

Information from the Health Care for the Homeless Program

Client Participation in HCH Governance Yields Responsive Programs

A well-known tenet of the mental health consumer self-help movement, "nothing about us without us," has become the standard for the Health Care for the Homeless (HCH) program.

The Health Centers Consolidation Act of 1996 requires that HCH grantees meet the same governance standards to which community and migrant health centers have been subject, including the establishment of a governing body with a consumer majority. The governing body must meet monthly, choose the

services the program offers, schedule hours of operation, approve the annual budget, select the director, and adopt general policies.

Recognizing the broad range of organizations that receive HCH grants, and the difficult circumstances of homeless people's lives, the Act permits HCH grantees to request a waiver of the governance requirements. Even when waivers are granted, however, grantees must describe specific plans to meet the intent of the legislation, particularly regarding consumer participation, according to Bureau Director Marilyn H. Gaston, M.D.

"Client participation in governance is an important step toward responsive and effective programs," Dr. Gaston said. "We urge HCH providers to undertake earnest, energetic efforts to involve their homeless clients in the governance of their organizations."

Identifying Interested Consumers

Identifying consumer participants is not a simple task. "As providers, we expect that homeless people will want to be involved,"

says Sue Watlov Phillips, executive director of Elim Transitional Housing in Minneapolis. "But many of them may not be interested or comfortable serving in this role."

Barbara Conanan, R.N., needed to identify consumers to serve on an advisory committee for the SRO/Homeless Program at Saint Vincents Hospital in New York City, which she directs. She asked the program staff and the directors of the shelters, drop-in centers, and single-room-occupancy hotels the program serves to nominate individuals who are leaders in their respective facilities. The SRO/Homeless Program provides hospital-based health care services to 31 locations in Manhattan. The hospital's board of directors is the program's governing body, but the advisory committee reports to the board on a quarterly basis.

Creating Opportunities for Involvement

Homeless people face a number of personal and systemic barriers to volunteer service, according to Mary Ann Gleason, executive director of the National Coalition for the Homeless.

The National Coalition helps train homeless and formerly homeless individuals to serve on nonprofit boards.

"People who are currently homeless may not be able to attend regular meetings because they are consumed with their daily struggles," Gleason points out. Systemic barriers include lack of child care, transportation, and time off from work.

"We tend to try to organize homeless people according to our middle-class structures," Phillips says. "But the reality of their lives is quite different." At Elim, Phillips prefers that a person has been stable in housing for at least two years before becoming a board member or staff person. The president, vice president, and secretary of Elim's five-per-

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In This Issue

Faced with increasing need and decreasing resources, homeless health care providers are looking closer to home for local strategies to address homelessness. They are involving their clients, integrating services, and advocating for change.

If you have an innovative program or service that helps extend resources at the local level, please send information to Nan Brady at the HCH Information Resource Center, (888) 439-3300, ext. 246.

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Client Participation (continued)

son board have experienced homelessness, as have more than 50% of the 17-member staff.

To help the consumer members of the SRO/Homeless Program Advisory Committee attend meetings, the directors of their respective programs provide transportation and help with child care arrangements. Still, Conanan says, retention of its homeless committee members has been the biggest hurdle the group has faced in its first year.

Helping Consumers Find Their Niche

Those consumers who do attend advisory committee meetings are actively involved, according to Conanan. "They really want to do a good job," she says.

To fuel their involvement, Conanan provides regular feedback about consumers' concerns. "If you can't make

changes, you should at least explain why," she advises.

In her training sessions, Gleason has discovered that some homeless people may be reluctant to express an opinion or ask a question for fear that they will seem ignorant. "Often, the problem is lack of information, not lack of intelligence on their part," Gleason says.

The National Coalition has 32 percent consumer representation on its 41-member board. To help board members who have experienced homelessness feel comfortable in their new role, the board had adopted a "buddy system," pairing a new consumer with an established board member. This gives the consumer at least one individual with whom he or she can share openly, Gleason notes.

An Ongoing Process

Successfully involving consumers in decision-making roles is a lengthy process, Conanan says. She acknowledges that it will take time for her program to achieve its goal of at least 50 percent consumer involvement. "Much of our work involves imparting knowledge, clearing up misperceptions, and providing information," she says.

But the result is worth the effort, Conanan believes. "When your consumers are educated, aware, and feel comfortable, it ultimately pays off for everybody," she says.

For more information about the SRO/Homeless

Program Advisory Committee, contact Barbara Conanan at (212) 604-2705. For more information about consumer training, contact Mary Ann Gleason at

(202) 737-6444. For more information about consumer involvement in program activities, contact Sue Watlov Phillips at (612) 788-1546. ▲

Make Advocacy a Priority

Call it education or public relations. Hold a bake sale to fund it. Whatever you do, make advocacy a priority for your Health Care for the Homeless (HCH) program, Jeff Singer, M.S.W., told participants at the National HCH Conference in St. Louis. Singer is president and chief executive officer of Health Care for the Homeless of Maryland.

Although HCH grants funds cannot be used directly to impact on legislation, much of what constitutes advocacy involves educating policy makers and the general public, Singer pointed out. Also, programs can use unrestricted monies to fund their advocacy agenda. "Above all," Singer said, "advocacy should be fun." He recommends the following ways to make advocacy a priority for your organization.

- **Make advocacy part of your mission.** In Baltimore, staff, clients, and board members agreed that part of their mission should be to provide "leadership and education to change the policies that lead to homelessness."
- **Hire staff for advocacy.** Staff who are dedicated to the role of education and public relations can develop public- and private-sector contacts and stay abreast of opportunities to influence legislation and public opinion.
- **Make advocacy a priority for all staff.** All HCH staff in Baltimore are required to commit 5 percent of their time to advocacy work. Many fulfill this by participation on community boards and coalitions.
- **Develop an advocacy agenda.** Advocacy efforts should focus on current topics of interest at the local, state, and national level.
- **Train new staff.** New staff should be trained in the importance of advocacy and ways in which they can contribute.
- **Make your voice heard.** In Baltimore, staff, clients, and board members distribute policy papers once a year on Homeless Advocacy Day at the state capital.
- **Communicate about the importance of advocacy.** To keep advocacy in the forefront of the Baltimore HCH agenda, the agency newsletter includes an advocacy column. The program also publishes an internal newsletter for staff. ▲

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A Shared Vision Leads to Change

What if you had all the resources you needed to provide the right services to homeless people, in the right amount, at the right time? Do you suspect you might be dreaming? Well, that's exactly what Rick Goscha, M.S.W., and Luella Sanders, M.S., L.M.L.P., suggest you do.

Goscha is program director of COMCARE of Sedgwick County's Homeless Program in Wichita, KS, and Sanders is the agency's systems integration coordinator. COMCARE is one of nine systems integration sites funded under the federal ACCESS (Access to Community Care and Effective Services and Supports) research demonstration program. The agency also provides mental health services to clients of the Hunter Health Clinic, Inc., a Health Care for the Homeless (HCH) grantee.

The dreaming/brainstorming that Goscha and Sanders recommend is the centerpiece of the Sedgwick County Strategic Management Model. Goscha says the model has helped COMCARE do everything from redesign its outreach efforts to plan for continuation of services when the ACCESS grant ends. As described by Goscha and Sanders at the National HCH Conference in St. Louis, the six-step model is a tool for achieving systems integration.

Define the Issue

Step one in the strategic management model is to *define the issue*. Too many times, homeless services

programs identify lack of money as the critical issue that needs to be resolved, Goscha says. "Money is always an issue, so you need to get beyond that. You have to focus on what the community needs, then use strategic planning to help identify needed resources."

In her role as systems integration coordinator, Sanders keeps her ear to the ground for problems and opportunities. "Having a systems integration coordinator is the most important component of our success with this model," Goscha says.

Identify Key Stakeholders

The second step is to *identify the key stakeholders* who need to be at the table. It goes without saying that consumers need to be involved, Sanders believes. However, Goscha adds, you must include consumers who are affected by the specific problem you're trying to resolve, as well as those agency representatives who have the resources to make changes in your community.

When everyone sits down together, it's important to be certain you have defined the issue appropriately, Goscha notes. "An agency may define an issue one way, based on staff frustration, but the consumer will say, 'How does this impact me?'"

Understand Perspectives

In step three, the stakeholders gathered at the table must *understand the perspectives* that each of them brings to an issue. "You have to approach this

process without any preconceived notions," Sanders says. In a stakeholders' meeting held to determine how to provide mental health services to individuals in crisis during nighttime hours, members of the mobile mental health crisis unit expressed fear for their safety when visiting homeless shelters. As a result, the group developed a strategy to address this concern.

Create a Shared Vision

Imagination and brainstorming play a key role in the fourth step of the model, which is to *create a shared vision*, or what Goscha likes to call a "preferred future." He asks participants to imagine that one year has passed from the date of their meeting and the situation has changed. "What does that look like?" he asks.

This step can be the most fun, but it also takes encouragement, according to Sanders. "People tend to think of what can be accomplished with available resources," she says. "We tell them to envision a situation in which they have unlimited resources and no barriers."

Develop a Plan

The fifth step, to *agree on outcomes and develop a plan*, is where the group "anchors its vision," Goscha says. "You set priorities and separate 'must haves' from 'would likes.'"

Goscha likes to call this phase "next steps with accountability," because this is when the stakeholders

decide *who* will do *what* and *when* it will be accomplished. Sanders provides feedback to all stakeholders on an ongoing basis. "The information generated provides the tools and the resources they need to succeed," she says.

Monitor Progress

The sixth and final step, to *monitor progress and make corrections*, is one of the most important, according to Goscha. Whether you hold further meetings or just talk on the phone, the important part is to give stakeholders an opportunity to say whether or not the issue has been successfully addressed.

Celebrate Success

To use the strategic management model effectively, Goscha and Sanders recommend that a stakeholders' meeting be completed in one afternoon. If two sessions are needed, the second one should be planned in advance, and it should be held within the week. "Developing a preferred future creates energy and enthusiasm, and you don't want to lose that between meetings," Sanders says.

Finally, Goscha and Sanders note, you should celebrate small successes. In some communities, getting people to the table may be a major accomplishment in itself.

For more information on the Sedgwick County Strategic Management Model, contact Rick Goscha or Luella Sanders at COMCARE, (316) 264-1770. ▲

“Neighbors Helping Neighbors” Extends Scarce Resources

Grace Hill’s Member Organized Resource Exchange (M.O.R.E.) in St. Louis has received national attention as an innovative service system for disadvantaged communities hard hit by current social and economic trends. But the concept on which the program is based is as old as the communities themselves.

Founded in 1903 as a settlement house, Grace Hill’s motto is “neighbors helping neighbors.” Years ago, says Grace Hill neighbor Gloria Drake, that’s just the way things were done.

“People helped each other all the time and never thought anything about it,” Drake says. “You’d go to one person’s house and they’d give you a chicken and to another person’s house and they’d give you a pie. By the time you got home, you’d have a whole dinner.”

A Computerized Barter System

Today, if you need dinner, you can stop by one of the Grace Hill settlement houses or neighborhood health centers and search the computerized M.O.R.E. database for the name of a neighbor who can provide this service. In return, you agree to share your time and talents, perhaps by taking a neighbor to the doctor or styling her hair. Known as the M.O.R.E. Time Dollar Exchange, this computerized barter system allows

participants to earn one “time dollar” for every hour of service rendered, regardless of what they do.

“I babysit for you, and you provide legal counseling to me,” Drake says. “We each earn one time dollar because your time is no more valuable than mine.”

“When you can make a difference in someone’s life, it gives you a good feeling on the inside.”

Time dollars can be exchanged for future services, or for goods in time dollar stores that offer essentials, such as cleaning supplies and diapers, that cannot be purchased with food stamps. Everything in the stores, from a pair of socks to a stove, costs one time dollar.

“Time dollar purchases are based on need,” Drake says. “I may not need a stove, but I might need a pair of socks.” In 1996, nearly 60,000 time dollars were exchanged, which represents \$315,000 (at minimum wage) of resources that neighbors shared.

Access to Community Resources

The M.O.R.E. system is at the heart of Grace Hill’s

social action model for community empowerment, which is based on the notion that everyone has something to give, according to Villie Appoo, Managing Director of Grace Hill Health Centers. Grace Hill provides health care, human services, and housing in 11 service areas covering 33 neighborhoods in the City of St. Louis and in St. Louis and St. Charles counties. Grace Hill Health Centers receive funds under the HCH, Public Housing, and Community Health Center programs.

In addition to the member resource exchange, the M.O.R.E. computerized work stations offer Grace Hill neighbors access to a database of community resources, along with a map to each location that shows cross streets and bus routes. The computers are also linked to the State Labor Department. More than 2,000 Grace Hill neighbors used the employment database in 1996.

“The M.O.R.E. system belies the need to have a separate building,” Appoo says. “You can have a resource center anywhere.”

Education and Work Opportunities

Men and women who have graduated from M.O.R.E.’s Neighborhood College operate the system, and they provide direct services to their neighbors. Nearly 40 courses, conceived and evaluated by teams of educators, volunteers, and

neighbors, are offered on a regular basis.

Some courses prepare participants to move from welfare to work, while others train community volunteers to help their neighbors in need. Most of the courses, which typically run 40 hours over 2 weeks, offer a \$35 stipend and 5 time dollars.

Many Neighborhood College graduates become Grace Hill employees. According to Appoo, more than half of Grace Hill’s staff are neighbors. “Our programs are conceptualized and provided by people who’ve used the services,” she says.

“A Good Feeling On the Inside”

A graduate of the Neighborhood College outreach class, Drake returned to volunteer at Grace Hill and has held a number of paid positions. Today, she helps contact patients who have been assigned by Medicaid to the Grace Hill Health Centers but who have not made an appointment.

“When you can make a difference in someone’s life, not because you have to but because you want to,” Drake says, “it gives you a good feeling on the inside.”

For more information on the Member Organized Resource Exchange, or to arrange a tour, contact the Grace Hill Advancement office at (314) 241-2200. ▲

NEWS FROM THE HCH CLINICIANS' NETWORK

Empowerment Generates Hope

Hope is not about forecasting a rosy future, according to David Hilfiker, M.D., keynote speaker at the Health Care for the Homeless (HCH) Clinicians' Network third annual membership meeting April 30 in St. Louis. Dr. Hilfiker is Medical Director of Joseph's House in Washington, DC, a residence for formerly homeless men with AIDS, and author of *Not All of Us Are Saints: A Doctor's Journey with the Poor* (Hill and Wang, 1994).

"I'd like instead to talk about hope as empowerment," Dr. Hilfiker said, the type of 'empowerment that results when clinicians and clients live in community with one another. To illustrate his point, Dr. Hilfiker shared the stories of three men who lived at Joseph's House, where Dr. Hilfiker and his family also lived for three years.

Howard, who burglarized homes to support his addictions, came to Joseph's House acutely ill, apparently demented, and marginally communicative. But Howard had gifts to share, as well. Based on his "experience," he helped Dr. Hilfiker burglar-proof their home, and he found his greatest fulfillment in tending other residents who were dying.

Ralph grew up in foster care and juvenile detention and served a 20-year prison sentence for murder. He came to Joseph's House bitter and contemptuous and remained so to the end. At his memorial service, Ralph's housemates acknowledged his unpleasantness, but they also shared endearing glimpses of his personality with which they could identify.

PeeWee was a drug dealer who spent many years in the violent world of the inner city. Shunned by his family when he contracted AIDS, the unconditional love that PeeWee experienced at Joseph's House was a new experience for him. In response, he became the first to offer his unquestioning support when Dr. Hilfiker confided his own struggles with depression.

"Our task as clinicians becomes much more than the provision of health care to homeless people," Dr. Hilfiker said. "It is also the inclusion of the excluded, the puncturing of the mechanism that names the scapegoat guilty, and the re-creation of community on the basis of the one who has been excluded."

1998 Award Winners Honored

Six Clinicians' Network members were honored at the annual membership meeting on April 30 for their dedication to improving the health and quality of life of homeless people.

Award for Outstanding Service: **James L. Dixon**, Director of Community Health Center's Homeless Medical Clinic, Colorado Springs.

Local Heros: **Linda Barnett**, RN, Health Care for the Homeless, Mercy Hospital, Springfield, MA; **Kathleen Loftus**, RN, Chicago Health Outreach; **Katherine K. Carr**, ARNP, Mobile Community Health Team Project, Manchester, NH; **Nancy Guyotte**, RN, Charter Oak Terrace/ Rice Heights Health Center, Hartford, CT; **James S. Withers**, MD, HCH Project, Alma Illery Medical Center, Pittsburgh.

Network Officers Elected

The Clinicians Network Steering Committee elected the following individuals to serve as 1998-99 officers: Chair: **Ardyce Mercier**, FNP, RNC; Chair-Elect: **Linda Dziobek**, RN; Secretary: **Karen Holman**, MD; Treasurer: **Amalia Torrez**, CDA.

HCH 101 Trains New Clinicians

More than 25 individuals from a wide range of clinical disciplines attended "HCH 101" at the National HCH Conference in St. Louis. Designed and taught by members of the Clinicians' Network Education Committee, this workshop is a practical introduction to providing health care for homeless people. For information on holding this course in your local area, contact Brenda Proffitt, Network Project Director, at (615) 226-2292.

We're Ready for Your Call

For more information on Network services and benefits, call (615) 226-2292 or visit the Clinicians' Network Home Page at <http://www.nashville.net/~hch>.

Medicaid Managed Care Changes Require Advocacy, Action

State options for developing and administering mandatory Medicaid managed care programs, enacted in the Balanced Budget Act (BBA) of 1997, “represent the most significant changes to the Medicaid program since it was created in 1965,” according to David C. Wunsch, policy analyst at Care for the Homeless in New York City. Under the BBA, states are no longer required to obtain an 1115 or 1915(b) waiver of the Social Security Act to enroll most individuals in mandatory Medicaid managed care programs. In the absence of a waiver, however, they must amend their state Medicaid plan to do so.

Further, the BBA continues the reasonable cost-based reimbursement provision for Federally Qualified Health Centers (FQHCs), which include Health Care for the Homeless (HCH) programs, for the next six years. However, payments begin decreasing after 1999 (see table).

States may continue reasonable cost-based reimbursement payments beyond October 1, 2003, but they are not required to do so. Based on a ruling from the Health Care Financing Administration (HCFA), states with existing 1115 waivers are not bound by the reimbursement provisions of the BBA.

States can, and should, take to ensure that the special needs of homeless people are adequately addressed in Medicaid managed care programs, Wunsch told participants at the National HCH Conference in St. Louis. To begin with, FQHCs must ensure that the needs of homeless people are protected in their state plan amendment. “Just because the need for waivers is ending doesn’t mean the opportunity for input is ending,” Wunsch says.

Under the state plan amendment process, HCFA will review the model contract that states will execute with managed care organizations (MCOs). Wunsch, whose organization has been funded by the Bureau of Primary Health Care to develop access and quality standards for managed care programs, recommends that providers ensure that model contracts include three key provisions.

First, the state must be able to ensure that the MCO has the ability and the capacity to provide key services to homeless people, including outreach and case management. Second, MCOs should be required to identify and enroll homeless people through outreach

and education and to provide ongoing risk assessment to people who might become homeless.

Finally, Wunsch says, homelessness should be considered a health risk factor, with payments to the MCOs adjusted accordingly. “Until appropriate methodologies for calculating a diagnosis-based risk adjustment are developed,” Wunsch says, “capitation is not appropriate for homeless people.”

Protecting Reasonable Costs

Safety net providers also need to be certain that their state plan amendment protects their financial interests, according to Jeff Singer, M.S.W., president and chief executive officer of Health Care for the Homeless of Maryland. Under the BBA’s reasonable cost-based reimbursement requirements, states will make up a portion of the difference between an FQHC’s actual costs and what the MCOs pay for services. Until these payments are phased out, Singer says, “providers must ensure that their state plan amendment defines ‘reasonable costs’ in ways that meet their revenue needs.”

Further, though states with existing 1115 waivers

are not bound by provisions of the BBA, HCFA will review the states’ existing reimbursement methodologies to ensure that they provide reasonable cost-based reimbursement. FQHCs in waiver states should gather data on Medicaid reimbursement and the adequacy of the rates they are paid to assist in this review.

States that are not complying with the terms and conditions for reimbursement set forth in their waiver must develop a corrective action plan. Those states that fail to take corrective action would be required to comply with the BBA provisions.

“We Need to Be Ready”

Singer predicts that within three to four years, every state will have a mandatory managed care program for Medicaid recipients. “When managed care arrives, if you don’t build in appropriate provisions, the needs of homeless people will not be protected,” Singer says. “We need to be ready.”

For more information on managed care standards for homeless people, contact David Wunsch at Care for the Homeless, (212) 366-4459. ▲

Cost-based reimbursement payments to FQHCs under the Balanced Budget Act

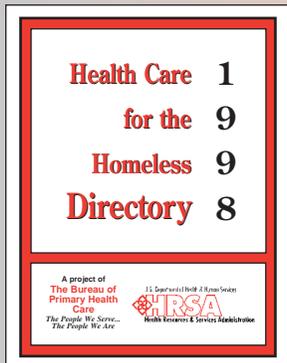
| FY 1998 | FY 1999 | FY 2000 | FY 2001 | FY 2002 | FY 2003 |
|---------|---------|---------|---------|---------|---------|
| 100% | 100% | 95% | 90% | 85% | 70% |

Reviewing State Contracts

There are a number of steps providers and advo-

HCH INFORMATION RESOURCE CENTER CONNECTIONS

New 1998 HCH Directory Published



1998 HCH Directory

The 1998 edition provides current listings for 128 HCH grantees, 10 Homeless Children's Program grantees, more than 300 subcontractors, and 66 government and private agencies who support the work of homeless health care providers. Information about the HCH grantees includes project descriptions, funding levels, services provided, and populations served. The *1998 Health Care for the Homeless Directory* will be mailed free of charge in July to all HCH grantees and subcontractors. Other interested persons may purchase a copy for \$10.50. To request a copy, contact the Information Resource Center at the toll-free number listed below.

Course Curricula Available

The HCH Clinicians' Network has collected course curricula on homelessness and health care from professional schools around the country. These materials have recently become part of the Information Resource Center's collection. They are intended to stimulate increased awareness of the health problems of homeless people for trainees

The Health Care for the Homeless (HCH) Information Resource Center has published the *1998 Health Care for the Homeless Directory*. The directory is a reference tool for health care providers and others who serve the medical and social service needs of homeless individuals.

entering health-related fields of study. The collection is available at no charge to faculty at schools of medicine, nursing, public health, and social work by calling the Information Resource Center at the toll-free number listed below.

Services Integration Resources

The following publications address ways that health care providers can integrate services to more effectively serve homeless people.

- Kahn A; Kammerman S. *Integrating Services Integration: An Overview of Initiatives, Issues, and Possibilities*. New York: National Center for Children in Poverty, 1992.
- Marzke C; Both D. *Getting Started: Planning a Comprehensive Services Initiative*. New York: National Center for Service Integration, 1994.
- Rog DJ; Gutman M. "The homeless families program: A summary of key findings." In Isaacs S; Knickman J (eds.), *To Improve Health and Health Care, 1997*. The Robert Wood Johnson Foundation Anthology. San Francisco: Jossey-Bass, 1997.
- U.S. Department of Health and Human Services. *Strengthening Homeless Families: A Coalition-Building Guide*. Washington, DC: HRSA, Administration for Children and Families, undated.
- Wilkins C. "Building a model managed care system for homeless adults with special needs: The health, housing, and integrated services network." *Current Issues in Public Health*, 2: 39-46, 1996.
- Yessian, MR. "Learning from experience: Integrating human services." *Public Welfare*, 34-42, Summer 1995.

For a comprehensive list of articles covering the issue of integrated services, contact the Information Resource Center for annotated bibliography #15—*Integrated Systems for Special Populations*.

How Can We Help You?

For more information, contact Project Coordinator Nan Brady at the HCH Information Resource Center. Toll-free (888) 439-3300, ext. 246 • E-mail: hch@prainc.com • Website: <http://www.prainc.com/hch>

Cooperative Agreement Executed

The Bureau of Primary Health Care has executed a cooperative agreement with the National Health Care for the Homeless Council in Nashville, TN, to help primary care associations, primary care offices, and other State-level partners understand and advocate for the health care needs of homeless people. The agreement will also enhance Health Care for the Homeless (HCH) practice through education and peer support.

Under the cooperative agreement, the National Council will maintain and expand the HCH Clinicians' Network, conduct research and analysis of HCH issues, participate in the activities of State-level partners, and provide training and technical assistance to HCH grantees and other providers who serve homeless people. For more information, please contact Sherilyn Pruitt at (301) 594-4473.

New Tracking Software Released

PRWT Services, Inc., and the University of Pennsylvania recently released version 1.3 of ANCHoR (Automated

National Client-Specific Homeless Services Recording), a software program that can help providers assess client needs, create individualized service plans, and record use of services. The program is designed to link dozens of service providers and track thousands of clients within a community or region. For more information, call PRWT Services at (800) 510-2624.

RWJ Seeks Community Leaders

The Robert Wood Johnson Community Health Leadership Program (CHLP) honors 10 outstanding individuals each year for their work in creating or enhancing health care programs serving communities with unmet needs. CHLP seeks individuals with between five and 15 years of service who have the leadership skills to overcome obstacles and find creative ways to bring health care services to their communities.

The nomination process is open to interested parties. For a brochure and information about preparing a Letter of Intent, which is due September 16, write to CHLP, 30 Winter Street, Suite 920, Boston, MA 02108.



Department of Health & Human Services

Health Resources and Services Administration
Bureau of Primary Health Care

Health Care for the Homeless
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