

ENVIROMENTAL ANALYSIS OF DELAWARES PUBLIC OUTPATIENT MENTAL HEALTH SYSTEM



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CONTENTS

Executive Summary.....	3
Introduction.....	5
Overview of Public Mental Health System.....	7
Special Interest Groups.....	11
Community Health Centers.....	13
Conclusion.....	18
Bibliography.....	19



EXECUTIVE SUMMARY

The Mid-Atlantic Association of Community Health Centers (MACHC) is uniquely positioned to lead an initiative in Delaware 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 Delaware 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 Delaware. 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 three (3) FQHCs in Delaware that provided primary health care to approximately 19,302 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 Delaware.

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 Delaware;
- 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: 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 Delaware 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 Health Resources and Services Administration’s (HRSA) 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

State Mental Health Agency

The Division of Substance Abuse and Mental Health (DSAMH) is the entity within the Delaware Department of Health and Social Services that is responsible for public mental health services for adults in Delaware. The community mental health services encompass mental health treatment, supportive housing services and mobile crisis intervention services. DSAMH also operates the Delaware Psychiatric Center that offers psychiatric evaluations and inpatient treatment. Other inpatient services are provided by three private psychiatric hospitals, one general hospital with a psychiatric unit and one nursing home or Intermediate Care Facility-Mental Health provider. In addition there are eight community mental health providers in Delaware of which four are state-operated. There is an Interagency Agreement with the Department of Services for Children, Youth and Their Families, Division of Child Mental Health Services, another state department that shares responsibility for children and youth mental health services.

Funding Mechanisms

The primary mechanism for financing community mental health providers is direct funds from DSAMH. The State's share of the Medicaid match is 50% and the following Medicaid options have been adopted for those with serious mental illness:

- Clinic option
- Rehabilitation option
- Under age 21 inpatient
- Over age 65 inpatient

Behavioral health services (mental health and substance abuse) are being delivered via managed care with an 1115 Waiver. Reimbursement to non-FQHCs is not cost-based and creates financial challenges to participating service providers. The mental health benefits are carved in and DSAMH does not have any responsibilities for contracting, monitoring, evaluating or serving as managed care agent. In 2002 the plan covered 84,500 individuals under Medicaid, with 4,186 receiving behavioral health services. (State Mental Health

Agency Profiling System 2002 Delaware, p. 11)

Treatment Modalities

- Inpatient Services (Non-State Hospital)

Inpatient services include services rendered to individuals in psychiatric units of general hospitals and in private psychiatric hospitals.



- **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.

- **Rehabilitation Services**

Rehabilitation services include psychiatric rehabilitation services intended to assist individuals in achieving independence in activities of daily living.

The table below from DSAMH’s web site (www.dhss.del.gov/dhss/dsamh) presents the type of community provider by geographic location.

Mental Health Programs

Location	Phone Numbers
Wilmington	
809 Washington Street	(302) 577-6490
Newark	
Hudson State Service Center	(302) 283-7530
Dover	
James Williams State Service Center	(302) 739-4170
Sussex	
Georgetown State Service Center	(302) 856-5490

Mental Health Centers

Location	Phone Numbers
Kent/Sussex Community Mental Health Center	(302) 422-1395
New Castle Community Mental Health Center	(302) 255-9450



Clients Served in the Public Mental Health System

DSAMH specifies eligibility criteria for recipients of mental health services from state-operated as well as state-funded providers (adults with serious mental illness and adults with any mental illness) with the determining factors including specific diagnoses, functioning, treatment history and duration. In 2002 the number of adults that were eligible for mental health services was 31, 685 or 5%. However, during 2002 the unduplicated count of adults with serious mental illness that received services was 2,860 and the unduplicated number of adults with any mental illness that received services was 4,748 for a total of 7,608. (State Mental Health Agency Profiling System 2002 Delaware, p. 5)

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 community mental health centers 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 recognize certain licensed independent practitioners and will reimburse for the services rendered only by these professionals.

Medicaid recognizes the following professionals as licensed independent practitioners:

- Physician
- Licensed Psychologist
- Licensed Social Worker – (clinical)
- Licensed Professional Counselor - (clinical)
- 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 Delaware 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.



According to the Health Workforce Profile for Delaware, compiled by the Bureau of Health Professions, Health Resources and Services Administration, in 2000 there were 83 psychiatrists, 390 psychologists and 1,560 social workers. For every 100,000 population there were 11.2 psychiatrists, 49.6 psychologists and 196.3 social workers. This placed Delaware 17th among states in psychiatrists per capita, 8th in psychologists per capita, and 14th in social workers per capita.



SPECIAL INTEREST GROUPS

There are numerous national and state organizations that are invested in the public mental health system in Delaware. 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 Delaware: 812 D Philadelphia Pike. Wilmington, DE 19809. 302/765-9740; 800/287-6423 (phone). www.mhamd.org

This organization is an affiliate of the National Mental Health Association (NMHA).

National Alliance for Mental Illness (NAMI) Delaware: 2500 West Fourth Street Suite 5
Wilmington, DE 19805. 302/427-2075; 888/427-2075 (phone) . 410/863-0474 (fax).
www.namide.org

NAMI Delaware 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.

Professional Associations

National Association of Social Workers, Delaware Chapter (NASW-DE). 3301 Green Street.
Claymont, DE 19703. 302/792-0356 (phone). 302/792-0678 (fax). [www.geocities.com/
HotSprings/6271/DENASW.html](http://www.geocities.com/HotSprings/6271/DENASW.html)

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

Delaware Psychological Association: P.O. Box 718. Claymont, DE 19703. 302/475-1574 (phone)
www.depsych.org.

This is the statewide professional association for psychologists in Delaware and is affiliated with the American Psychological Association (APA).

Psychiatric Society of Delaware :131 Continental Drive, #405. Newark, DE 19713-4308. 302/658-7596 (phone). 302/658-9669 (fax)

This state medical specialty society is affiliated with the American Psychiatric Association.



Pennsylvania Counseling Association: P.O. Box 226. Edinboro, PA 16412. 717/571-6240 (phone) 801/340-4669 (fax). www.pacounseling.org.

This professional association for counselors is an affiliate of the American Counseling Association (ACA). The Pennsylvania affiliate has served Delaware since the Delaware state branch became inactive.

Delaware Nurses Association : 2644 Capitol Trail, Suite 330. Newark, DE 19711. 302/368-2333 (phone). 302/366-1775 (fax). www.nursingworld.org/snass/de/

This is a statewide professional membership organization for registered nurses in Delaware and is affiliated with the American Nurses Association.

Other Organizations

Community Legal Aid Society, Inc. Community Services Building, Suite 801. 100 West Tenth Street. Wilmington, DE 19801. 302/575-0660 (phone). 302/575-0840 (fax). www.declasi.org

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



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.

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

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. (BPHC, 2002, "Experts with Experience: Community and Migrant Health Centers, Highlighting a Decade of Service 1990-2000")

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.

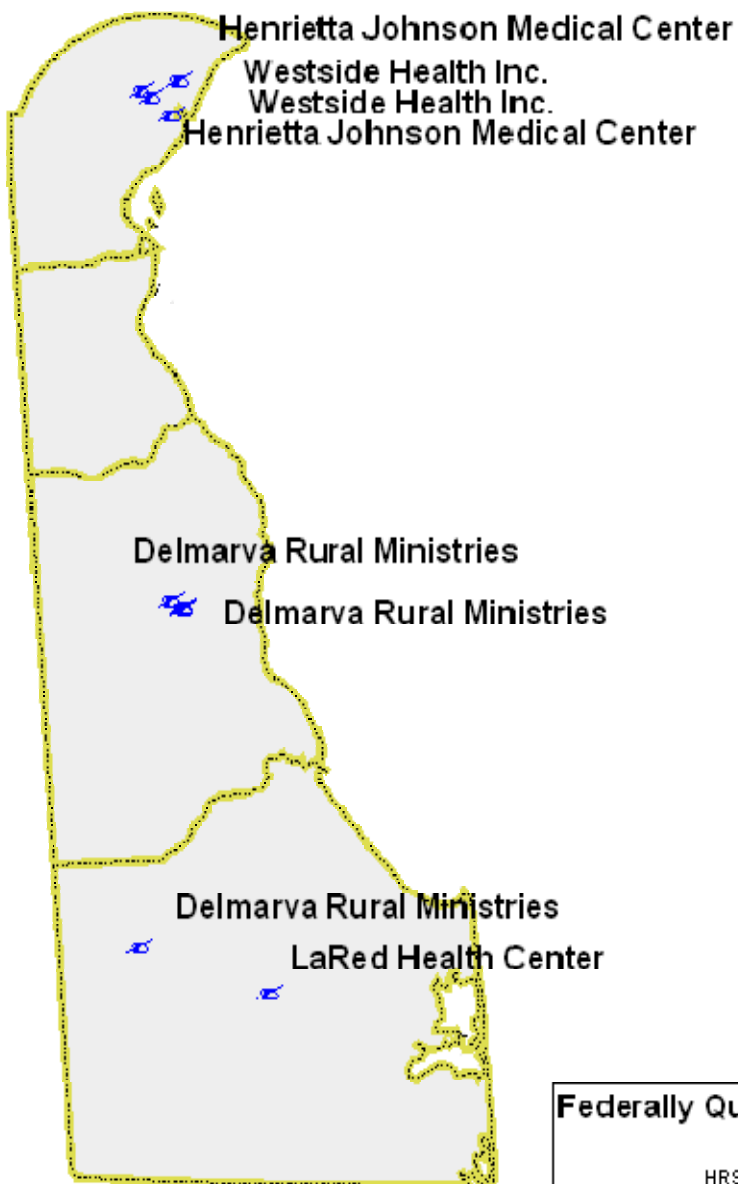
In calendar year 2003 the three FQHCs in Delaware provided services to 18,191 unduplicated users, generating a total of 57,116 visits. Female users were 62.4% of the total and males the remaining 37.6%. The pediatric age group (15 years and younger) were 23% of the total and 5% were geriatric. The proportion of users described as best served by languages other than English was 44.2% of the total.

The current staffing patterns of the FQHCs include 38.64 primary health care professionals including laboratory and support staff personnel; 5.41 dentists, dental hygienists and assistants; and 7.43 case managers, education specialists, outreach workers, and others.

In reviewing the clients by diagnostic categories 39 were identified with alcohol dependence, 15 with drug dependence and 876 with mental disorders including mental retardation, 5.49% of the total users. (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. (Connecting the Pieces, p 1).

To support these services the 3 FQHCs generated a combined total of \$7,946,059 from the following sources (Bureau of Primary Health Care):



**Total Revenue Received By Delaware FQHCs 2003**

	Amount	Percent of Total
<u>Grant Revenue</u>	<u>4,136,841</u>	<u>52.1%</u>
Federal	3,472,033	43.7%
BPHC Grants	3,472,033	43.7%
Other Federal Grants	0	0.0%
Non-Federal	664,808	8.4%
State and Local	664,808	8.4%
Grants and Contracts		
Foundations/Private	0	0.0%
Grants/Contracts		
<u>Revenue from Service to Patients</u>	<u>3,800,947</u>	<u>47.8%</u>
Patient Self-Pay	605,059	7.6%
Third Party Payers	3,195,888	40.2%
Medicaid	2,388,903	30.1%
Medicare	375,019	4.7%
Other Public	132,576	1.7%
Other (Private) Third Party	299,390	3.8%
<u>Revenue From Indigent Care Programs</u>	<u>0</u>	<u>0.0%</u>
<u>Other Revenue</u>	<u>8,271</u>	<u>0.1%</u>
<u>Total Revenue</u>	<u>7,946,059</u>	<u>100.0%</u>



NEED FOR SERVICES/GAPS IN SERVICES

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 (161,477 individuals based on US Census 2002 total population estimate of 807,385 for Delaware). They also indicate that about 3.5% of the population has severe and persistent mental illness (28,258 individuals based on US Census 2002 total population estimate). 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.



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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