause inefficiencies in reporting and also require staff time to "walk" clients through the application process.**

Office of the Health Officer

6. Please share the metrics for programs within the Office of the Health Officer used in FY 2024 for determining program efficacy and success (provide at least 3).

In the Office of the Health Officer, we measure efficacy and success by using a variety of metrics, including but not limited to:

1) Recruitment: Time to Fill Vacant Positions
2) Prompt Payment: Time to Pay Invoices
3) Workplace Culture: Employ Engagement Rate
4) Grant Execution: Percent of Grant Dollars Awarded vs Expended.

7. Please provide programmatic information for FY 2024 on the Office of the Health Officer's programs, ensuring that all programs are represented.

In FY 2024, the Local Behavioral Health Authority (LBHA) continued to work collaboratively with public and private sector partners to develop a robust continuum of crisis behavioral health services in the County. Based on the Crisis Now model, the continuum includes the 9-8-8 Call Center, eight Mobile Response Teams and a 16-chair, 23-hour Behavioral Health Crisis Stabilization Center (BHCSC) in the Southern part of the County. Support from the LBHA was provided to ensure alignment of the mobile response and crisis center programs with Code of Maryland Regulations (COMAR) and the State's reimbursement model. The LBHA has supported the planning of workflows that will enhance the triage of consumer calls to ensure there is always someone to call, someone to respond, and a place to go when an individual is in crisis, emphasizing that crisis services are for anyone, anywhere and at any time.

9-8-8 Call Center:
Operated by the Community Crisis Services, Inc, the call center has been an integral part of the crisis system. It serves as a main entry point for mobile response calls and is a free and confidential 24/7 suicide and crisis lifeline that utilizes call, text, and chat to increase response rates, and increase suicide prevention. It is one of a few call centers in the state able to respond to text and chat messages and offer American Sign Language (ASL) support on crisis calls. There are seven grants awarded by Maryland Department of Health (MDH), Behavioral Health Administration and monitored by the LBHA which fund the 9-8-8 Hotline used to implement, and support continued 9-8-8 hotline services utilizing best practice standards. In FY 2024 the 9-8-8 Call Center answered 20,088 calls. The call center has over 100 staff scheduled according to call volume 24/7 to meet the call volume needs.

In FY 2024, the LBHA applied to and was awarded an MDH funding opportunity to support Mobile Crisis Teams and Behavioral Health Crisis Stabilization Centers (MCT-BHCSC). Under the MCT-BHCSC grant opportunity, this one-time only funding will help broaden the service reach of the County's Mobile Response Teams and Dyer Care Crisis Stabilization Center to elevate the overall quality of services, staff proficiency and fortify the infrastructure crucial to entering the fee-for-service system.

September 5th marked the official opening of the Dyer Care Center (DCC) as the County's first Behavioral Health Crisis Stabilization Center. The DCC, operated by RI International, is a 16-chair facility offering crisis prevention, intervention and stabilization services, 24/7/365 to adults based on Substance Abuse and Mental Health Services Administration (SAMHSA) National guidelines for Behavioral Health Crisis Care. Since the opening day, the Dyer Care Center has served 48 individuals. Currently the Dyer Care Center operates under a variance approved by MDH/BHA to only serve the adult population. Per COMAR, behavioral health crisis stabilization centers must serve the lifespan. The LBHA continues to seek providers in the County capable of offering these services to the pediatric (child and adolescent) population. The Dyer Care Center is primarily funded by Totally Linking Total Care in Maryland (TLC-MD) under the Health Services Cost Review Commission (HSCRC) grant.

The Mobile Response Team (MRT) vendor iMind Behavioral Health entered Prince George's County's crisis continuum in FY 2023 and operates 24 hours a day, 7 days a week. The LBHA/HD and "Totally Linking Care" (TLC) partner to fund eight (8) teams that are available 365 days a year, providing round-the-clock services to Prince George's County residents. The MRT responded in person within one hour of the requests with an average response time being 30 to 45 minutes. For FY 2024, there were 1,211 in-person dispatches. Additionally, there have been 2,747 resolutions handled telephonically.

Local Behavioral Health Authority	Services provided	Number of those who received assistance in FY 2024
Services provided directly by the LBHA include:	➢ **Information and referral support for residents seeking behavioral health services.**	➢ **1,002 calls and emails were answered in FY 2024 by the LBHA.**
	➢ **In-Home Intervention Program for Children (IHIP-C)**	➢ **Seven youth and their families were supported.**
	➢ **Assertive Community Treatment (ACT)**	➢ **94 individuals with serious mental illness were served**
	➢ **Uninsured Authorizations**	➢ **261 exception requests for the uninsured/underinsured.**
	➢ **Adult Coordination Services**	➢ **147 Residential Rehabilitation Program (RRP) Applications reviewed and 113 approved**
	➢ **Child & Adolescent Coordination Services**	➢ **17 RTC Certificate of Need (CONS) requests reviewed for youth in need of residential placement.**
	➢ **Maryland Recovery Net (MDRN) Substance Use Client Support Services**	➢ **89 approvals for MDRN**
	➢ **Mental Health Consumer Support Services**	➢ **Five approvals for support services**
	➢ **Homeless ID Project**	➢ **20 individuals experiencing homelessness received ID cards and/or birth certificates**
LBHA Community Education & Outreach: The LBHA regularly engages in public education and awareness initiatives, including the following activities in FY 2024	➢ **Adult Behavioral Health Expo**	➢ **The LBHA hosted an Adult Behavioral Health Expo with 33 Behavioral Health providers from around the County for Mental Health Awareness Month.**
	➢ **Suicide Awareness Campaign targeting the lesbian, gay, bisexual, transgender, queer, intersex, and asexual (LGBTQIA), Older Adults and Hispanic populations.**	➢ **176,155 residents.**
	➢ **The LBHA joined the "Go Green" campaign during May is Mental**	➢ **Eleven providers shared their pictures and joined the Local Behavioral Health Authority in lighting up the landscape of Prince George's County green.**

	Health Awareness Month	**The LBHA/HD lit up all three Health Department main buildings in Largo, Cheverly and Clinton, as well as the County's Administration Building.**
LBHA Contract Monitoring Services	**LBHA Contract Monitors manage and monitor grant-funded specialty services awarded through BHA and other funding sources to ensure compliance with local, state, and federal requirements.**	**Three Contract Monitors monitor 52 grant funded contracts.**
LBHA Program Monitoring Services	**Program Monitors, in partnership with BHA and the Medicaid Administration Services Organization (ASO), recruit, retain and evaluate public behavioral health providers. (Including investigating critical incidents/ complaints, completing site visits and processing exceptions for the uninsured.)**	**Four Program Monitors monitor 196 providers/ 633 programs. There are 38 pending licenses at this time.**
The LBHA monitors (52) Grant-funded programs and services (services may be supported by multiple awards)		
Program	**Services Provided**	**Number of those who received assistance in FY 2024**
988 Lifeline	**Seven grants fund the 9-8-8 Hotline to implement and support continued 9-8-8 hotline services.**	**20,088 calls answered**
Homeless Outreach	**Identifies behavioral health treatment needs and linkages to services for homeless individuals**	**140 individuals served**
Projects for Assistance in Transitioning from Homelessness (PATH)	**Assists homeless individuals with securing permanent housing.**	**127 individuals assisted**
Supplemental Security Income and Social Security Disability Insurance (SSI/SSDI) Outreach and Recovery (SOAR)	**Assists individuals with mental illness to secure SSI/SSDI benefits.**	**Nine individuals served**
Adolescent Clubhouse	**Provides non-clinical services to Prince George's County youth ages 12 to 17 with primary substance abuse disorders and/or co-occurring mental health disorders that may hinder the recovery process.**	**352 individuals served**
Senate Bill 512- Children in Need of Assistance/ House Bill	**Substance use disorders (SUD) counselors work collaboratively with the Department of Social Services to conduct assessments of**	**108 (SB512) individuals served 106 (HB7) individuals served**

7- Child Welfare involved Families/Supervision	**referred individuals and families identified in the child welfare system as having a substance-related disorder.**	
Community Case Management	**Provides behavioral health screening, referral, and ancillary linkages to substance use disorder, mental health disorder, or co-occurring SUD and mental health (MH) disorder services for individuals at risk of continued substance use or relapse who have been referred by public and private agencies.**	**203 individuals served**
Jail Based Level 1 Treatment Services	**Also known as the Rebirth Program and is located within the Department of Corrections (DOC), provides SUD screening, assessment, and evidence-based treatment to self and court-referred individuals. In addition, referrals are made to aftercare and community resources upon release into the community.**	**177 individuals served**
Peer-To- Peer General / Federal	**Unique in that the delivery of services is facilitated exclusively by individuals who identify as having lived experience in behavioral health recovery. Services focus on supporting recovery and the establishment of life in the community for any individual with SUD history (General) or forensic history (Federal).**	**937 individuals served (General) 1,011 individuals served (Federal)**
Recovery Support in Postpartum Women	**Provides non-clinical assistance and recovery support to assist pregnant and postpartum women, as well as women with children, who have an opioid or other substance-related disorder to maintain recovery.**	**28 individuals served**
Social Worker	**Provides support to the Mental Health Court program that links inmates with mental illness, who have misdemeanor charges to mental health treatment as a condition of their release.**	**Nine individuals served**
Drug Court	**Case management for the preparation of documents for court, time spent in court, and non-reimbursable clinic case management associated with SUD treatment services. Transportation was provided in FY 2024.**	**289 received transportation services**
Maryland Community Criminal Justice Treatment Program	**Provides mental health and case management services to individuals in the Department of Corrections (DOC) who have been identified as having serious mental illness and/or are at risk for re-institutionalization.**	**713 individuals served**

Trauma, Addictions, Mental Health & Recovery	**Psycho-educational groups in DOC, individual sessions, medication referrals, case management, aftercare planning and follow-up to women who have experienced trauma.**	**139 individuals served**
First Episode Psychosis	**Provides community-based, person-centered, recovery-oriented services and support, to ages 15-30, who are within two years of the initial onset of psychotic symptoms.**	**52 individuals served**
Substance Abuse Treatment Outcomes Partnership	**Provides Hospital Diversion and Offender Reentry programs (ORP) that utilize Screening, Brief Intervention and Referral to Treatment (SBIRT) and person-centered and recovery-focused models to identify individuals among the target populations and start them on their way to recovery. The goal is to reduce hospital readmissions and recidivism.**	**287 individuals served**
Temporary Cash Assistance	**Provide screenings and case management services to residents referred by the Department of Social Services (DSS). Applicant and recipients that screen positive for substance use are referred to community providers for a clinical assessment and/or treatment. One licensed staff person stationed at each location: Hyattsville, Temple Hills and Landover.**	**839 individuals served**
Mental Health Client Support Services	**Support funds administered as funding of last resort for the purchase of emergency goods to enable an adult to access or retain community-based mental health services and shall be linked to the client's treatment, rehabilitation or recovery plan goals.**	**Five individuals received funding for emergency goods.**
Continuum of Care Grant I	**Supportive housing program for individuals who have a mental illness and forensic history.**	**30 individuals served**
Continuum of Care Grant II	**Supportive housing program for families who have a mental illness and forensic history.**	**33 individuals served**
Deaf and Hard of Hearing Services	**Provides interpreting services for deaf and hard of hearing consumers with mental illness and their families.**	**509 individuals served**
Therapeutic Nursery Program	**Program designed for preschool children and their families ages three to five years old who are experiencing social, behavioral, and emotional challenges and are not able to learn in a generalized preschool program.**	**12 individuals served**

State Care Coordination	**Provide care coordination services to individuals in SUD residential treatment programs or actively engaged in outpatient services. Assistance is provided with accessing recovery support services.**	**202 individuals served**
Residential Rehabilitation Program (RRP) Medical Complexity Enhancement (Federal)	**Federal program that provides nursing services in a Residential Rehabilitation Program (RRP) environment to older adults with mental illness.**	**112 individuals served**
RRP Medical Complexity Enhancement	**Provides nursing services in an RRP environment to older adults with mental illness.**	**288 individuals served**
Strengthening Families in Recovery	**Provides additional services for pregnant and postpartum women and women with children in recovery. Expungement of criminal records, to support families that need documents/certificates from vital records (i.e. birth certificates), and for transportation for job appointments, school appointments, medical, mental health, and other appointments that benefit the family.**	**New Award – numbers pending**
Behavioral Health in Assisted Living	**Provides psychogeriatric services to elderly persons with mental illness (MI) in an assisted living home.**	**Five individuals served**
Crisis Intervention Team Training	**An innovative first-responder model of police-based crisis intervention training to help persons with mental disorders and/or addictions access medical treatment rather than place them in the criminal justice system due to illness-related behaviors. It also promotes officer safety and the safety of the individual in crisis.**	**56 First Responders trained**
Mobile Response Team	**Provide immediate assessment, intervention, and treatment and follow-up to individuals experiencing a psychiatric emergency. Teams partner with other community resources such as the police, crisis intervention agencies, shelters, and others.**	**1,211 dispatches**
Crisis Response System	**Provide on-site emergency intervention for all ages including assessment and brief treatment for psychiatric crises. Resources available include mobile response team (MRT) services, urgent care appointments, and emergency disaster response following the crisis.**	**2,747 (service calls received)**

Senior Outreach & Training	**Provides outreach and training to the elderly, family members, professionals, and community members on issues related to mental illness in older adults.**	**104 individuals trained**
Advocacy	**Peers provide advocacy, support, and education to individuals with mental illness, their families, and the community.**	**212 individuals served**
Wellness and Recovery Center	**Offer peer support services and provide adults with the ability to connect with others in recovery while navigating local support services and overcoming barriers to their own personal recovery.**	**36 unduplicated/ 176 duplicated**
Urgent Care Clinician	**Funding support for iMind BH Urgent Care Operations.**	**1,056 visits**
Suicide Prevention	**Training to educate stakeholder, service providers and the community on suicide awareness and prevention.**	**261 individuals trained**

8. Please discuss programs in the Office of the Health Officer where the stated goals have fallen short of expectations in FY 2024 and discuss the reasons why the expected successes were not achieved.

The Office of the Health Officer fell short of spending down on Grant funding and the collection of Indirect costs due to the following issues:

- **Funding Load and Appropriation Timelines**
- **Ability to create grant funded positions outside of the budget development season**
- **Lack of a grants management system to assist with tracking and deadlines**
- **Long external approval process**
- **Lack of infrastructural support due to general fund challenges in IT, Human Resources, Communications, and Administration.**

Behavioral Health

9. Please share the metrics for programs within the Behavioral Health Division used in FY 2024 for determining program efficacy and success (provide at least 3).

The Behavioral Health Division (BHD) has developed and is implementing a multiyear strategic plan (FY 2025 - FY 2030), which serves as the division's roadmap for the next five years' priorities, goals, and metrics. Since the division relies heavily on grants for >88% of its funding, our capacity to provide essential support to residents and maintain the salaries of employees hinge on our success in establishing and nurturing solid and productive relationships with grantors. Demonstrating a successful track record in grant programming highlights our efficacy and underscores our commitment to sustaining vital services and fostering community growth. Since we have numerous grants, the three measures that define efficacy and success for this division are:

1. **Continuation of Winning Proposals: our ability to win the grant awards to which we apply. This means we need an annual grant writing budget.**
2. **Overcoming County Systemic Barriers: our ability to utilize a county system in which processes and procedures are created to support the spending of general fund dollars. This is counterintuitive to successful spending needs for grant dollars.**
3. **Performance: Our ability to perform well on grants as measured by successfully implementing.**

10. Please provide programmatic information for FY 2024 on the Behavioral Health Division's programs, ensuring that all programs are represented.

Based on our divisional strategic plan, programs are divided into seven strategic priorities, reflected below, along with related programs and services described.

1. **Internship/Training: Creating a Workforce Pipeline: Our goals include partnering with public health, psychology, social work, and counseling students who plan to work in Prince George's County when they graduate. We will offer experience, training, and support for seamless entry into the county's workforce through the Health Department and collaboration with community partners.**

Programs, Services, and Outcomes

- **Our goal is to develop formal partnerships with behavioral health organizations and local institutions of higher learning to build and sustain the behavioral health public health workforce pipeline, recognizing that nearly half of behavioral health clinicians surveyed in a recent poll[1] report being overworked and experiencing burnout. We plan to develop a program curriculum and establish memorandum of understanding (MOUs) for sites and agreements with eligible student participants who will commit to working in the County for three years post-completion. The division is applying for grant funding to implement this project. Our goal is to impact the behavioral health workforce shortage[2].**
- **Internal to the division, we are seeking to ensure an engaged, active, and well-trained division workforce and improve our employee engagement scores through activities that support internal employee growth, increase the culture of trust, and establish competencies for each classification level.**

2. **Technical Support, Training, Consultation: Building a High-Quality Division and Partnership: Goals include training providers and non-profit organizations on using best-practice tools to improve outcomes.**

Programs, Services, and Outcomes

- **The division has an approved peer recovery training curriculum. Its goal and measure are to train 20 new people each year and ensure that 80% of those trained meet the requirements for full certification. To date, the division has trained 42 people; of that number, six have become certified.**

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[1] National Center for Health Workforce Analysis (December 2023) Behavioral Health Workforce, 2023. https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/Behavioral-Health-Workforce-Brief-2023.pdf

[2] National Council for Mental Wellbeing. (April 2023) New Study: Behavioral Health Workforce Shortage Will Negatively Impact Society https://www.thenationalcouncil.org/news/help-wanted/?utm_source=media-outreach&utm_medium=pr&utm_campaign=2023-workforce-survey

- **The division provided training on the Crisis Continuum to more than 100 public safety personnel in preparation for the opening of the Dyer Crisis Stabilization Center**
- **Based on a request from Fire and Emergency Management Services (EMS), the division is creating a mental health training series consisting of five two-hour training sessions slated to begin in January 2025.**
- **The division is working with stakeholders to build a data dashboard so that policymakers, providers, and stakeholders to have the information they need to make data-informed decisions about services and resources within the County. The TLC-HSCRC Crisis Continuum Funding initiated the dashboard and is being further developed and maintained by the Opioid Abatement Funding.**

3. **Building Capacity for MAT and Medications for Opioid Use Disorder While the division has operated a Joint Commission on Accreditation of Healthcare Organizations (JCAHO) - accredited outpatient medication-assisted treatment program for people who are diagnosed with opioid use disorder for many years, we are making a significant shift in how Prince George's County's Health Department provides Medication Assisted Treatment (MAT) services.**

<u>Program, Services, and Outcomes</u>

- **Effective November 25, 2024 (pending in-person client notification and press release), we will transition from directly offering MAT services at the Cheverly Health Center by no later than March 31, 2026, to focus on facilitating partnerships that enhance access to these vital services within our community.**
- **We are working with the nearby MAT providers below to ensure they are prepared to receive the clinic's 82 clients and meet the county's needs. The division's MAT counselors and case managers will work with every client to provide full support for their choice of provider and assist with addressing any barriers to care (i.e., transportation). Nearby MAT clinics are:**
  - **We Care Methadone Clinic***
    Address: 8730 Cherry Ln, Laurel, MD 20707 ·
    Phone: (301) 490-7995
    (Prince George's County)
  - **Another Way- Methadone Clinic & Suboxone Clinic**
    Address: 1363 Holton Ln, Takoma Park, MD 20912
    Phone: (301) 434-2622
    (Montgomery County)
  - **Open Armms Inc - Methadone Clinic & Suboxone Clinic**
    Address: 2590 Business Park Dr, Waldorf, Md 20601
    Phone: 301-645-5538
    (Charles County)

***We Care (our current county-based MAT provider) is not opposed to any new opportunities or support for expanding operations into central and southern counties.**

- **Zoning challenges may be experienced by providers who may be interested in opening a physical Methadone Treatment program in the county. We will work with the LBHA to support the establishment of such a program but are realistic in our understanding that this process may take years. Therefore, we are excited by the treatment opportunities afforded by the Opioid Abatement Funding.**

- **We are also considering applying for a grant to fund a Mobile Methadone Treatment service for the southern and central regions of the County.**
- **This realignment reflects our commitment to the principles of Public Health 3.0, which calls for public health departments to evolve their roles by fostering partnerships and adapting to the dynamic health landscape.**

4. **Recovery Initiatives: Providing Peer-Led-Recovery-Focused Support for Residents: We support people who are diagnosed with or at risk for mental health and substance-related problems. We engage youth and adults in the criminal justice system, providing peer-led and recovery-focused support.**

   Program, Services, and Outcomes

   - **Our goal is to sustain the current peer recovery training program and certify 50 new forensic peers annually. To date, we have trained 42.**
   - **We plan to continue building capacity for recovery-based training by ensuring that 10 division staff and 20 community partners are trained as trainers in delivering recovery-based tools.**
   - **We plan to develop a youth-focused peer recovery training curriculum.**
   - **Specific programs under this priority include:**
     - **Peer Recovery Program funded by grant funds to provide peer support to persons in the community who are struggling with addiction. In 2024, 234 persons were supported, and our goal was to support 160 persons.**
     - **Forensic Peer Program is funded by grant funds to provide peer support to persons who are coming out of incarceration. Our FY 2024 goal was to support 100 persons, and our outcomes demonstrated support provided to 603 persons.**

5. **System of Care Work: Describes a network of community-based services/organizations working together to meet the needs of children, youth, and families.**

   Programs, Services, and Outcomes

   - **Programs under this priority include the Systems of Care Grant (SAMHSA 2023-2027), Healthy Transitions Grant (SAMHSA 2023-2028), Opioid Impacted Families Health Resources and Services Administration (HRSA 2024-2028), Offender Reentry Program (SAMHSA 2023-2027)**
   - **Establish community-based, youth-guided, and family-driven culturally competent partnerships that enhance families' well-being and increase access to behavioral health services by reducing barriers such as stigma, transportation, and financial constraints.**
   - **Establish referral pathways for treatment, early intervention, and integrated care.**
   - **Collect and analyze data from the data dashboard to ensure quality of service provision and meaningful outcomes.**
   - **Create a county-wide social marketing campaign to reduce the stigma surrounding behavioral health conditions and raise awareness of available services and how to access them.**
   - **The HRSA-funded 2.4 million four-year Opioid-Impacted Families grant was received this past September 2024.**

6. **Screening and Connection to Care: Programs that provide behavioral health and risk screenings to understand needs and connect to a provider who can help.**

   Programs, Services, and Outcomes
   Programs under this priority include:
   - **The Health Department operates two one-stop shops, each a centralized hub where residents can access a wide variety of services to meet all their social determinants of health.**
   - **The grant-funded Assessment and Case Management Unit supports persons on parole and probation who are required by the courts to be screened for SUD and MH challenges and linked for treatment services that may be needed. The program screened 671 individuals under community supervision in FY 2024.**
   - **The Hospital and Community Case Management Program is grant-funded to provide support for patients of the University of Maryland Capital Region Hospital who may have an underlying substance use disorder contributing to their medical reasons for admission and includes treatment linkages. This program sought to serve 250 persons in FY 2024 and served 380. Case Managers are grant-funded to assist persons with linkages to support services that may cause barriers to treatment adherence, such as transportation. In FY 2024, they assisted 203 persons.**
   - **Two grant-funded specialty docket programs, Drug Court and Mental Health Court, provide assessment and connection to care for clients of each docket. However, the positions for both programs remain vacant and do not have reportable metrics for FY 2024.**

7. **Prevention Initiatives: Working with the Community to Prevent Mental Health Substance Use Disorders and Opioid-Related Deaths we strive to provide information and resources to prevent mental health and substance use disorders. We strive to deliver information to help prevent opioid-related deaths.**

   Programs, Services, and Outcomes
   - **Programs under this priority include our Prevention Initiatives, Opioid Abatement Funding Management, Tobacco Enforcement, and Educational Initiatives, which include Naloxone Outreach and Strengthening Families.**
   - **The FY 2024 Prevention Substance Use Block Grant:**
     - **TV commercials and social media community awareness campaigns promoted the safe storage of medications, yielding a reach of 1,610,268 persons.**
     - **Educated 540 persons at school presentations, faith-based and community events.**
     - **Disseminated 5,055 pieces of educational materials on substance use directly to individuals in the community at youth and community events.**
     - **Collaborated with local law enforcement, the Drug Enforcement Agency (DEA), and faith-based organizations to collect 194 pounds of prescription drugs at two National Prescription Take Back events.**
     - **14 families were served through the Strengthening Families Program.**

- **ARPA- American Rescue Plan- conducted four quarterly Opioid Fatality Review Team Meetings. The ARPA provides a small amount of money for the multi-disciplinary team to review actual fatal drug overdose cases in the county and promote cooperation among agencies to potentially prevent similar deaths in the future.**
- **The Opioid Abatement Funding Task Force has convened and assembled workgroups representing Prevention, Harm Reduction, Treatment, Public Safety, and Recovery. These groups are meeting to survey available county services, identify current gaps and provide recommendations.**
- **Opioid Operational Command (MOOR Block Grant) In FY 2024, Naloxone "train the trainer" training was provided to five government agencies, five community organizations, and three municipalities which allows these agencies to register as Naloxone Distribution Sites. Naloxone training was conducted for 263 people. This grant additionally implemented marketing campaigns targeting local challenges related to opioid abuse and misuse.**
- **Tobacco Control Community Supports grassroots partnerships that promote community dialogue on tobacco-related disparities in ethnic/racial, LGBTQ+, low-educated, behavioral health, and low-income populations. In FY 2024, education was provided to community organizations and attended community meetings to provide education regarding tobacco and the harms of tobacco.**
- **Tobacco Cessation Provides direct cessation services, including virtual/remote options (e.g., classes, one-on-one counseling, group counseling, and Nicotine Replacement Therapies). Limited services were provided in FY 2024 due to the vendor's illness. Mini-grants were awarded to sub-vendors to conduct smoking cessation services. However, moving forward in FY 2025, the American Lung Association will train an employee to facilitate cessation counseling rather than utilizing a vendor.**
- **Partner with Luminis Health to acquire referrals for tobacco cessation. Additionally, we will add the collaboration with the Langley Park Multi-service Center as a referral source.**
- **Tobacco Enforcement Initiative Random compliance checks were conducted with one full-time Tobacco Enforcement Officer and one student decoy. 1,071 tobacco vendors were visited by the enforcement officer and student decoy. 790 retail outlets were compliant and 281 were non-compliant which accounts for a 29 percent non-compliance rate. The goal for FY 2025 is to visit 1,000 tobacco vendors and bring the non-compliance rate below 20 percent.**
- **Tobacco Use Diabetes Over a three year period, collaborate with the Health and Wellness division to create and build public health efforts to educate Prince George's County residents on the harmful effects of tobacco. Sponsor and/or host community meetings to educate and train community and focus on Menthol. Schedule meetings with a faith-based partner and community-based partner to raise awareness about menthol and tobacco to the county cessation program and the Maryland Tobacco Quitline. We will expand multimedia campaigns and educational marketing efforts to include education on the dangers of menthol and the predatory marketing and advertising of menthol in black communities. The three components of the Cigarette Restitution Fund (CRF) grant are Community, Cessation, and School based.**

Not all programs in the table below can separated individually, efforts often overlap to work in collaboration and increase effectiveness. Many of the programs involve advertising, education, and outreach. As such, we cannot always quantify the number who received assistance. Numbers are provided in the table when possible, but for others the narrative above provides a more accurate explanation of efforts.

Behavioral Health Division Program	Services Provided	Number of those who received assistance in FY 2024
Dare to Be You Program	Unfamiliar with this program.	
Naloxone Outreach Education	See above priority #7(Question #10)	Trained 1,274 individuals
Communities That Care Program	Unfamiliar with this program.	
Youth Ambassadors Training	Youth ambassadors trained to educate other youth on tobacco, vaping, and menthol.	15 schools
Annual Alcohol and Drugs Public Awareness Campaigns	See above priority #7(Question #10)	
Behavioral Health Outpatient Services	See above priority #3(Question #10)	
Tobacco Control Program	See above priority #7(Question #10)	
Adolescent Recovery Clubhouse	Provides non-clinical services to Prince George's County youth ages 12 to 17 with primary substance abuse disorders and/or co-occurring mental health disorders that may hinder the recovery process.	110 youth and young adults
Bridges2Success	Case management and monitoring support to youth offenders from ages 11-21 who are under legal care and custody of the Department of Juvenile Services (DJS)	150 youth
Go Slow	This was a social media campaign that was initiated by the LBHA five years or so ago.	
The Bridge Center at Adam's House	Reentry services to returning citizens. It additionally supports veterans and transitional-aged youth by screening clients, identifying needed services, linking clients to the appropriate providers, and providing ongoing support.	493 individuals
Alcohol & Drug Prevention Program	See above priority #7(Question #10)	
Step Forward	This was a behavioral health educational and awareness campaign to support reducing stigma initiated several years ago by the Office of the Health Officer (previous Deputy Health Officer: J. Duval Harvey). The current System of Care grant continues to utilize this campaign and the remaining marketing materials. SAMHSA has since prohibited the purchasing of marketing materials so	

	the STEP FORWARD promotional items must be preserved.	
Additional Behavioral Health Divisional Programs Not Listed on This Request		
Temporary Cash Assistance	Screen persons who apply for cash assistance for mental health disorders and, when substance use may be problematic, links individuals to services.	839 individuals
House Bill 7	Links mothers who have a newborn who was born with drugs in their system to substance use disorder treatment.	106 individuals
Senate Bill 512	Assist people involved with child protective services in cases where substance use may be a factor	108 individuals & families
Langley Park Multi-Service Center	Supports the county's Latinx community in connection with critical health services, health insurance, food benefits, legal and employment services, and case management to assist with all other needs.	7,299 individuals
Hospital Diversion/Community Case Management	See above priority #6(Question #10)	
Problem-Solving Court	See above priority #6(Question #10)	
Peer Recovery Program	See above priority #4(Question #10)	
Injury Prevention Program	Conducted one multi-media (streaming and radio) campaign to raise awareness and promote the prevention of driving under the influence of alcohol or other substances.	384,719 streaming impressions; 105,000 (18+ male Hispanic focus), 443 individuals at community events, disseminated 723 pieces of literature
Strengthening Families in Recovery (SFIR) Postpartum	See above priority #6(Question #10)	
System of Care	Serves children and youth, birth through age 21, at risk for or with serious emotional disturbances (SED), and their families.	72 families served
Healthy Transitions	Improves and expands access to developmentally, culturally, and linguistically appropriate services and supports for transition-aged youth and young adults (ages 16-25) who either have, or are at risk for developing, serious mental health conditions	27 Transition-aged youth were referred and 18 served

11. Please discuss programs in the Behavioral Health Division where the stated goals have fallen short of expectations in FY 2024 and discuss the reasons why the expected successes were not achieved.

The lack of ability to fill vacant position identification numbers (PINs), budget load timeline, human resources (HR) staffing challenges vs. workload, hindered the division's ability to meet the performance measures for grant-funded work. When new grants are awarded, we first must identify a vacant PIN that can be used to manage the grant. This process may take months. Once we identify a grant-merit PIN that can be used, it may need to be reclassified or reallocated. Meanwhile, we must report low or no grant performance in the quarterly reports each quarter. Continuous years of reporting low to no grant performance may indicate an erroneous perception that the grant funding is unnecessary.

Specific examples include the System of Care Grant awarded in September 2023, which will be filled in December 2024.

Further complicating the timeline to fill vacancies, existing staff attempt to compensate for the lack of filled positions to support residents in receiving the services they need, doubling and sometimes tripling their workload. The inevitable burnout of this strategy creates retention challenges, and existing staff seek positions that are more balanced and offer relief from the secondary trauma often experienced when working with vulnerable client populations. This leads to additional vacancies, thus creating a cyclical pattern that is difficult to break.

Another critical variable is needing more PINs/positions to recruit and hire quickly. However, during this budget cycle, we were able to request additional PINs for anticipated grant-funded work as an enhancement which has been very helpful. Therefore, in the future, when we receive a new grant award, we will already have a PIN to start the hiring process.

It is crucial to recognize that the performance of our grants is not just important—it is absolutely vital for the survival of the Behavioral Health Division. With over 88% of our funding coming from grants, the stakes couldn't be higher. If we fail to meet our grant funder obligations or tarnish our reputation by being unable to utilize these funds effectively, the repercussions and financial impact will be severe. We risk losing critical funding opportunities that could jeopardize the salaries of 91 dedicated grant merit and LTGF employees, and, more alarmingly, we would severely diminish the essential services and supports provided to our residents. The future of our community's health and well-being hangs in the balance—failure is not an option.

Health and Wellness

12. Please share the metrics for programs within the Health and Wellness Division used in FY 2024 for determining program efficacy and success (provide at least 3).

A major function of the Health and Wellness Division is helping residents navigate and enroll in insurance through the Maryland Children's Health Program (MCHP). Significant increases in caseload for the MCHP program occurred as a result of the Healthy Babies act which grants insurance coverage via the exchange to expectant mothers regardless of immigration status. The program has successfully kept up with demand, employing multi-lingual staff to provide culturally competent services to 17,916 residents in FY 2024.

The Health and Wellness Division applied to the Center for Disease Control and Prevention (CDC) to be an Umbrella Hub Organization (UHO) and received our award letter on September 27, 2023, making us the first UHO in the state of Maryland. Operating a UHO means that community-based organizations can bill Medicaid for diabetes prevention programming services through the Health Department for a fee of 20% of total reimbursement. This is an important sustainability strategy to reduce reliance on grant funding and to build community-based capacity for diabetes prevention programming. Additionally, the Health and Wellness Division has secured contracts with five of six Managed Care Organizations in the County to reimburse for Diabetes Prevention Program and Family-Based Behavioral Treatment for Childhood Obesity Services as part of the PreventionLink2 grant. This difficult but important accomplishment directly contributes to the sustainability of the Division's chronic disease prevention and management efforts.

Housing remains a critical unmet need for some Prince Georgians. The Health and Wellness Division is proud to report providing supporting and funding housing for 114 individuals, including offering housing-based case management services and tenancy-based case management and support services to individuals at risk of institutionalization or hospitalization as part of the Assistance in Community Integration Services program, a Medicaid 1115 waiver program.

13. Please provide programmatic information for FY 2024 on the Health and Wellness Division's programs, ensuring that all programs are represented.

Program	Service Population	Services Provided	Number of qualifying applicants in FY 2024	Number of those who received assistance in FY 2024
Administrative Care Coordination Unit (ACCU)	Active Maryland Medicaid beneficiaries	Provide Medicaid education, HealthChoice care coordination, resource linkage to eliminate social determinants of health (SDOH) barriers	1.68 million Marylanders of which 333,467 PGCO residents are enrolled in Medicaid	3,370 referrals were processed by the ACCU program
Assistance in Community Integration Services	Active Maryland Medicaid Resident of Prince George's County meeting the required health and housing criteria.	Housing based case management services; tenancy-based case management and tenancy support services.	51	114
Adult Evaluation and Review Services	Individuals of all ages who are chronically ill or disabled	Comprehensive evaluation to assess the individual 's medical, functional, and psychosocial needs	1,522 Participants receiving services	1,885 total assessments (1,086 annual, 799 initial)

Care for Kids	Children under the age of 21 who reside in Prince George's County, are not eligible or enrolled in any other health insurance plan, and with household income within the Federal Poverty Guidelines	Assistance with the completion of an application for enrollment in the Care for Kids Program (health care services provided at Kaiser Medical Care facilities)	920	920
Non-Emergency Medical Assistance Transportation Program (NEMT)	Medicaid recipients in Prince George's County that have no other means of transportation to Medicaid covered medical services	Provide no cost transportation for Prince George's residents to the nearest Medicaid provided service	5,003 clients screened and determined eligible for NEMT services	5,003 clients received services. 53,057 transports completed in FY 2024
Nurse Monitoring Program	Individuals of all ages who are receiving services from a Medicaid program	Evaluate the quality of Personal Assistance Services (PAS)	1,375 patients receiving services	996 assessments completed in FY 2024
Community Health Worker Initiative	PGC Residents, 18 years and older	Health education, Covid-19 prevention measures, connecting residents to needed health and social services (following a Social Determinants of Health Assessment)	5,188	5,188
Prevent Type 2 Diabetes	Priority Population for PreventionLink is African American and Latino Population at least 18 years old. However, all Prince George's County adult residents are eligible	Diabetes Prevention Program for adults	172 referrals	126
Dine, Learn & Move	All County residents	Promote healthy eating, active living and reinforce health behaviors in order to reduce the prevalence of various chronic diseases amongst county residents	All adult County residents *Please note some residents have already taken the class in other fiscal years*	367
Living Well Chronic Disease Self-Management Program	Residents with arthritis, diabetes, heart disease, hypertension, or other chronic conditions that	Chronic Disease self-management lifestyle change program	Referrals are not required 266,262 (35.5%)	18

	require ongoing medication		Adult population *Please note some residents have already taken the class in other fiscal years*	
Living Well Diabetes Self-Management Program	Adults with diabetes or caregivers of patient diagnosis with diabetes	Diabetes Self-Management Education programs	Referrals are not required	29
Living Well with Hypertension	Prince George's County (PGC) Adults	Standalone Living Well workshops delivered in February for Heart Month and May for High Blood Pressure Awareness Month	No referral required	64
Nutrition Education/Healthy Eating Education Programming	PGC Residents	Includes community events, conferences, workshops hosted by the Chronic Disease Program during March is National Nutrition Month health awareness and PGCHD events	No referral required	556
PreventionLink of Southern Maryland – Diabetes Self-Management Education and Support (DSMES) and Family Based Behavioral Therapy (FBT) (childhood obesity treatment) Note: Regarding FBT, year 1 was a planning year	Priority Population DSMES -African American and Latino Population at least 18 years old FBT- African American and Latino Population children 6 years old -18 years old. Note we will serve all eligible participants	Evidence-based programs for Diabetes Management and Child-hood Obesity	14 – DSMES (referred by provider) 83,256 residents with diabetes – 11.1%	4 - DSMES
Maryland Children's Health Program (MCHP)	Children under the age of 19, pregnant women and adults 19-64 who meet the program's financial eligibility requirements.	Assistance with enrollment in health insurance or a Managed Care Organization Resources on other programs.	17,916	17,916

14. Please summarize the Health and Wellness Division's program successes and achievements realized in FY 2024.

- **We have successfully trained Community Health Workers (CHWs) in Public Health Emergency Preparedness, Mental Health First Aid; Professional development training and Chronic Disease Management. Additionally, seven CHW managers from Prince George's County Health Department and its partner agencies attended CHW Supervisors training. CHWs assisted 5,188 residents in addressing their health and social needs.**

- **CHWs are integrated in many community-based sites, including:**
  - **Four Health Centers: Gerald Family Health Care, Truly Blessed Health and Wellness Center, Family and Medical Counseling Service, and Luis A Casas LLC.**
  - **Two Hospitals: Luminis Health Doctors Community Medical Center and University of Maryland Capital Region Medical Center (Emergency Room and Food as Medicine Program for pregnant women and mothers)**
    - **Significant increases in caseload for the MCHP program occurred as a result of the Healthy Babies act which grants insurance coverage via the Exchange to expectant mothers regardless of immigration status. The program has successfully kept up with demand, employing multi-lingual staff to provide culturally competent services to over 17,000 residents in FY 2024.**
    - **Many Health and Wellness Programs, including PreventionLink2 (PL2), ACCU, NEMT, and the CHW initiative were successfully onboarded onto EPIC.**
    - **The Health and Wellness Division was awarded a $5 million cooperative agreement with the Centers for Disease Control and Prevention (CDC) in 2024, PreventionLink2 (PL2). This agreement will allow us to continue the work implemented in the PreventionLink Project which aimed to reduce the impact of diabetes, hypertension, and stroke by linking residents to preventive services, assisting them to overcome social determinants of health (SDOH), and enhancing the capacity of their providers to deliver quality care. PreventionLink2 will build on the outcomes and lessons learned from PreventionLink and focus on (i) increasing access to lifestyle behavior change interventions for adults with pre-diabetes and diabetes and adolescents who are obese or overweight; (ii) enhancing the capacity of lifestyle behavior change programs to become and remain self-sustaining; and (iii) scaling up CHW services countywide to support the assessment and mitigation of social determinants of health and early identification and linkage to care of residents at risk for chronic disease.**

- **The Prince George's County Health Department has been recognized by CDC as an Umbrella Hub Organization with full plus recognition (the first in the state of Maryland). The Health Department will serve as the lead organization under the umbrella hub arrangements (UHAs). We will connect community-based organizations (CBOs), pharmacies, and Federally Qualified Health Centers (FQHCs) with health care payment systems to pursue sustainable reimbursement for the National Diabetes Prevention Program (NDPP) and Medicare Diabetes Prevention Program (MDPP) lifestyle change programs. The Umbrella Hub is now authorized to bill Medicare for Diabetes Prevention Services for eligible members.**
- **Assistance in Community Integration Services (ACIS) provided support to the National Council on Independent Living when they needed to identify a Maryland resident who has a disability and lived experience with homelessness. The ACIS client participated on a panel for the Advancing Housing, Health, and Social Care Partnerships Conference in Washington, DC.**

- **The Maryland Medicaid ACIS pilot team was selected for the U.S. Department of Housing and Urban Development and the U.S. Department of Health and Human Services Housing and Services' Partnership Accelerator program. The technical assistance opportunity was a joint application between the Maryland Departments of Health, Disabilities, Aging and the Department of Housing and Community Development. It is a 12-month opportunity that will allow these departments to collaborate with federal and other state partners to expand and strengthen housing support services for Marylanders.**
- **Maryland Medicaid received approval from the Centers for Medicare and Medicaid to pilot the ACIS program in 2017 to address health-related social needs, specifically related to housing and those experiencing housing instability. The pilot delivers housing and tenancy case management support services for qualifying individuals experiencing housing insecurity currently in four jurisdictions: Prince George's County, Baltimore City, Cecil County and Montgomery County. A recent program evaluation performed by the Hilltop Institute indicates that more than 70% of program participants achieved stable housing. Marylanders receiving assistance also had significant reductions in emergency room visits as well as inpatient admissions over the course of a year following enrollment. Consequently, Governor Moore allocated $5.4 million in the Administration's proposed FY 2025 budget to expand and build upon the pilot's success. FY 2025 will be the first time that MDH has level funded ACIS and Prince George's County is not required to provide a 50% dollar match.**
- **The nurse monitoring and assessment evaluation and review services programs (NM/AERS) are mandated to provide services to clients within 90 days of referral. The NM program currently has a backlog of 864 cases and the AERS program has a backlog of 611, totaling to 1,475 cases across both programs. The backlog spans as far back as seven months. Of note, without an assessment, these individuals are unable to receive home care services, so the impact is significant and leads to complaints at the County and State levels. As of last week, Medicaid leadership is requesting a formal corrective action plan to illustrate how we will address the backlog. Two NM registered nurse positions are currently unfunded, which will worsen the backlog. The program is significantly understaffed and will continue operating at a deficit without further investment. Both programs are revenue generating.**

Environmental Health/ Disease Control

15. Please share the metrics for programs within the Environmental Health/ Disease Control Division used in FY 2024 for determining program efficacy and success (provide at least 3).

- **Food facilities within the County are licensed and inspected per COMAR mandates. (Food trucks, weekend events, special events, farmers markets, nursing homes and schools included).**
- **Pre-opening inspections were conducted at public swimming pools prior to the Memorial Day holiday per the clients/applicants request per County Code.**
- **Communicable disease outbreaks are investigated per COMAR mandates.**
- **Hepatitis case management for mothers and infants at risk.**
- **Animal bites of humans are investigated per COMAR mandates.**
- **Nursing and environmental case management of children with asthma and elevated blood lead levels is conducted per grant through MDH.**
- **Health impact assessments are completed of development projects per County Code.**
- **Continue to work with Joint Base Andrews, State of Maryland and Environment Protection Agency (EPA) for contamination sites in the County.**
- **Percolation tests conducted during the seasonal high water table and year round depending on soil types.**
- **Inspections and plan reviews to correct failing on-site sewage disposal systems are completed per COMAR and County Code.**
- **Complaints for food, pools and other environmental public health issues are investigated.**
- **Food service manager training for nonprofit facilities completed per County Code.**
- **Utilized money from the Bay Restoration Fund to correct failing on-site systems. Properties either repaired the system or connect to the public sewer lines.**

16. Please provide programmatic information for FY 2024 on the Environmental Health/ Disease Control Division's programs, ensuring that all programs are represented.

Program	Services Provided	Number of those who received assistance in FY 2024
Food Protection Program	1. Food Service Facility (FSF) high & moderate priority inspections 2. Follow-up inspections of high & moderate priority FSFs 3. Number of high & moderate FSF inspections required by the State 4. Percentage of state-mandated inspections completed	1. 3,481 facilities inspected 2. 911 follow-up inspections 3. 6,176 inspections 4. 56.36% completed
Communicable Disease Surveillance Program	1. Vaccine-preventable disease investigations 2. Food and water-related disease investigations 3. Animal bite investigations 4. Other disease investigations 5. Total Investigations	1. 10 investigations 2. 870 investigations 3. 1,446 investigations 4. 11,756 investigations 5. 13,777 investigations

17. Please summarize the Environmental Health/ Disease Control Division's program successes and achievements realized in FY 2024.

- **There were several months in FY 2024 where Food Protections staff exceeded the average number of inspections per inspector per month. Several months, the number of routine inspections per inspector exceeded 300.**
- **Pool preopening inspections were conducted with most approved prior to Memorial Day weekend.**
- **Investigations of potentially rabid racoons and bats were conducted in County neighborhoods.**
- **The Communicable disease program provided vaccine and supplies and staff to assist with four no cost animal vaccination clinics in the County.**
- **Percolation tests of properties requiring soil evaluation during seasonal high-water tables (wet season) were completed January through April.**

Family Health Services

18. Please share the metrics for programs within the Family Health Services Division used in FY 2024 for determining program efficacy and success (provide at least 3).

Many of the metrics for determining program efficacy and success center around a number of individuals served and are included in the table below. However, we also track metrics such as number of appointments scheduled vs appointments kept (no-show rate), number of clients per provider, and various health outcomes (% of low birthweight babies, infant mortality rate, etc.).

19. Please provide programmatic information for FY 2024 on the Family Health Services Division's programs. Please ensure that all programs are represented.

Program	Service population	Services provided	Number of qualifying applicants in FY 2024	Number who received assistance in FY 2024
Women Infant and Children (WIC) Breastfeeding	**1. Pregnant Women 2. Post Partum Women <6 months**	**1. Breastfeeding Education 2. Breastfeeding Support**	**1,422**	**1,422**
WIC	**1. Pregnant Women 2. Post Partum Women 3. Children Under 5 years**	**1. Supplemental Foods 2. Nutrition Education 3. Breastfeeding Support 4. Community Service Referrals**	**11,670**	**11,106**
Dental	**1.Maternity clients 2.Children <18 years old 3. Ryan White Clients**	**1. Oral Health Education - All 2. Complex Radiological evaluation - All 3. Adult and child prophies 4. Periodontal Debridement - Adults 5. Dentures/Bridges – Ryan White clients 6. Oral Cancer screenings -Adults 7. Dental sealants – pediatric 8. Restorations - All 9. Referrals to specialties as needed**		**Total # of children served FY 2024: 547 Total # Maternity Patients: 7 Total# of Ryan White (RW) 97**
Immunizations	**Children and Adults of all ages**	**1. Immunizations for children 0-18 Vaccines for Children (VFC Program) 2. Young adults in High School vaccinations with private stock vaccines 3. Adults with Flu, Monkeypox, Measles, Mumps, Rubella (MMR) and Covid vaccines 4. School immunization record screenings 5. Hearing and vision screening for private schools Community Flu program (seasonal)**	**7,432**	**7,432**
The Maternal and Child Health Center at Laurel	**Adults, adolescents**	**1. Family planning contraception (BCP, Depo-Provera, Nexplanon, LARC evaluations/placements, annual physicals) 2. STI screening, testing, and treatment (Rapid and clinic testing) 3. Personal Responsibility Education Program (PREP) services 4. Referrals (GYN, Mammograms) 5. Sports Physicals 6. School Physicals 7.Sick visits**	**Types of assistance: 1. Family planning services including LARS 2. Sports/School physicals 3. Sick visits 4. STI screenings 5.PREP Services**	**1081 total patients seen and received services at MCH@ Laurel clinic and Cheverly RHRC**

RHRC – Cheverly	**Adults, Adolescents**	**Family planning (contraception (BCP, Depo-Provera, Nexplanon, LARC evaluations/placements, annual physicals) 2. Sexually Transmitted Infections (STI) screening, testing, and treatment (Rapid and clinic testing) 3. Pre-Exposure Prophylaxis (PrEP) services 4. Referrals (Gynecological (GYN), Mammograms)**	**Type of Assistances: 1. STI/ Testing. And treatment. 2. Pregnancy testing and counseling WIC/ Babies Born Healthy referrals. 3. Birth control medication management. 4. Wellness exams. Domestic and IPV referrals.**	**1081 total patients seen and received services at MCH@ Laurel clinic and Cheverly RHRC**
Human immunodeficiency viruses (HIV) Testing and Outreach	**Adults, Adolescents**	**HIV/STI screening, testing, risk assessments and linkage to care**	**2,293 HIV rapid tests**	**1,835 persons tested**
Sexual Risk Avoidance Education for youth	**GLI -Making Proud Choices**	**Virtual and In-Person sexual risk avoidance and financial literacy**	**169 Registered**	**120 received pre and post testing**
HIV/AIDS Program (HAP)	**Adults HIV positive**	**HIV/AIDS Program (HAP) provides holistic, comprehensive, coordinated, and quality HIV medical care to uninsured and underinsured persons living with HIV disease. HAP promotes access to Medical Case Management, Non-Medical Case management (housing, food voucher, transportation, and linguistics), Behavioral Health, Dental, and Early Intervention (EIS) services. Medical Case management coordinates the intake process for newly diagnosed and persons living with HIV. They assist clients in adhering to treatment plans, provide education, linkage to additional services, assist with health insurance and Maryland AIDS Drug Assistance Program (MADAP) applications, which pays for medication and insurance copay.**	**371 Clients**	**371**

		Non-Medical Case Management provides the Ryan White Eligibility requirements and additional support (housing, food voucher, transportation and linguistics) services as needed. **Behavioral Health services provide assessments and individualized counseling and referrals for mental health and substance abuse/use.** **Outpatient Ambulatory services provide lab, Seropositive Clinic (SPC), education, medication, vaccination, and referrals for additional services.**		
Healthy Beginnings	**1. Pregnant Women** **2. Postpartum Women** **3. Infants birth-two years** **4. Community Providers/Agencies/ Organizations**	**Prenatal case management (from time of enrollment – 6 month postpartum – longer on an individual client basis). Receive minimum of one postpartum home visit.** **Case management services include clinical assessments, connection to care (insurance, Obstetrics (OB) provider, mental health, specialists, dental, and primary care)** **SDOH are addressed with all clients and referrals are made to appropriate community organizations, county agencies and services.** **Postpartum Case management for mom (focuses on comorbidities in the postpartum period, attendance at postpartum visit, postpartum depression screenings, connection to mental health services as needed, education on the maternal warning signs, contraception for birth spacing, connection to primary care, completion of dental visit).** **Infants birth – two years: provide case management to parent or guardian to ensure that infant is connected to a pediatrician, all visits are kept and well child visit schedules are followed, insurance, WIC, connect to any community resources/ services infant needs, provide parent/guardian education that includes safe**	**119 new clients (prenatal)** **596 (newly enrolled)** **677 (includes infants from prenatal and postpartum enrolled client births + multiples)**	**138 total clients (prenatal)** **697 (new + continuing clients)** **794 (includes continuing clients enrolled prenatal and postpartum + multiples)**

		sleep and infant safety. Provide diapers, pack-n-plays, and supplies. Home visits. **Provided educational sessions and trainings for Safe Sleep, Infant Care, and Teen Parenting**		
Tuberculosis (TB) Control and Prevention	**1. Treatment for active and suspected patients with TB.** **2. Contact investigation.** **3. Treatment for Latent Tuberculosis Infection (LTBI).** **4. Evaluation of immigrant class B who entered the country with abnormal chest-x-ray or positive QuantiFERON.** **5. Reporting of all TB cases to MDH and CDC.**	**1. Provided patient education on evaluation and TB treatment.** **2. Screening for TB, LTBI.** **3. Blood work screening for TB.** **4. Onsite chest x-rays.** **5. Sputum collection.** **6. Onsite medication dispensing for TB and LTBI patients.** **7. Doctors appointments, for evaluation and treatment for TB and LTBI.** **8. Direct Observation Therapy (DOT), in clinic and in the community.** **9. Small scale and large- scale contact investigation in the community.**	**1. Number of patients seen and received services. 1,585** **2. Number of DOT 7,574** **3. Number of contacts screened 357.** **4. Number of health assessments completed. 1,175**	**Number of patients seen 1,585.**

20. Please summarize the Family Health Services Division's program successes and achievements realized in FY 2024.

- **Ending the HIV Epidemic (EHE)-Status Neutral Summit: Over 120 providers and community based-organizations attended.**
- **<u>The WIC Breastfeeding program</u> achieved a breastfeeding initiation rate of 86%, which exceeded the 80% goal by +6%. Which indicates more mothers are breastfeeding their babies from birth. Higher initiation rates also indicate longer durations for breastfeeding.**
- **<u>The WIC program</u> held 27 pop-up enrollment events. These enrollment events increased our program participation by 2.7%.**
- **<u>The HAP Program</u> number of clients served increased from 350 to 371 despite shortage of staff.**
- **<u>The Maternal and Child Health Center at Laurel:</u> The clinic has provided comprehensive care to a majority of residents since the clinic was newly opened and continues to reach out, improve, and expand our services to patients who need them.**

- **<u>The Healthy Beginnings Program:</u> Educated 716 pregnant and newly delivered moms about the importance of safe sleep for their infant and provided 139 pack-n-plays to families without a crib or bassinet so that they would have a safe sleep environment for their infant to combat preventable sleep related deaths in the county.**
- **<u>Dental Services:</u> Pregnant patient successfully cared for (preventative and restorations) and followed up on postpartum. She then scheduled two of her children with the clinic for prophy. We now care for the family.**
- **<u>Cheverly RHRC:</u> A homeless client walked in and was added to the schedule and received services. He stated that everyone was so nice and that the "doctor" took time with him, and he did not feel bad about himself. The programs now accept all walk-in clients, and no one is turned away. Fiscal staff are trained how to determine how to schedule walk in clients so patients can have a seamless visit.**
- **<u>Tuberculosis program</u>: There were 1,585 patients seen despite the shortage of nurse case managers. The program met all its performance measures for FY 2024. There were 54 patients diagnosed with active Tuberculosis. All 54 patients received evidence-based practice treatments. There were three major contact investigations in the community, the TB team provided patient education and screening of the contacts in the community. No TB out-break was reported in the community or multiple genotype sequences.**

Health Department

Attachment A, Question 1

	FY 2024 Authorized General Fund and Grant Funded	FY 2024 Authorized PT	FY 2024 Authorized Grant Funded	
Position titles	**FT Positions**	**PT Positions**	**LTGF Positions**	**Funded Positions**
Account Clerk	5	0	2	5
Accountant	7	0	2	5
Administrative Aide	32	0	3	29
Administrative Assistant	15	0	4	7
Administrative Specialist	14	0	0	10
Associate Director	5	0	0	5
Auditor	3	0	1	3
Budget Assistant	0	0	0	0
Budget Management Analyst	11	0	2	9
Building Engineer	1	0	0	1
Building Security Officer	4	0	0	3
Buyer	0	0	1	0
Citizen Services Specialist	1	0	0	1
Communications Specialist	1	0	1	0
Community Developer	58	1	14	51
Community Development Aide	2	0	0	2
Community Development Assistant	57	1	10	49
Community Health Nurse	59	1	4	64
Community Services Manager	1	0	0	1
Compliance Specialist	2	0	1	0
Counselor	37	0	19	28
Data Coordinator	0	0	1	0
Data Entry Operator	1	0	0	1
Dental Assistant	0	0	1	
Dental Hygienist	0	0	1	
Dentist	1	0	0	1
Deputy Director Officer	2	0	0	1
Disease Control Specialist	30	0	5	17
Early Childhood Specialist	0	0	1	
Environmental Health Specialist	35	0	0	30
Equipment Operator	2	0	0	
Facilities Manager	1	0	0	1
Facilities Superintendent	2	0	0	2
General Clerk	16	0	1	11
Graphic Artist	0	0	1	1
Health Aide	8	0	0	8
Health Officer	1	0	0	1
Human Resources Analyst	9	0	1	7

	FY 2024 Authorized General Fund and Grant Funded	FY 2024 Authorized PT	FY 2024 Authorized Grant Funded	
Position titles	**FT Positions**	**PT Positions**	**LTGF Positions**	**Funded Positions**
Human Resources Manager	1	0	0	1
Information Technology Engineer	1	0	0	
Information Technology Project Coordinator	0	0	0	
Licensed Practical Nurse	3	1	3	3
Mail Services Operator	2	0	0	1
Maintenance Services Attendant	1	0	0	1
Nurse Practitioner	6	0	3	2
Nutritionist	1	0	1	1
Permits Specialist	1	0	0	1
Physician Program Manager	1	0	0	1
Physician Assistant	2	0	0	1
Physician Clinical Specialist	1	0	0	
Physician Supervisor	0	0	0	
Planner	6	0	1	4
Police Officer Supervisor	1	0	0	
Procurement Officer	1	0	0	1
Program Manager	1	0	1	
Program Monitor	0	0	3	
Project Director	1	0	0	
Programmer-Systems Analyst	2	0	0	2
Property Standards Inspector	0	0	0	0
Provider Health Literacy Lead	0	0	1	0
Public Health Lab Scientist	2	0	0	2
Public Health Program Chief	9	0	0	9
Public Information Officer	1	0	0	1
Public Safety Aide	3	0	0	3
Radiology Technician	1	0	0	1
Safety Officer	1	0	0	
Service Aide	0	0	1	1
Social Worker	5	0	4	3
Supervisor	1	0	0	
Supervisory Clerk	1	0	0	1
Supply Property Clerk	1	0	0	1
System Analyst	3	0	0	
FY 2024 TOTAL	**483**	**4**	**94**	**395**