

ENVIROMENTAL ANALYSIS OF MARYLANDS PUBLIC OUTPATIENT MENTAL HEALTH SYSTEM



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EXECUTIVE SUMMARY

The Mid-Atlantic Association of Community Health Centers (MACHC) is uniquely positioned to lead an initiative in Maryland to integrate mental health services and primary care. MACHC is the foremost advocate for the health care needs of underserved residents in the state. The association has successfully increased access and availability of primary care services throughout Maryland and is now committed to applying its resources to ensure sound, feasible strategic-planning efforts for successful integration.

The benefits to service integration of primary care and mental health services have been empirically established. Practices have redesigned care models by providing coordinated, short duration, solution-focused interventions delivered simultaneously by primary care providers and behavioral health care providers as part of all primary care visits. These “embedded programs” are staffed and organized to provide both primary health care and behavioral services in a coordinated manner. In this recovery-oriented system, the results have been impressive:

- Medical cost savings: up to 70% savings in inpatient costs for older populations and 40% medical cost reductions in Medicaid patients receiving targeted, coordinated, recovery-oriented treatment
- Cost effectiveness: a savings of approximately \$500 per case of depression treated
- Improved process of care: improved recognition of mental health disorders, improved primary care provider skills in medication prescription practices, improved patient adherence to medication and reduced “drop-out” rates
- Improved clinical outcomes: improvement in depression remission rates, improved health status indicators in hypertension and diabetes, improved self management skills for patients with chronic conditions, better clinical outcomes than by treatment in either the primary care sector or the behavioral health sector alone, and
- Improved consumer and provider satisfaction.

The transformation of services is not easy without knowledge, support, encouragement and skills. This document is designed to provide a concise overview of the public mental health system in Maryland. It is intended as a tool to help ground discussions and activities in the realities within the state and as a first step in improving the accessibility, quality and cost of services for low income and underserved people.

In addition to the challenges of successfully merging the two very different cultures of mental health and primary health care delivery systems, there are many additional issues at both the state and local level that will require examination and discussion as this initiative moves forward. These include:

- Identifying start-up funds for the establishment of integrated programs
- Ensuring that reimbursement rates reflect the cost and time required for the provision of services
- Overcoming stigma



- Securing adequate space
- Determining staffing needs
- Scheduling
- Coordinating medical records
- Identifying training and orientation needs of staff
- Assuring the availability for consultation
- Meeting cultural issues and language needs
- Supplying necessary transportation
- Establishing outcome measures- clinical and financial
- Interfacing with the managed care reimbursement systems

Interestingly, some of the current market forces or trends facing community health centers are also challenging the community mental health centers. The emphasis on clinical outcomes, focus on consumer centered care, diminishing or stagnant resources, challenges to attract and retain qualified workforces, aging infrastructures, and growing client populations with more complex presenting problems continue to stress the capabilities of these organizations. These issues can also serve to motivate the organizations to re-evaluate the respective service delivery system which often reveals consumer populations in need of primary care treatment and mental health services.

However, recognition of the need for integrated care is just the beginning. A comprehensive analysis of the community health center's readiness to embark on a change initiative of this order is the first step to designing and implementing the integration model that will best meet the needs of the consumers, the community and the organization.



INTRODUCTION

The Mid-Atlantic Association of Community Health Centers (MACHC) represents the Federally Qualified Health Centers (FQHCs) of Maryland and Delaware. There are thirteen (13) FQHCs in Maryland that provided primary health care to approximately 161,442 individuals in 2004. MACHC and its members are committed to the improvement and integration of primary health care and specialty behavioral health services to the underserved and low income populations of Maryland.

MACHC recognizes that the integration of these services increases access, quality, and cost effectiveness of all levels and types of care. MACHC has, therefore, committed to a series of activities designed to expand the availability of affordable and integrated services to the clients of its member organizations within the two states it represents. This initiative is composed of the following tasks:

- 1: Conduct an environmental analysis of the public mental health outpatient system in Maryland;
- 2: Reach out to the state agencies responsible for primary health care and mental health services to create a dialogue among policy makers and service providers focused on the needs of the underserved;
- 3: Provide MACHC membership with materials and “best practices” for service integration;
- 4: Provide on-site assessment and technical assistance to selected FQHCs; and
- 5: Support the individual FQHCs in competition for funds under the Health Resources and Services Administration’s (HRSA) expansion of access to essential health care services.

The individual FQHCs in Maryland vary widely in their current approaches employed to meet the mental health needs of consumers. Each community health center (CHC) is committed to a full range of services for consumers and provides mental health services either directly or through referral mechanisms. However, the system is fragile and complicated for both the consumers and the providers. The primary care providers (PCP) desire to increase their knowledge of the mental health service delivery system and to improve their level of collaboration with existing mental health programs. Even the health centers that have been able to benefit from HRSA’s essential service expansion initiative require a more in-depth knowledge of the existing programs, state policies, advocacy groups and staffing issues.



BACKGROUND

Despite long-standing financial support (via grants, contracts, Medicaid and Medicare) at the local, state and Federal levels, services for primary care and behavioral health remain limited and fragmented in many communities. This is especially true in communities with large numbers of low income, uninsured and/or minority populations. This gap in services is multi-faceted: chronic underfunding of the public system, inadequate reimbursement for services, and a shortage of professionals trained and willing to work with underserved populations. The stigma of being labeled as mentally ill also is a major barrier for consumers seeking or continuing appropriate services. As a result, primary care providers are often caught between patients experiencing untreated behavioral health illnesses and a lack of available referral options. The national data below illustrates many of the issues involved in the current system of care: (Strosahl, Kirk, p. 57-90).

- Only 25% of patients referred by the PCP to specialty mental health services make the first appointment
- 50% of psychiatric conditions go undiagnosed
- Mental health outcomes in primary care patients are only slightly better than spontaneous recovery
- 50% of all mental health services are provided by PCPs
- 70% of CHC patients have mental health problems
- 67% of psychoactive agents are prescribed by PCPs
- 80% of antidepressants are prescribed by PCPs
- Less than 30% of individuals in mental health treatment complete follow up visits within a month of establishing a care plan or the prescribing of medication
- 50-60% of mental health patients do not adhere to their psychoactive medications within first 4 weeks
- 92% of elderly receive mental health care from PCPs
- Top 10% of users of primary care services consume 33% of services
- Distressed patients consume twice the annual average amount of care

A recent study of adults discharged from psychiatric hospitals found 20% with chronic and serious conditions such as HIV infection, brain trauma, cerebral palsy and heart disease. As many as 75% of individuals with schizophrenia have been found to have high rates of serious physical illnesses, such as diabetes, respiratory, heart and/or bowel problems and high blood pressure. High rates were also seen for vision (93%), hearing (78%), and dental (60%) problems. (Bazelton Center for Mental Health Law, p. 1)



OVERVIEW OF PUBLIC MENTAL HEALTH SYSTEM

Mental Hygiene Administration

The Mental Hygiene Administration (MHA) is the administration within the Maryland Department of Health and Mental Hygiene (DHMH) that is responsible for overseeing the delivery of the Public Mental Health System (PMHS) in Maryland. Its duties include formulating a State mental health plan for needed services; establishing eligibility for State funding of local mental health programs; establishing the qualifications of staff and quality of professional services and establishing eligibility for receiving mental health services. MHA also operates five public State psychiatric hospitals (Catonsville, Cumberland, Cambridge, Chestertown, and Sykesville), one forensic hospital (Jessup) and three residential treatment centers (RTCs) for children and adolescents (Baltimore, Cheltenham and Rockville), known as Regional Institutes for Children and Adolescents (RICAs). Since 1991, Core Service Agencies (CSAs) have assisted MHA in the management of the system at the local level. Consumers, including Maryland's consumers' group On Our Own of Maryland, (a state-wide mental health consumer education and advocacy organization that promotes equality in all aspects of society for people who receive mental health services and develops alternative, recovery-based mental health initiatives) are an integral part of MHA's strategic planning process. MHA also actively involves various advocacy and family organizations, such as the Alliance for the Mentally Ill, the Mental Health Association of Maryland and the Maryland Coalition of Families for Children's Mental Health, as well as providers.

On July 1, 1997, in accordance with Senate Bill 750 and Maryland's 1115 Waiver MHA, in conjunction with the CSAs, implemented the fee-for-service (FFS) sector of the PMHS. The PMHS was designed for Medicaid recipients and individuals who, as a result of the severity of their mental illnesses, required financial assistance to obtain the psychiatric services they needed.

The FFS system is administered by an Administrative Service Organization (ASO) providing the following services:

- Maintaining a 24-hour access for clinically related calls
- Referring individuals to qualified service providers
- Preauthorizing non-emergency care
- Reviewing authorization plans to assist in determining whether an individual meets the Medical Necessity Criteria and is part of the Public Mental Health System
- Conducting utilization reviews of services
- Collecting and maintaining data
- Providing needed reports
- Processing claims (electronic and paper)
- Managing the collection of Federal Medicaid Funds



- Assisting with the evaluation of the PMHS

Prior to the initiation of the FFS in 1997, MHA administered State general funds for mental health services as well as some federal grant funds. MHA administered only a portion of the State and federal Medicaid dollars which was claimed by agencies to which MHA provided contractual funding. Generally, these were limited to Community Mental Health Centers, Psychiatric Rehabilitation Programs, Mobile Treatment Programs, and Mental Health Case Management Programs. Mental health and ancillary services not included in the Medicaid Plan and services provided to individuals without insurance who met financial and psychiatric eligibility for services were funded through contracts. Based upon fund availability and the CSAs’ budgetary requests, MHA transferred funds to the CSAs which, in turn, contracted with local providers to provide mental health services for residents within their jurisdictions.

Below is a comparative chart (state-wide) of the prior system and the current PMHS:

Prior to ASO	Current
200 providers.	4,000 providers
30,000 consumers served.	90,000 consumers served. (200,000 consumers have accessed the system since 1997.)
Very limited data reporting for MHA and local county governments beyond the 1960s psychiatric case registry.	Up-to-date reporting on providers, consumers, claims, utilization review, and the system that is used to evaluate performance outcomes, effectiveness, efficiency and costs of mental health related services. This data is also used by
No coordination of care between somatic and mental health providers.	Coordination of care occurs between the managed care organization (MCO) and primary care providers (PCPs) via ASO’s authorization and reporting system.
No statewide continuity of care information.	The ASO is the cohesive entity that ties all groups together by tracking all care transactions.
No prevention information.	ASO’s reporting alerts MHA of all members using high cost services so that prevention programs can be provided as necessary.

As depicted in the table above, the service system has grown dramatically both in providers and consumers. (Maryland Health Partners Reports Presentation, September 2004)

Core Service Agencies

The CSAs are the local mental health authorities responsible for planning, managing, and monitoring public mental health services at the local level. Each CSA exists under the authority of the Secretary of the Department of Health and Mental Hygiene and is an agent of the county government, which has approved the organizational structure.



As stipulated by the Health General Article, 10-10-1203, Annotated Code of Maryland, the functions of the Core Service Agencies are to plan, develop, and manage a full range of treatment and rehabilitation services for persons with serious mental illness in their jurisdictions.

Organizationally, the CSAs exist in a number of forms: as a unit of county government (e.g. health department), as a quasi-public authority, or as a private, non-profit corporation. Whatever the structure selected, the CSA is an agent of county government, and as such, the County is the appropriate body to decide on the organizational structure. The model selected ideally emerged from a local process which involved stakeholders at all levels- citizens, consumers, providers, policy makers, and advocates. The CSA must be governmental or not-for-profit in nature. The CSA must be able to link with other human service agencies to promote comprehensive services for individuals in MHA's priority population who have multiple human needs. A listing of the CSAs in Maryland is provided in Appendix A.

CSA responsibilities within the PMHS include:

- Managing contracts utilizing state general funds
- Assessing the service needs of their communities and planning the implementation of delivery systems that meet consumers' needs
- Collaborating with MHA to determine the criteria for performance standards
- Collaborating with ASO in processing complaints, grievances, and appeals
- Monitoring contract compliance of ASO and reporting the findings to MHA
- Authorizing mental health vocational (supported employment) services, community prevention and support services, and enhanced support services for consumers
- Involving consumers, providers, families, and the community in planning for the mental health needs of all citizens
- Authorizing Residential Rehabilitation Placements (RRP)
- Approving of data collection worksheet waivers

Funding Mechanisms

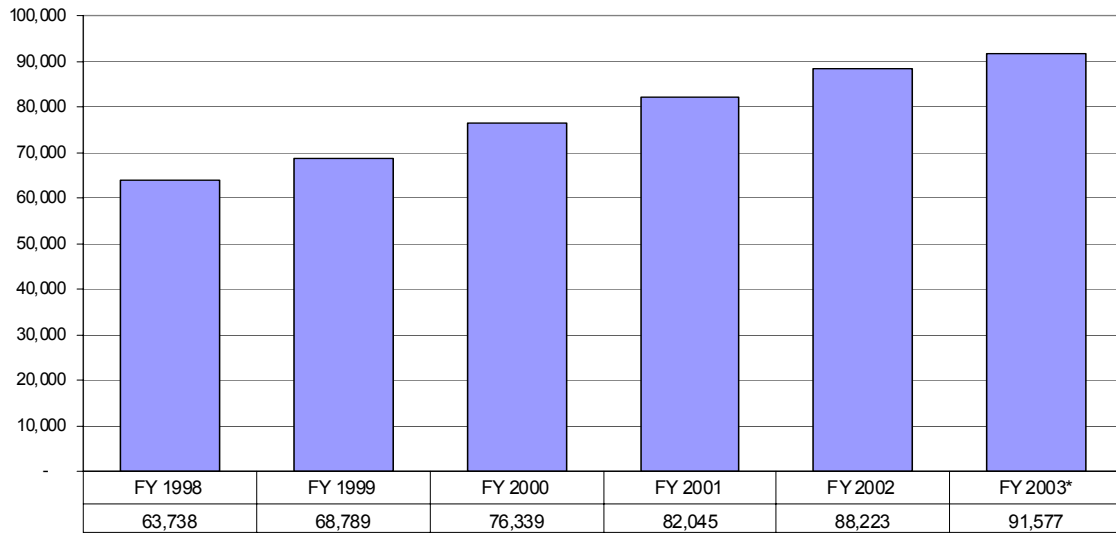
In addition to the funds appropriated to operate the State hospital system, Maryland's PMHS is financed by three major funding mechanisms:

- State and Federal Medicaid dollars that are Federally matched at a rate of approximately 50%;
- State general funds used to fund services which are not eligible for Medicaid reimbursements and for services rendered to the uninsured population; and
- State general grants provided by MHA and managed by the CSAs.



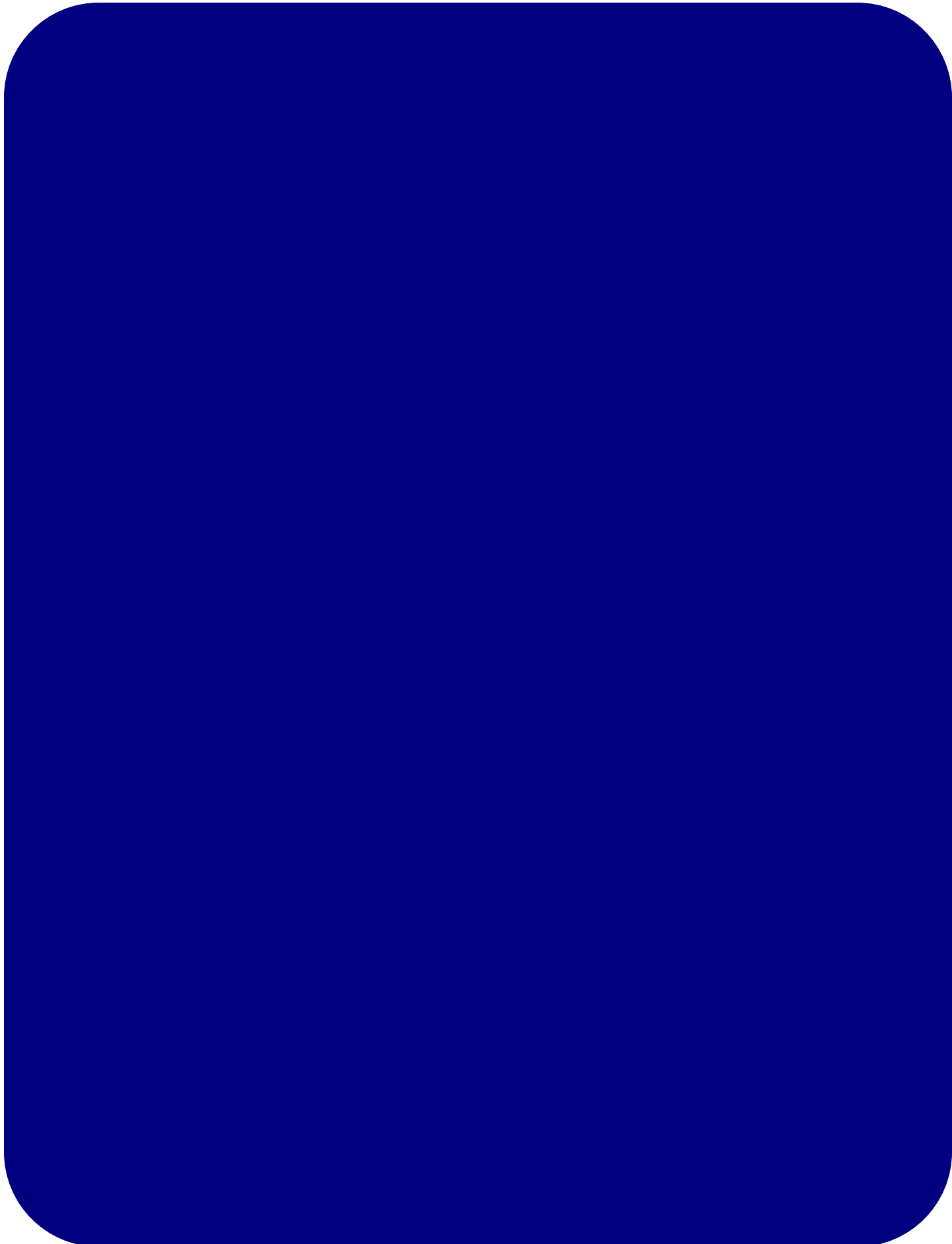
Number of Consumers Served

During fiscal year 2003 approximately 92,000 consumers received services within the PMHS. This reflects a 3.8% increase from the previous fiscal year. The historical trend is examined in the chart below. (Maryland Health Partners Report, September 2004)



Medicaid Penetration Rate

As indicated in the following table, Maryland’s total Medicaid population was approximately 600,000 in 2003. Of this number, approximately 40,000 children and 36,000 adults were served in the PMHS. As these data indicate, a greater percentage of adults who are eligible for Medicaid Assistance receive mental health services than children. On the other hand, the increases in PMHS enrollment have been fueled largely by the growth in the number of children served. (Maryland Health Partners Report, September 2004)





Treatment Modalities

Inpatient Services (Non-State Hospitals, Non-RTCs)

Inpatient services include services rendered to individuals in psychiatric units of general hospitals, in private psychiatric hospitals, and in residential treatment centers for children and adolescents. It should be noted that Maryland has a system of hospital rate setting which provides for services to uninsured individuals who require acute care but do not have the ability to pay for it.

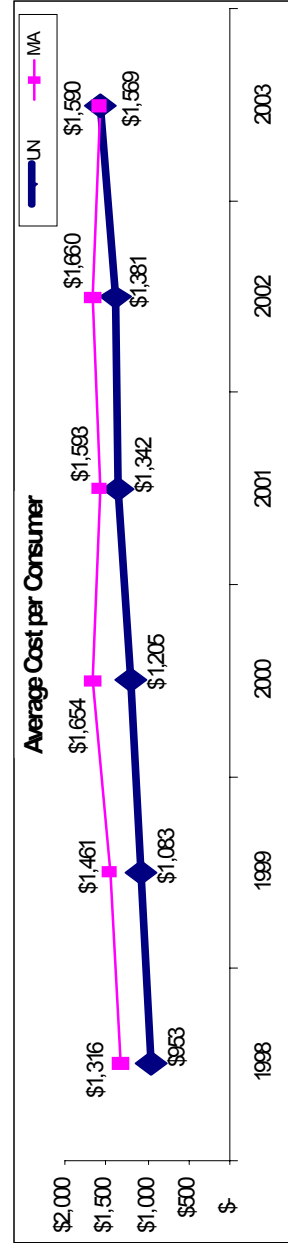
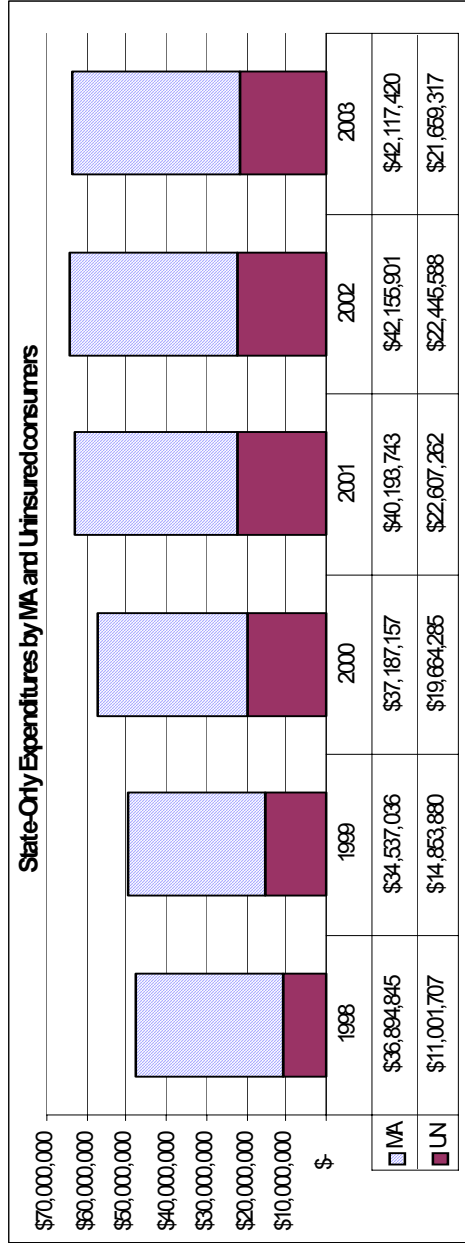
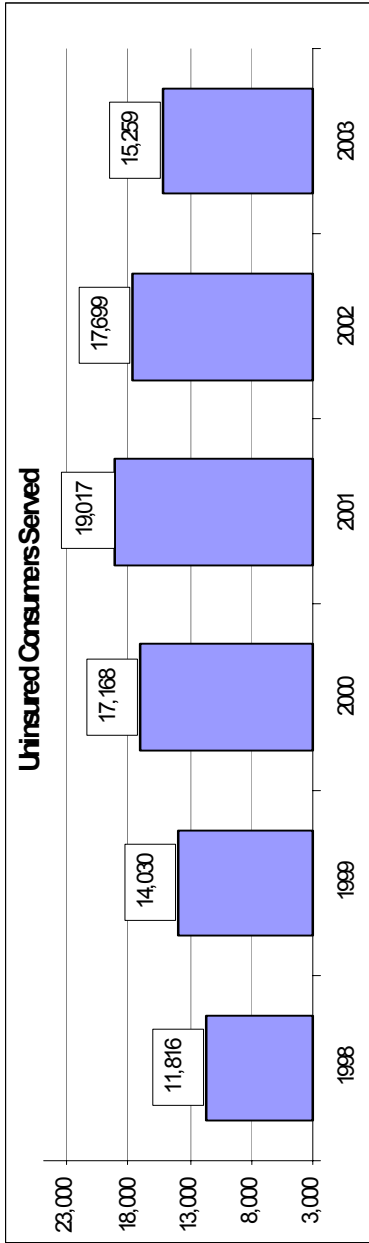
Outpatient Services

Outpatient services include those services provided in hospital outpatient departments, in outpatient mental health centers, and by individual practitioners including psychiatrists, certified nurse psychotherapists, licensed and certified clinical social workers, licensed psychologists and licensed and certified professional counselors. Additionally, partial hospitalization and mobile treatment services are included in this modality.

Rehabilitation Services

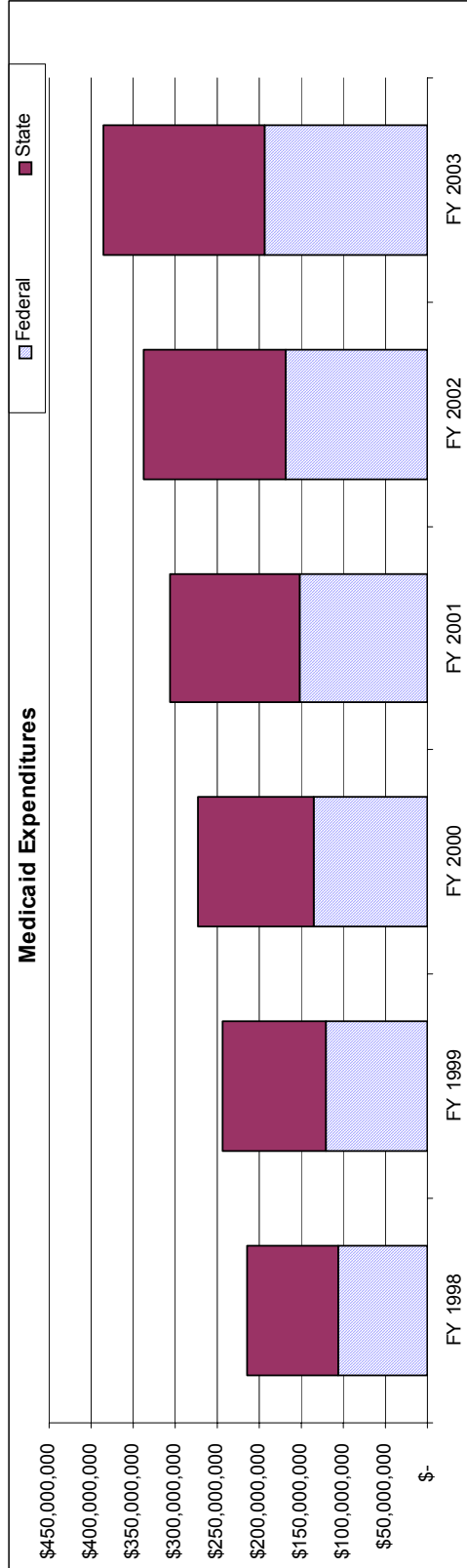
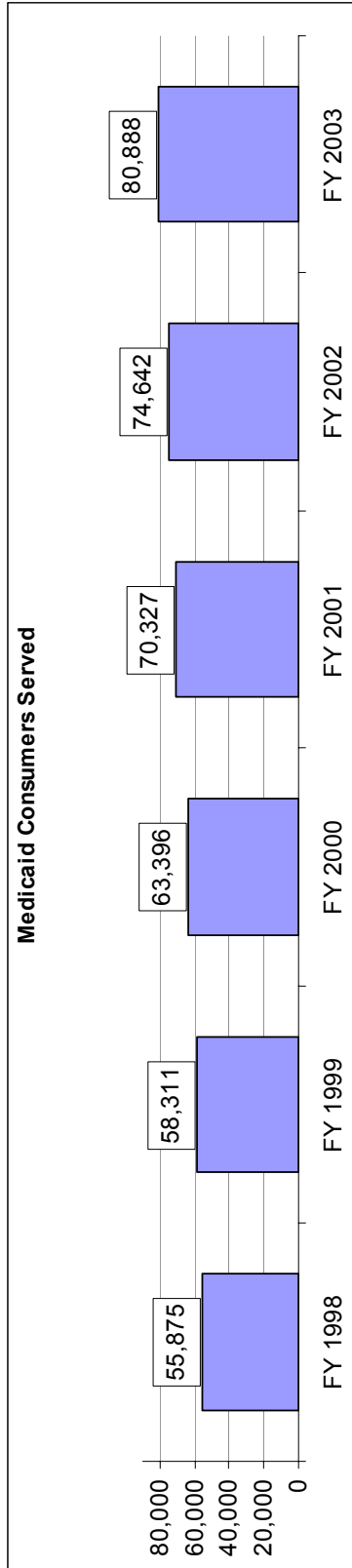
Rehabilitation services include psychiatric rehabilitation services intended to assist individuals in achieving independence in activities of daily living. These services may be provided at a Psychiatric Rehabilitation Program (PRP) activity center (on-site services) or in another setting such as the individual's living unit. Residential Rehabilitation Program (RRP) services assist individuals by providing residences and associated supports. Crisis bed services and supported employment services are included in this category. These three classes of services are completely funded using State general funds since they are not eligible for Medical Assistance funding.

The following charts examine the numbers of individuals served and the average cost of service by the payment sources for these individuals. Expenditures for services not subject to Medical Assistance reimbursement are examined by medical assistance eligibility status of the consumer.





The following analysis examines Medical Assistance expenditures and recipients in the PMHS



Average Cost per Consumer

	FY 1998	FY 1999	FY 2000	FY 2001	FY 2002	FY 2003
FY 1998	4,281					
\$	\$	\$	\$	\$	\$	\$
	4,469	4,455	4,565	4,572	4,809	



The final analysis examines the number and type of provider by geographic location. It is significant to note that any willing provider who meets Medical Assistance requirements may be certified to participate in the Maryland Medical Assistance system and by inference in the PMHS. Some individual practitioners see very few Medical Assistance consumers, so that the numbers of such practitioners may provide a slightly misleading view of the availability of services within certain jurisdictions.

Number of Providers by County and Type

county	Case Management	Group Home	Home Health	Hospitals	Individual Practitioner	Mobile Treatment	Non-Hospital based Partial Hospitalization	Outpatient Mental Health Facilities	Physician - Total	Psychiatric Rehabilitation	Residential Crisis	Residential Rehabilitation	Residential Treatment Center	Respite	Supported Employment	Other
Allegany	1			3	17	1	1	3	53	1	1	1		1	1	12
Anne Arundel	1	1		6	89	1	2	7	149	14	1	7	1		3	26
Baltimore	3		1	11	305	2	1	29	548	45	3	14	4	3	7	106
Baltimore City	8		1	47	315	10	2	44	1,202	57	7	15	6	3	8	145
Calvert	1			1	11			1	22	2	2	1			1	9
Caroline					4			5	1	2	1	1		1	1	2
Carroll	1	1	1	2	38	1	1	4	107	6	1	5		1	3	10
Cecil	1			1	13	1		1	16	4		2			2	7
Charles	2			1	29	2		6	28	5		1			1	11
Dorchester				4	7		1	2	13	2	1	1	2	1	1	4
Frederick	1	1		4	31	1		4	46	5	1	4	1	1	1	10
Garrett				1	3	1		1	17	2	1	2		2	3	7
Harford	2			4	42	1		4	68	7	1	4			6	16
Howard	1	1		4	77	2	1	7	56	8	1	4	1	1	1	20
Kent	2			2	1	1		5	1	3	1	3		1	1	1
Montgomery	2	1	2	6	276	1	1	15	310	15	1	8	3	1	5	54
Prince Georges	2			5	128	3	2	28	191	41	2	15	2	1	2	68
Queen Annes	1				6			2	1	1		1		1	1	1
Saint Marys	2			1	8		1	4	5	5	1	2			2	5
Somerset	1			2	3			2	6	2		1		1		3
Talbot				2	2		1	4	41	4	1	2		2	2	7
Washington	1		1	3	8	4	1	5	80	7	1	3		2	2	9
Wicomico	1			2	17	1	2	7	42	6	2	2		3	1	15
Worcester	1			1	9			1	6	1						2
Grand Total	35	5	6	113	1,439	33	17	191	3,009	245	30	99	20	26	55	548

Count of providers is a duplicate count – every location of service is counted once

Other category includes Group Practices, Labs and FQHCs



CLIENTS SERVED IN THE PUBLIC MENTAL HEALTH SYSTEM

The fee-for-service sector of the Public Mental Health System (PMHS) was established to provide specialty mental health services to individuals eligible for Medical Assistance as well as for indigent, uninsured individuals who by virtue of their income, family size, and service need are eligible for State subsidized services. In general, this encompasses several groups of patients. This program was established to provide ease of access to those in need of specialty mental health services, i.e. services that go beyond those that might ordinarily be provided by a primary care practitioner during a normal somatic office visit. Consequently, the PMHS provides services to a broad spectrum of consumers.

First, there are many patients who need such services due to a transient, situational issue. Often, trauma associated with life events leads to mental distress that may require intervention. Many individuals receive short term services in the PMHS for such reasons.

A second group of individuals served by the PMHS are those who need support and perhaps medication for a relatively minor psychiatric issue. This group of patients is often seen monthly or quarterly; many may receive services primarily related to medication and related issues.

One primary focus of the Mental Hygiene Administration (MHA) is to provide services to adults with severe and persistent mental illness and children with severe emotional disturbance. Such individuals experience symptoms which regularly interfere with one or more activities of daily living. Often, the PMHS provides services beyond traditional therapy that may include some social supports. In addition to treatment and rehabilitation services, the PMHS provides residential rehabilitation, case management, and supported employment services for individuals who experience this level of disability. Individuals with severe and persistent mental illness have a higher incidence of chronic somatic disease than observed in the general population.

Another group of consumers of particular interest are those with co-occurring mental health and substance abuse issues. Individuals who experience such issues present special treatment challenges, and often these individuals also experience additional serious somatic issues.

One feature which distinguishes Maryland's PMHS is the funding of services for uninsured individuals and the funding of services not eligible for Medical Assistance reimbursement through the fee-for-service model. This provision helps assure that those individuals in need of services who are not covered under public or private insurance can receive care. To meet eligibility requirements, consumers must have a PMHS psychiatric diagnosis, meet medical necessity and meet one of the following criteria:

- receiving Maryland Pharmacy Assistance;
- receiving SSDI for mental health reasons;
- homeless within the state of Maryland;
- newly released from prison/jail/Department of Correction facility (within 3 months);
- discharged (within 3 months) from a Maryland-based psychiatric hospital or residential crisis service;



- receiving service as required by order of a Conditional Release.

Exceptions may be granted based on urgent need.



STAFFING

Community mental health centers have traditionally employed a multidisciplinary approach to service delivery that predominantly includes psychiatrists, clinical psychologists, social workers, psychiatric nurses and mental health counselors. Many of the community mental health centers in Maryland cite difficulties in recruiting and retaining qualified mental health professionals particularly psychiatrists and professionals that specialize in treating children and adolescents. These challenges are often exacerbated for rural clinics.

An important consideration for developing staffing plans for the provision of community mental health services is that of designated licensed independent practitioners. The various payor sources, including Medicaid, Medicare, and major private insurers such as MAMSI, Magellan/Care First, Aetna and Kaiser Permanente, recognize certain licensed independent practitioners and will reimburse for the services rendered only by these professionals. Community mental health centers are able to bill for services rendered by other professionals (individuals who cannot practice under their own credentials) only if the program has been designated by the state as an Outpatient Mental Health Clinic (OMHC) which (according to Maryland regulations) requires supervision by licensed independent practitioners.

In Maryland, the current Administrative Services Organization (ASO) for public mental health services is MAPS-MD which replaced the Maryland Health Partners as the organization that authorizes services and pays claims for publicly funded mental health services. This entity is responsible for processing and paying Medicaid claims and recognizes the following professionals as licensed independent practitioners:

- Physician
- Licensed Psychologist
- Licensed Certified Social Worker – Clinical (LCSW-C)
- Licensed Clinical Professional Counselor (LCPC)
- Psychiatric Nurse Practitioner

Medicare reimburses for outpatient mental health services provided by physicians and selected physician extenders, as long as the physician is supervising the service. Recognized physician extenders include physician's assistants, nurses, psychologists, and social workers.

Each of the major private insurers in Maryland, including MAMSI, Magellan/Care First, Aetna, and Kaiser Permanente, recognizes a different set of professionals as eligible for reimbursement for mental health services. Although each insurer accepts licensed physicians and licensed psychologists, the insurance plans differ in the certification/licensure requirements for social workers, counselors and nurses.

Each of the licensed independent practitioners is licensed by the State of Maryland to practice independently. The following table portrays the licensing entity for each independent practitioner and the respective requirements for licensure.



Licensed Physician	Licensed Psychologist	Licensed Certified Social Worker – Clinical (LCSW-C)	Licensed Clinical Professional Counselor (LCPC)	Advanced Practice Registered Nurse/Psychiatric Mental Health (APRN/PMH)
<p>Board of Physicians www.mbp.state.md.us</p> <p>Education Degree of doctor of medicine or osteopathy</p> <p>Experience 1 year training in postgraduate medical training program</p> <p>Examination Includes oral competency in English language</p>	<p>Board of Examiners of Psychologists www.dhnh.state.md.us/psych/</p> <p>Education Doctoral degree in psychology</p> <p>Experience 2 years of professional supervised experience of which 1 year is supervised postdoctoral experience</p> <p>Examination Examination for Professional Practice in Psychology (EPPP) and Maryland State Exam</p>	<p>Board of Social Work Examiners www.dhnh.state.md.us/bswe</p> <p>Education Master's in Social Work</p> <p>License Licensed Graduate Social Worker (LGSW)</p> <p>Experience 2 years or minimum of 104 weeks (3000 hours) of supervised clinical social work experience with 144 hours of face-to-face supervision</p> <p>Examination Clinical</p>	<p>Board of Professional Counselors and Therapists www.dhnh.state.md.us/bopc/</p> <p>Education Master's degree with minimum of 60 graduate semester hours with minimum of 3 credit hours in specific areas</p> <p>Experience 3years (3000 hours) of clinical supervised experience in counseling of which 1500 hours are face-to-face client hours and 2 years are post graduate supervised clinical experience</p> <p>References 3 professional references of which 1 must document supervised experience</p> <p>Examination National Counselors Examination (NCE) of National Board for Certified Counselors (NBCC) plus test on Maryland Professional Counselors and Therapists Act</p>	<p>Board of Nursing www.mbon.org</p> <p>Education Master's or higher degree</p> <p>License Registered Nurse</p> <p>Certification Specialist in psychiatric or mental health nursing issued by American Nursing Association (ANA)</p>



According to the Health Workforce Profile for Maryland, compiled by the Bureau of Health Professions, Health Resources and Services Administration, in 2000 there were 1,093 psychiatrists placing Maryland 5th among states in psychiatrists per capita. Maryland was ranked 1st among states for psychologists per capita with 5,390 and the 8,000 social workers earned 31st place among states in social workers per capita. In summary, for every 100,000 population in Maryland there were 21.3 psychiatrists, 101.5 psychologists and 150.6 social workers. These professionals work in private and public settings in a wide range of programs. While Maryland is relatively rich in health professionals, many individuals who reside in Maryland are employed around the Nation's capital by the federal government and in related administrative capacities. The numbers may therefore slightly overstate the availability of these resources.



SPECIAL INTEREST GROUPS

There are numerous national and state organizations that are invested in the public mental health system in Maryland. Each entity has a unique perspective and most represent a special interest group with individualized missions. Many of these organizations function as watchdogs of the system and work to ensure their interests are protected and/or promoted. Other groups represent providers of mental health services and/or the professional disciplines involved in mental health service delivery. The following brief organizational descriptions are organized into three categories by membership or representation. The linkages between national and state and/or local organizations are identified and contact information is provided.

Consumer and Family Advocacy Groups

Mental Health Association of Maryland (MHAMD): 711 West 40th Street, Suite 460, Baltimore, Maryland 21211 410/235-1178; 800/572-6426 (phone). www.mhamd.org.

This organization is an affiliate of the National Mental Health Association (NMHA). MHAMD works with its network of local affiliates to unite consumers, family members, professionals, advocates and concerned citizens to promote mental health and prevent/ameliorate mental disorders. The Mental Health Association for each county in Maryland is listed in Appendix B.

National Alliance for the Mentally Ill - Maryland (NAMI - Maryland) 804 Landmark Drive, Suite 122 Glen Burnie, Maryland 21061-4486. 410/863-0470; 800/467-0075 (phone). 410/863-0474 (fax). www.md.nami.org.

NAMI – Maryland is an affiliate of the National Alliance for the Mentally Ill (NAMI). Most NAMI members have family members who have experienced serious mental health issues. This group provides advocacy services as well as information and referral services. Maryland’s local chapters of NAMI are listed in Appendix C.

On Our Own of Maryland, Inc. (OOOMD) 410/646-0262 or 800/704-0262 (phone) .www.onourownmd.org

The organization provides technical assistance, information and referral services, and monitoring of the mental health system. Major activities of this consumer group include an annual summer conference and Anti-Stigma and Advocacy Training projects.

Affiliates throughout Maryland are presented in Appendix D.

Provider Organizations

The Community Behavioral Health Association of Maryland (CBH). 18 Egges Lane Catonsville, Maryland 21228-4511. 410/788-1865 (phone). 410/788-1768 (fax). www.cbh.bluestep.net.

This state association is affiliated with the National Council for Community Behavioral Healthcare (NCCBH) and serves as the professional association of community behavioral healthcare programs in Maryland. The organization provides advocacy and support as well as technical assistance.



Maryland Association of Resources for Families and Youth (MARFY). 1517 S. Ritchie Highway Suite 102. Arnold, Maryland 21012. 410/974-4901 (phone). www.marfy.org.

This organization is comprised to 55 private sector agencies that provide services to children, youth and families.

Maryland Hospital Association (MHA). 6820 Deerpath Road. Elkridge, Maryland 21075. 410/379-6200 (phone). www.mdhospitals.org.

The association represents Maryland hospitals and health systems and is the main advocate before legislative and regulatory bodies on behalf of its membership which includes acute-care hospitals and health systems, psychiatric facilities, veterans' hospitals, chronic, and long-term-care facilities. The association is allied with the American Hospital Association.

Professional Associations

National Association of Social Workers, Maryland Chapter (NASW-MD). 5740 Executive Drive, Suite 208. Baltimore, Maryland 21228. 410/788-1066 or 800/867-6776 (phone). 410/747-0635 (fax). www.nasw-md.org.

This professional organization represents social workers in Maryland as the state chapter of the National Association of Social Workers. The organization provides networking and continuing education opportunities.

The Maryland Psychological Association (MPA). 10025 Gov. Warfield Parkway, Suite 102. Columbia, Maryland 21044-3308 .410/992-4258, 410/995-0499, 301/596-3999 (phone) . 410/992-7732 (fax) . www.marylandpsychology.org

This is the statewide professional association for psychologists in Maryland and is affiliated with the American Psychological Association (APA). In addition to educational events and referral services, the organization has a professional mentoring program for new psychologists.

Maryland Psychiatric Society, Inc. . 1101 St. Paul Street, #305. Baltimore, Maryland 21202 410-625-0232 (phone). 410-625-0277 (fax). www.mdpsych.org .

This state medical specialty society is composed of physician members that specialize in behavioral healthcare.

Maryland Association for Counseling and Development (MACD). www.loyola.edu/macd .

This professional association for counselors is an affiliate of American Counseling Association (ACA). Services include professional development activities and support services.

Maryland Nurses Association (MNA). 21 Governor's Court, Suite 195. Baltimore, Maryland 21244. 410/944-5800 (phone). 410/944-5802 (fax). www.nursingworld.org

This is a statewide professional membership organization for registered nurses in Maryland.



Other Organizations

Maryland Disability Law Center (MDLC). The Walbert Building 1800 N. Charles Street, 4th floor. Baltimore, Maryland 21201. 410/727-6352 or 800/233-7201 (phone). 410/727-6389 (fax). 410/727-6387 (TDD). www.mdlcbalto.org

This organization is a private, non-profit organization staffed by attorneys and paralegals that serves as the Protection and Advocacy organization for Maryland.

Maryland Association of Core Service Agencies (MACSA). 115 North Market Street. Frederick, Maryland 21701. 301/682-9754 (phone). 301/682-6019 (fax). www.bmhsi.org/MACSA.

The membership of this association is composed of the Core Service Agency for each county in Maryland.



COMMUNITY HEALTH CENTERS

The Community Health Center (CHC) Program, which establishes and oversees FQHCs, is a Federal grant program funded under Section 330 of the Public Health Service Act to provide for primary and preventive health care services in medically-underserved areas throughout the U.S. and its territories.

FQHCs were first funded by the Federal Government as part of the War on Poverty in the mid-1960s. By the early 1970s, about 100 neighborhood health centers had been established under the Economic Opportunity Act in the Office of Economic Opportunity (OEO). These centers were designed to provide accessible, affordable personal health care services to low income families. The Public Health Service began funding neighborhood health centers in 1969. With the phase-out of OEO in the early 1970s, the centers supported under this authority were transferred to the Public Health Service. Currently, the CHC Federal grant program is authorized under section 330 of the Health Centers Consolidation Act of 1996.

FQHCs provide family-oriented primary and preventive health care services for people living in rural and urban medically underserved communities. FQHCs exist in areas where economic, geographic, or cultural barriers limit access to primary health care for a substantial portion of the population. Services are tailored to the needs of the community. Services are targeted for low income patients and sliding fee schedules based on family size and poverty guidelines are utilized to make medical care affordable for low income individuals who are often uninsured. FQHCs also receive cost-based reimbursement from Medicaid and Medicare. Generally, FQHCs services include the following:

- Primary and preventive health care, outreach, and dental care
- Essential ancillary services such as laboratory tests, X-ray, environmental health, and pharmacy services as well as related services such as health education, transportation, translation, and prenatal services
- Linkages to welfare, Medicaid, mental health treatment, substance abuse treatment, WIC, and related services.
- Access to a full range of specialty care services.

Federal funding for FQHCs falls within Health Resources and Services Administration (HRSA) and the Bureau of Primary Health Care. The FQHCs operate under a total budget concept. A grant application identifies a targeted service area and population to receive services. The application describes the array of primary health care and enabling services that are planned and the expected outcomes. A total cost projection is developed for the planned services including anticipated reimbursements from grants and contracts for the delivery of services. All patients are charged the full cost for services with the provision of a sliding fee scale based on Federal poverty guidelines for clients with family incomes up to 200% of the poverty level. The total cost minus the anticipated revenues is the basis for the level of grant award from HRSA. FQHCs are responsible for any increases in costs or shortfalls of revenue. Expansions in capacity or services offered must be competed under HRSA funding initiatives. The FQHCs are eligible for the reimbursement of mental health services to Medicaid and Medicare eligible clients at the existing cost based reimbursement



rate.

HRSA has introduced an initiative to integrate behavioral health providers into primary care and has established funding support for various approaches such as:

- Behavioral health grants for existing CHCs
- New primary care delivery sites that are to include mental health services
- Behavioral health providers applications for new primary care sites

Financial support for these initiatives is available through a competitive grant application process administered by HRSA.

FQHCs also serve as a catalyst for economic development, generating jobs and assuring the presence of health professionals and facilities in underserved areas. FQHCs use local services and purchase goods and services from local merchants. In FY 2000, the CHC investment generated over \$3 billion in revenues for impoverished underserved communities across the country. (Bureau of Primary Health Care)

Developing networks and comprehensive integrated delivery systems is critical to the success of health services delivery. Collaborating with public and private partners to obtain capital and infrastructure resources is necessary to develop and maintain primary health care capacity in the most underserved areas.

In calendar year 2003, the thirteen FQHCs in Maryland provided services to 156,025 unduplicated users, generating a total of 677,515 visits. Female users were 59.8% of the total and males the remaining 40.2%. The pediatric age group (15 and younger) were 35% of the total and 7% were geriatric. Users described as best serviced by languages other than English was 4.7% of the total. A list of the FQHCs is presented in Appendix E.

Of the total number served, 4,175 were identified as receiving mental health specialist services and 3,708 substance abuse specialist services. This represents 2.7% and 2.4% of the total users respectively. However, in reviewing the clients by diagnostic categories, 934 were identified with alcohol dependence, 3,507 with drug dependence and 8,563 with mental disorders including mental retardation, 5.49% of the total users. The FQHCs reported that their collective costs in providing these services represented 6% of the totals. (Calendar Year 2003 Data, National Rollup Report).

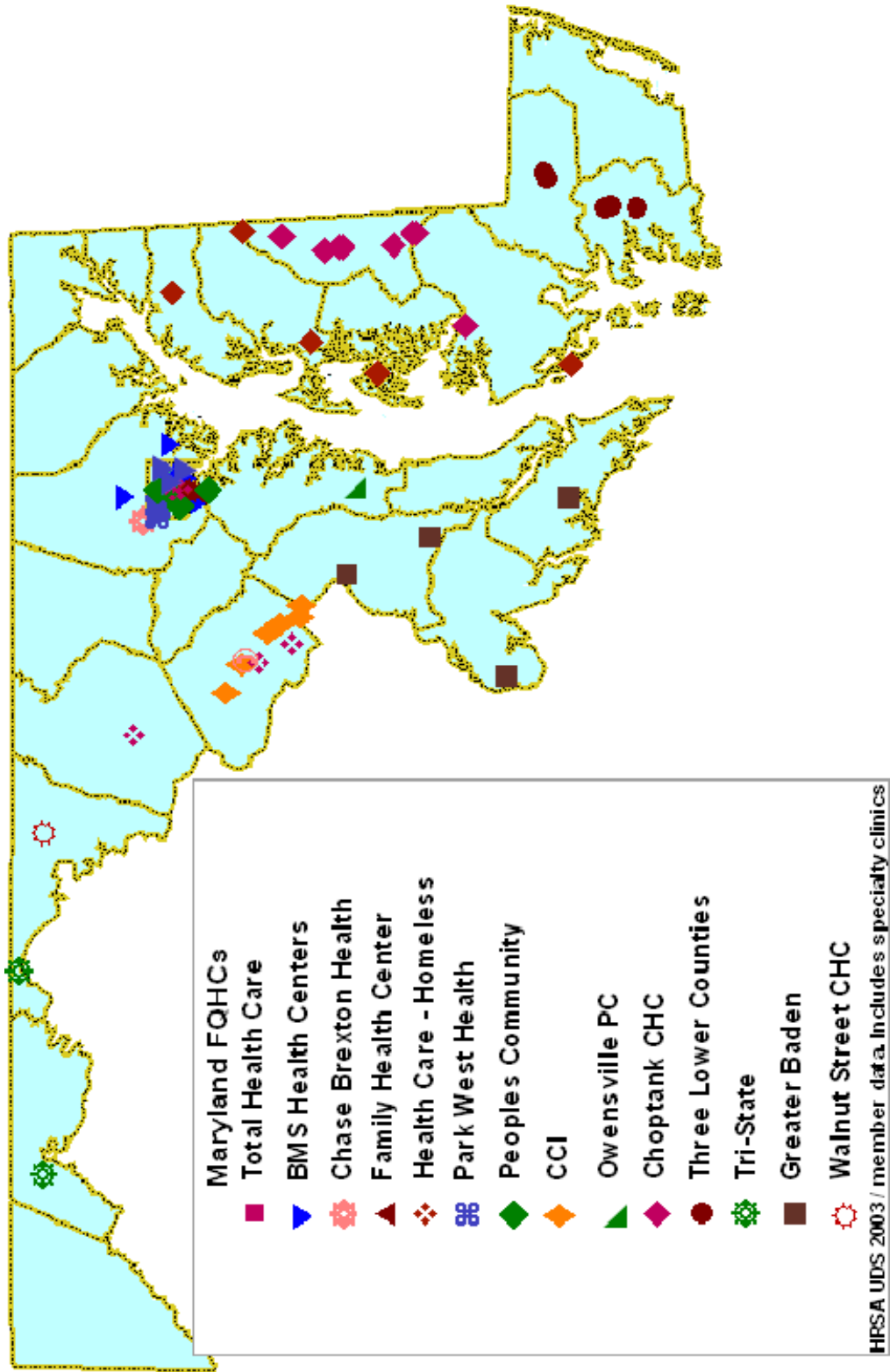
In comparison, the FQHCs in Michigan recently estimated 50% of the patients have a behavioral or emotional problem and approximately 33% of direct patient hours are focused on behavioral or emotional issues. (Michigan Primary Care Association, p.1)

Providing these services were full time equivalents of 397.69 primary health care professionals including laboratory and support staff personnel; 37.36 dentists, dental hygienists and assistants; 25.13 mental health specialists; 29.61 substance abuse specialists; 9.80 pharmacy personnel and 110.94 case managers, education specialists, outreach workers, etc.

To support these services the 13 FQHCs generated a combined total of \$100,664,500 from the following sources (Bureau of Primary Health Care):

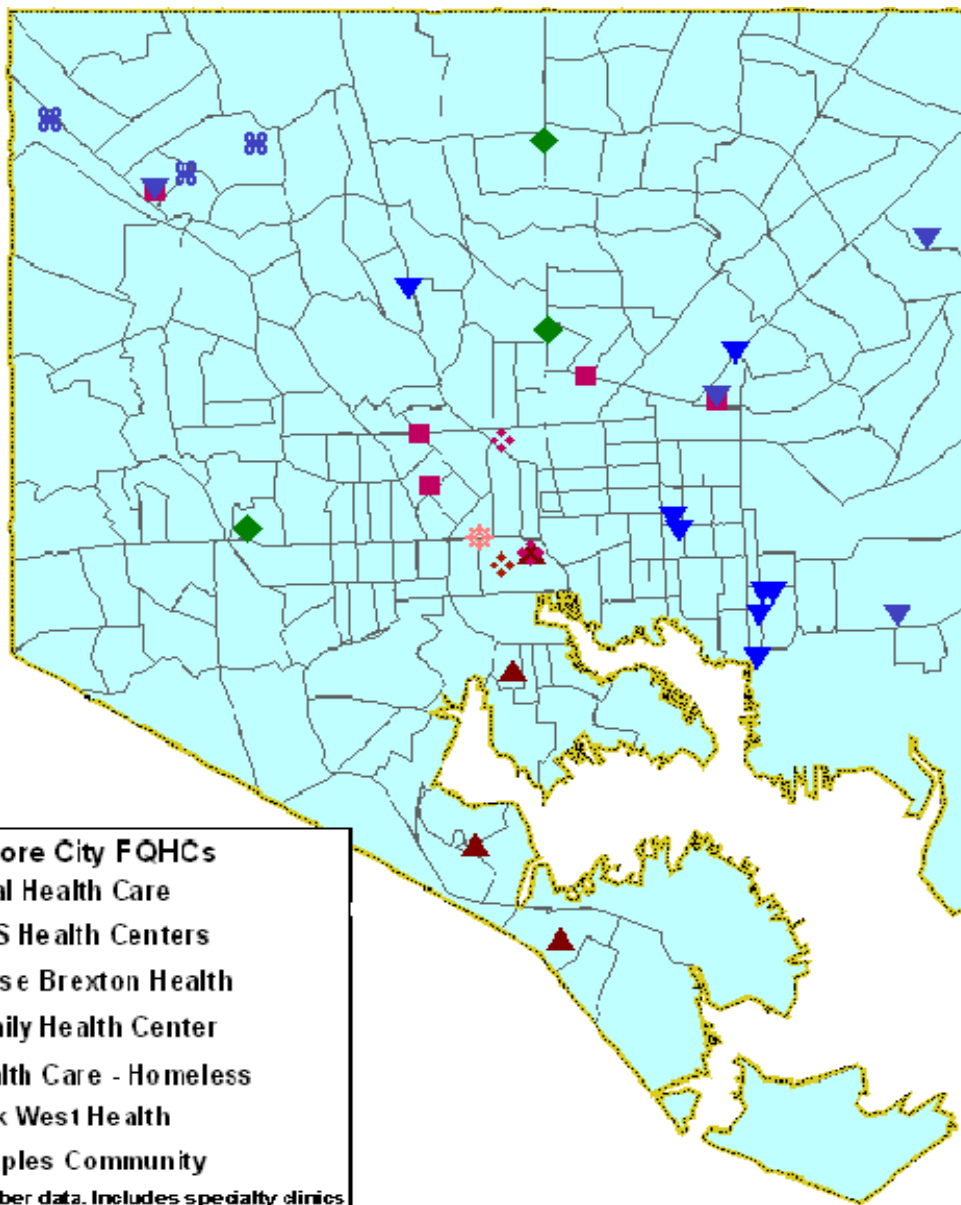


Federally Qualified Health Center sites – Maryland





FEDERALLY QUALIFIED HEALTH CENTER SITES – BALTIMORE CITY





Total Revenue Received By Maryland FQHCs 2003

	Amount	Percent of Total
<u>Grant Revenue</u>	<u>29,604,178</u>	<u>29.4%</u>
Federal	20,167,490	20.0%
BPHC Grants	17,335,735	17.2%
Other Federal Grants	2,831,755	2.8%
Non-Federal	9,436,688	9.4%
State and Local	7,851,412	7.8%
Grants and Contracts		
Foundations/Private	1,585,276	1.6%
Grants/Contracts		
<u>Revenue from Service to Patients</u>	<u>67,729,414</u>	<u>67.3%</u>
Patient Self-Pay	2,316,528	2.3%
Third Party Payers	65,412,886	65.0%
Medicaid	44,624,352	44.3%
Medicare	12,621,784	12.5%
Other Public	2,402,711	2.4%
Other (Private) Third Party	5,764,039	5.7%
<u>Revenue From Indigent Care Programs</u>	<u>0</u>	<u>0.0%</u>
<u>Other Revenue</u>	<u>3,330,908</u>	<u>3.3%</u>
<u>Total Revenue</u>	<u>100,664,500</u>	<u>100.0%</u>



NEED FOR SERVICES/GAPS IN SERVICE

The estimation of need for mental health services is much more of an art than a science. The costs associated with epidemiological surveys are prohibitive and the survey methodology is difficult and involves very sensitive questions.

Two classic, generally accepted survey research efforts have attempted to estimate the prevalence of mental health problems. These studies indicated that 20% of the population will experience a mental health problem serious enough to be considered diagnosable during their lifetimes. They also indicate that about 3.5% of the population has severe and persistent mental illness. No valid and reliable means have been devised to translate these numbers into service needs, and no method for determining the number of individuals being served and maintained by the private sector currently exist.

Many states also use random telephone surveys to estimate the prevalence of mental disorders, but the instruments are usually designed to obtain other health information. Mental health questions are introduced as a small part of the survey. Often the questions asked revolve around inpatient experiences and depression. The methodologies for such surveys also provide special problems in attempting to generalize results, and the issue of attempting to relate number of individuals who have mental health problems to the services that they require provides additional challenges that limit the feasibility of using such efforts to estimate the need for mental health services.

The final method for estimating the need for mental health services is through surveys and focus groups of key informants. Often, officials from local departments of education, social services, juvenile services, and law enforcement are surveyed to determine both the need for services and the availability of services for individuals with multiple service issues. At the present time, such surveys are probably the most reliable and valid available. In Maryland, local Core Service Agencies (CSAs) perform such analyses on a routine basis. In most instances, the local CSA is the best barometer of both service need and service availability.



CONCLUSION

Integrating mental health services and primary care can be accomplished in a variety of ways. One way to conceptualize this is to look at an integration continuum with one end depicted as well-defined cross referral processes, progressing through co-located services to the other end of the spectrum at fully integrated services. This is not to imply that there are only three models for integration – there are multiple variations on these that are determined by setting, consumer population, resources and environment. Some models include incorporating a mental health component into a primary care setting and the reverse is another representation, establishing a primary care clinic in a mental health setting.

At the systemic level, an initiative to integrate mental health services and primary care requires commitment, communication and collaboration of the involved parties. This process is similar to the one employed by an individual health center: 1) an assessment to determine the challenges, opportunities, needed resources and strategies to move the organization; 2) a selection of the integration model or hybrid that is deemed most suitable; 3) a comprehensive plan for the change initiative with goals and objectives tied to timeframes, and 4) an evaluation plan for the process.



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APPENDICES



APPENDIX A: CORE SERVICE AGENCIES

<p>Allegany County PO Box 1745 Cumberland MD 21501 Email: mhso@hereintown.net</p>	<p>1-301-777-5643</p>
<p>Anne Arundel County 2666 Riva Road Suite 160 Annapolis MD 21401 Email: mhaaac@aol.com</p>	<p>1-410-222-7858</p>
<p>Baltimore City Baltimore Mental Health Systems Inc. 201 E Baltimore Street, Suite 1340 Baltimore MD 21202 Email: sbaron@bmhsi.org</p>	<p>1-410-837-2647</p>
<p>Baltimore County 6401 York Road, Third Floor Baltimore, MD 21212 Email: rblankfeld@co.ba.md.us</p>	<p>1-410-887-2731</p>
<p>Calvert County PO Box 980 Prince Frederick MD 20678 Email: Dweems@chihn.state.md.us</p>	<p>1-410-535-5400</p>
<p>Caroline County Mid-Shore Mental Health Systems Inc. 8221 Teal Drive Suite 203 Easton MD 21601 Email: msmhscsa@fastol.com</p>	<p>1-410-770-4801</p>
<p>Carroll County 290 S Center Street PO Box 460 Westminster MD 21158-0460 Email: ewatts@carr.org</p>	<p>1-410-876-4440</p>
<p>Cecil County 401 Bow Street Elkton, MD 21921 Email: dsommers@cecilcountyhealth.org</p>	<p>1-410-996-5112</p>



Charles County Charles Co. Human Services Partnership P.O. Box 2150, 6 Garrett Avenue LaPlata, MD 20646	1-301-609-9016
Dorchester County Mid-Shore Mental Health Systems Inc. 8221 Teal Drive Suite 203 Easton MD 21601 Email: msmhscsa@fastol.com	1-410-770-4801
Frederick County 22 S Market Street Frederick MD 21701 Email: mhmaslc@fred.net	1-301-682-6017
Garrett County Mt. Top Mental Health Associates 428 Weber Road Oakland MD 21550-1943 Email: tyoder@gcnetmail.net	(toll-free) 1-877-286-8642 301-334-8144
Harford County 18 South Main Street Bel Air, MD 21014 Email: csadrummond@qwest.net	1-410-803-8726
Howard County Howard County Mental Health Authority 4785 Dorsey Hall Drive Suite 111 Ellicott City MD 21042-7728 Email: wells@hcmha.org	1-410-313-7350
Kent County Mid-Shore Mental Health Systems Inc. 8221 Teal Drive Suite 203 Easton MD 21601 Email: msmhscsa@fastol.com	1-410-770-4801
Montgomery County 401 Hungerford Drive, Suite 501 Rockville, MD 20850 Email: daryl.plevy@montgomerycountymd.gov	1-240-777-1400



Prince George's County Department of Family Services Mental Health Authority Division 5012 Rhode Island Avenue Hyattsville MD 20781 Email: cgbillingsley@co.pg.md.us	1-301-985-3890
Queen Anne's County Mid-Shore Mental Health Systems Inc. 8221 Teal Drive Suite 203 Easton MD 21601 Email: msmhscsa@fastol.com	1-410-770-4801
Somerset County 11680 Somerset Avenue Princess Anne, MD 21853 Email: shdcore@ezy.net	1-443-523-1810
St. Mary's County 22655 Washington Street, PO 1706 Leonardtown, MD 20650 Email: mhasm@olg.com	1-301-475-4361
Talbot County Mid-Shore Mental Health Systems Inc. 8221 Teal Drive Suite 203 Easton MD 21601 Email: msmhscsa@fastol.com	1-410-770-4801
Washington County 339 E Antietam Street, Suite 1 Hagerstown MD 21740 Email: Phillipd@wcmha.org	1-301-739-2490
Wicomico County 108 East Main Street Salisbury, MD 21801 Email: romanda@dhhm.state.md.us	1-410-543-6981
Worcester County P.O. Box 249 Snow Hill, MD 21863 Email: worcsa@dmv.com	1-410-632-3366



APPENDIX B: COUNTY MENTAL HEALTH ASSOCIATIONS

<p>Maryland - MHA in Talbot County 611 B Dutchman's Lane Easton, Maryland 21601</p>	<p>Phone: 410.822.0444 Toll-Free: N/A Fax: 410.820.7283 Email: tmills@mhamdes.org</p>
<p>Maryland - MHA of Howard County 11702 Lightfall Court Columbia, Maryland 21044</p>	<p>Phone: 410.995.3323 Toll-Free: Fax: 410.997.4227 Email: None</p>
<p>Maryland - MHA of Metropolitan Baltimore 711 West 40th Street Suite 460 Baltimore, Maryland 21211</p>	<p>Phone: 410.235.1178 Toll-Free: Fax: 410.235.1180 Email: mhaofmd@aol.com</p>
<p>Maryland - MHA of Montgomery County 1000 Twinbrook Parkway Rockville, Maryland 20851</p>	<p>Phone: 301.424.0656 Toll-Free: Fax: 301.738.1030 Email: info@mhamc.org</p>
<p>Maryland - MHA of Prince George's County P.O. Box 89 Hyattsville, Maryland 20781</p>	<p>Phone: 301.699.2737 Toll-Free: N/A Fax: 301.699.2746 Email: <u>N/A</u></p>
<p>Maryland - MHA of Southern Maryland 1170 Overlook Drive Accokeek, Maryland 20607-3516</p>	<p>Phone: 301.283.2410 Toll-Free: Fax: None Email: None</p>
<p>Maryland - MHA of the Lower Shore P.O. Box 269 Snow Hill, Maryland 21863</p>	<p>Phone: 410.543.2057 Toll-Free: Fax: None Email: foxtrot@shore.intercom.net</p>
<p>Maryland - MHA of Washington County 8162 Arcadia Lane Boonsboro, Maryland 21713</p>	<p>Phone: 301.733.0330 Toll-Free: Fax: N/A Email: <u>N/A</u></p>



APPENDIX C: AFFILIATES OF NATIONAL ALLIANCE ON MENTAL HEALTH ILL-NESS (NAMI) MARYLAND

NAMI—Howard County, Maryland (410) 772-9300 Director - Susan Hesel Howard County Mental Health Authority 8775 Cloudleap Court, Suite 227 Columbia, MD 21045
NAMI Maryland Lower Shore Patti Weiss f2f@namimdls.org (410) 641-6809 www.NAMIMDLS.COM Serves Worcester, Wicomico and Somerset Counties
NAMI Montgomery County <i>Executive Director</i> - Esther Kaleko-Kravitz Phone: 301-949-5852 Fax: 301-949-5853 10730 Connecticut Avenue Kensington, MD 20895 http://www.namimc.org/



APPENDIX D: AFFILIATES OF ON OUR OWN

<p>On Our Own of Anne Arundel County, Inc. 1819 Bayridge Avenue, Suite 206 Annapolis, MD 21403 410-295-1224 Contact Person: Patrice O'Toole</p>	<p>Office of Consumer Advocates, Inc. (OCA) 265 Mill Street, Suite 200 Hagerstown, MD 21740 301-790-5054 Fax: 301-791-3097 Contact Person: Ethel Nemcek</p>
<p>On Our Own of Calvert County, Inc. P.O. Box 2961 Prince Frederick, MD 20678 410-535-7576 301-855-1251 Contact Person: Frank Munsterteiger</p>	<p>Hope Station/Satellite Center (part of OCA, Inc. - Allegany County) 111 South George Street, Suite 7B Cumberland, MD 21502 301-759-4888 Phone/Fax Contact Person: Kelly Snyder</p>
<p>On Our Own of Carroll County, Inc. P.O. Box 1174 Westminster, MD 21158 410-751-6600 Fax: 410-751-2644 Contact Person: Jeanne Medlin Jeanfm623@aol.com</p>	<p>Hearts and Ears 11 East Chase Street, Suite 7B Baltimore, MD 21202 410-837-7778 Fax: 410-837-7884 Contact Person: Paula Lafferty Office@heartsandears.org www.heartsandears.org</p>
<p>On Our Own of the Eastern Shore Chesapeake Rural Network, Inc. (CRN) 109 Flatland Road Chestertown, MD 21620 410-778-4648 888-866-4648 Fax: 410-801-0022 Contact Person: Janice Brathwaite</p>	<p>The Harvey House 120 South Third Street Oakland, MD 21550 301-334-1314 Contact Person: Dan Snyder harveyhouse@iceweb.net</p>
<p>On Our Own of Frederick County, Inc. 217 North Market Street P.O. Box 2744 Frederick, MD 21701 301-620-0555 (phone/fax) Contact Person: Earlene Duncan onourownoffrederick@juno.com</p>	<p>Helping Other People Through Empowerment 1426 East Fairmount Avenue 410-327-5830 Fax: 410-327-5834 Baltimore, MD 21231 Contact Person: Clarissa Netter</p>
<p>On Our Own of Howard County, Inc. P.O. Box 1666 Ellicott City, MD 21041 410-772-7905 Fax: 410-772-7906 Contact Person: Pat Bohnet onourown@toad.net</p>	<p>On Our Own, Inc. (Baltimore City) 6301 Harford Road Baltimore, MD 21214 410-444-4500 Fax: 410-444-0239 Contact Person: Tony Wright Tonyw21214@aol.com</p>



On Our Own of Montgomery County, Inc.

434 East Diamond Avenue
Gaithersburg, MD 20877
240-683-5555
Fax: 240-683-5461
Contact Person: Robin Stearn
www.onourown.homestead.com

On Our Own Center (Baltimore County)

10 Dunmanway
Baltimore, MD 21222
410-282-1701
800-307-2203
Fax: 410-282-2431
Hours: call for hours

On Our Own of Prince George's County, Inc.

6513 Queen's Chapel Road
University Park, MD 20782
301-699-8939
Fax: 301-699-5378
Contact Person: Mike McMenamin

On Our Own of Cecil County

270 Cherry Grove Road
Earleville, MD 21919
410-275-2149
Contact Person: Cynthia Pease

On Our Own of St. Mary's, Inc.

P.O. Box 1245
41660 Park Avenue
Leonardtown, MD 20650
301-997-1066
Fax: 301-997-1065
Contact Person: Linda Morrell
ooostminc@ameritel.net

D.C. Mental Health Consumers League, Inc.

P.O. Box 34562
Washington, D.C. 20043
202-390-4183
Contact Person: Jesse Price
PKQ66@erols.com

Lower Shore Friends, Inc.

P.O. Box 3508
Salisbury, MD 21802
410-334-2173
Fax: 410-334-6361
Contact Person: Wilmore "Bunky" Sterling
wlmrstrl@aol.com

On Our Own of Charles County, Inc.

P.O. Box 1651
White Plains, MD 20659-1651
Contact Person: Lillian Bowie
www.geocities.com/oomd

On Our Own of Harford County

954 Hillswood Road, F
Bel Air, MD 21014
410-420-8627
Contact Person: Christine Hoy



APPENDIX E: FEDERALLY QUALIFIED HEALTH CENTERS IN MARYLAND

Baltimore Medical System, Inc.

3501 Sinclair Lane
Baltimore, MD 21213

Service Types: Dental Care Services, Enabling Services, Mental Health/Substance Abuse Services, Obstetrical and Gynecological Care, Other Professional Services, Primary Medical Care, Specialty Medical Care

Chase Brexton Health Services, Inc.

1001 Cathedral Street
Baltimore, MD 21201

Service Types: Dental Care Services, Enabling Services, Mental Health/Substance Abuse Services, Other Professional Services, Primary Medical Care, Specialty Medical Care

Choptank Community Health System, Inc.

609 Daffin Lane
PO Box 660
Denton, MD 21629

Service Types: Dental Care Services, Enabling Services, Mental Health/Substance Abuse Services, Primary Medical Care

Greater Baden Medical Services, Inc.

Suite 160
9440 Pennsylvania Avenue
Upper Marlboro, MD 20772

Service Types: Dental Care Services, Enabling Services, Mental Health/Substance Abuse Services, Primary Medical Care

Health Care for the Homeless, Inc.

111 Park Avenue
Baltimore, MD 21201

Service Types: Enabling Services, Mental Health/Substance Abuse Services, Primary Medical Care

Park West Medical Center, Inc.

3319 West Belvedere Avenue
Baltimore, MD 21215

Service Types: Dental Care Services, Enabling Services, Obstetrical and Gynecological Care, Other Professional Services, Primary Medical Care



People's Community Health Center

3028 Greenmount Avenue
Baltimore, MD 21218-3991

Service Types: Dental Care Services, Enabling Services, Mental Health/Substance Abuse Services, Obstetrical and Gynecological Care, Primary Medical Care, Specialty Medical Care

South Baltimore Family Health Centers, Inc.

631 Cherry Hill Road
Baltimore, MD 21225

Service Types: Dental Care Services, Enabling Services, Mental Health/Substance Abuse Services, Obstetrical and Gynecological Care, Other Professional Services, Primary Medical Care

Three Lower Counties (TLC) Community Services, Inc.

12137 Elm Street
PO Box 191
Princess Anne, MD 21853

Service Types: Dental Care Services, Enabling Services, Mental Health/Substance Abuse Services, Obstetrical and Gynecological Care, Other Professional Services, Primary Medical Care

Total Health Care, Inc.

1501 Division Street
Baltimore, MD 21217

Notes: Administrative/Clinic

Service Types: Dental Care Services, Enabling Services, Mental Health/Substance Abuse Services, Obstetrical and Gynecological Care, Other Professional Services, Primary Medical Care, Specialty Medical Care

Tri-State Community Health Center, Inc.

130 West High Street
Hancock, MD 21750

Notes: Administrative/Clinic

Service Types: Enabling Services, Mental Health/Substance Abuse Services, Other Professional Services, Primary Medical Care

Walnut Street Community Health Center

24 North Walnut Street, Suite 200
Hagerstown, MD 21740

Service Types: Enabling Services, Primary Medical Care



For additional information on this report and the Community Health Center Mental Health Initiative contact: Esther Lwanga, MPH, Community Development Manager

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