

Information from the Health Care for the Homeless Program

PCAs and PCOs Become Leading Advocates for Underserved Groups

Health care providers who serve homeless people have heard this advice before. Any change that affects the financing and delivery of health care services to vulnerable individuals requires that they be "at the table." But this time the change cuts closer to home.

As part of its national campaign to achieve 100% access to care and 0 health disparities (see related story), the Bureau of Primary Health Care has launched a pilot project to invest its State partners—Primary Care Associations (PCAs) and Primary Care Offices (PCOs)—with the

authority to develop statewide strategic plans that may be used to determine how Bureau funds are spent.

Future funding decisions may be based on the recommendations from PCAs and PCOs in States that have completed analyses of their State marketplaces, notes Heidi Nelson, executive officer of Chicago Health Outreach (CHO), a Health Care for the Homeless grantee. "You must go out and become involved with your PCA and PCO today," Nelson says.

An Eye on State Policy

State Primary Care Associations are private, nonprofit membership associations that represent Bureau-supported programs and other community-based providers of preventive and primary care to underserved groups. Primary Care Offices are located within the State health agency or other unit of government that has principal responsibility for promoting access to primary care. The Bureau funds both PCAs and PCOs through grants.

"PCAs let us know what is going on in their State,

relative to primary care for underserved individuals, and they take our expectations, concerns, and priorities to the State," notes HCH Director Jean Hochron, M.P.H. PCAs and PCOs also receive targeted funds for special Bureau initiatives.

In particular, PCAs and PCOs are responsible for

gathering data in four critical areas:

- **Quarterly State Health Policy Updates.** PCAs and PCOs are required to document the impact on safety net providers and underserved individuals of such activities as

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Achieving 100% Access Is a Collaborative Effort

The Bureau of Primary Health Care has launched an ambitious campaign for HRSA to achieve 100% access to preventive and primary health care services and eliminate health disparities in communities across the country in the next 10 years. And the good news is, it's working.

"The message of this campaign is clear," says Regan Crump, Dr.P.H., acting director of the Bureau's Division of Programs for Special Populations. "100% access is the only right thing, and disparities are unacceptable. We have examples of how this can work, and we'll use our connections if you have the commitment."

The campaign is built on identifying champions who can help assess health care needs, leverage resources, and build partnerships to increase access to health care in a given community. "Our role is to listen and to tap our programs, connections, and resources to suit the community's needs," Crump says.

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In This Issue

States are emerging as leaders in the effort to achieve 100% access to primary and preventive health care. This issue highlights ways in which HCH providers can become active at the State level. It also features profiles of two innovative substance abuse programs.

Information about Y2K assistance is featured in the HCH Information Resource Center column on page 7.

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PCAS and PCOS (continued)

Medicaid managed care, the Children's Health Insurance Program (CHIP), and welfare reform.

- **Unmet Need Data.** PCOs and PCAs take a lead role in identifying communities and populations within the State that lack access to preventive and primary health care services.
- **Health Disparities Data.** PCOs and PCAs also take a lead role in identifying communities and populations within the State that have major disparities in health status/outcomes.
- **Marketplace Analysis.** PCAs and PCOs are charged with analyzing the broader context within which health care is financed and delivered in their State.

Together, these data should be used to identify and develop key State, marketplace, and community strategies and activities to expand preventive and pri-

mary care capacity and eliminate health disparities, according to Jim Macrae, director of the Bureau's Office of State and External Affairs, which funds and monitors PCA/PCO activities.

"We are asking PCAs and PCOs to become the recognized leaders for the underserved in their State," Macrae says. "To do so effectively, they need to understand the issues that homeless people face."

A Voice for Homeless People

As executive officer of CHO, Nelson has been a member of the Illinois Primary Care Association (PCA) since 1992. She's discovered how to be a voice for homeless people, without being the "squeaky wheel."

"You're at the table to represent the people you serve, but if you try too hard, no one listens anymore," says Nelson. Instead, she's learned to be a team player and to look for common ground. Though this might feel like an uphill battle, Nelson says, the advantages are many. They include the following:

- The opportunity to have your voice heard at the State and Federal level. "When you work as a team, it opens doors," Nelson says.
- The chance to help form policy around primary care for vulnerable individuals. Nelson encouraged her PCA to lobby the State legislature to restore Medicaid payments for dental services.

A New Way of Doing Business

The State marketplace analyses (SMPAs) completed by State PCAs and PCOs will play an increasingly important role in future Bureau funding decisions, according to Jim Macrae, director of the Bureau's Office of State and External Affairs. In a pilot process to help determine the use of supplemental Bureau funds this year, PCAs in seven States that completed their SMPA (CO, HI, OR, MI, NJ, TX, VA) were invited to develop a Statewide Investment/Resource Priorities (SIRP) plan. The SIRP plan outlined recommendations for how to spend additional monies designed to increase access points and expand health center programs.

"SIRP is a way for States to recommend how we invest our money, rather than having us dictate to them," Macrae says. However, he acknowledges problems with the initial SIRP process. In particular, few States included HCH projects as priority concerns. Money earmarked for HCH programs will not be withheld from those States that did not include homeless programs as a priority, according to Macrae, but HCH projects not included in a SIRP plan will not receive a special funding preference (though other preferences are available).

There will continue to be a delicate balance between the desire to let States decide how best to spend Federal dollars and the need to protect the interests of special populations, Macrae says. However, he believes that SMPAs and the strategic plans that result from them will become the cornerstone of Bureau efforts to increase access to care and eliminate health disparities. "We encourage HCH providers to be part of that process," Macrae says.

- The ability to share resources with colleagues and do things better. HCH providers should be a resource to PCAs, notes Marsha McMurray-Avila, a program specialist with the National Health Care for the Homeless Council and a member of the Bureau of Primary Health Care's PCA/PCO Work Group. "An integrated approach to health care is the hallmark of HCH projects, and other

PCA members can learn from these efforts," McMurray-Avila says. HCH providers can invite PCA staff to visit their sites and can make presentations at PCA board meetings and conferences, she notes.

To contact your PCA, visit the Bureau's State home page at <http://www.bphc.hrsa.dhhs.gov/bphc/stintel/st.htm> or call the National Council at (615) 226-2292. ▲

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A Tapestry of Substance Abuse Services in Albuquerque

As Behavioral Health Program Director for the Albuquerque Health Care for the Homeless (HCH) program, Michael Robertson, Ph.D., firmly believes that the best way to help homeless people is to ask them what they need. He makes no exception for homeless people who are drinking and using drugs, even if they are not ready to stop.

A “Woven Cloth”

Robertson’s goal is to develop a continuum of substance abuse services that allows homeless people to “enter the system at any point and move through it with fluidity,” he says. Rather than a linear model, he perceives of a continuum as a woven cloth, with over-

lapping strands. In Albuquerque, the continuum of services includes harm reduction outreach, which Robertson acknowledges is controversial, even within his own program.

Harm reduction helps people who are not yet ready to be abstinent learn how to make their behavior “less harmful to themselves and to the community,” Robertson explains. Albuquerque offers a needle exchange program and provides education to sex workers and drug users about how their choices affect their health.

“At first, clean needles may be all that they want,” Robertson says. But by not pushing homeless addicts away, he adds, “you find out

what needs you’re not meeting.”

Every outreach encounter allows HCH staff to engage homeless people into the full range of substance abuse services the program offers. A drop-in center provides a place to sit and get a cup of coffee; those who are motivated to do so may participate in facilitated group discussions or specific problem-solving sessions. Staff make referrals to day or residential treatment programs for homeless people who wish to begin their recovery.

A Safe Place to Move Ahead

Homeless people who have been clean and sober for several months may

enter Casa Los Arboles, safe housing based on the social model of substance abuse recovery. Social model programs are not treatment in the traditional sense of the word. Rather, they represent a sociocultural approach that “places responsibility for recovery on the individuals who are recovering,” notes Robertson.

Social model programs began in California in the 1940s and grew out of the underlying AA principle, embodied in the program’s 12th step, of one alcoholic helping another. Because social model programs are run by individuals in recovery rather than by professional staff, their costs are relatively low. One review of national
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Achieving 100% Access (continued)

For example, when community leaders in El Paso, TX, heard about development of a successful health care system for uninsured individuals in Hillsborough County, FL, the Bureau paid for staff from Hillsborough to visit El Paso. Bureau staff attended a meeting of community organizers in El Paso, helped find financial partners for this new venture, and provided a letter of support when the community applied for Empowerment Zone designation.

“We didn’t give them a grant to do this,” Crump notes. “We were the champions on their behalf.” El Paso’s new managed care

system served its first 100 patients earlier this year.

PCAs Step Forward to Help

Often, campaign champions are State or local leaders. In Virginia, the State Primary Care Association (PCA) has made a commitment to help 5 to 10 communities a year develop an integrated system of access to care. PCA Executive Director John Cafazza notes, “This makes sense for Virginia, and with other partners, we can make it happen.”

To this end, Cafazza hired Karen Northup, a former health center director, to manage the campaign in Virginia. One of her key roles

will be to develop partnerships with organizations that share the same mission and vision and that are willing to make a commitment to mobilize resources. The Virginia Municipal League and the Virginia Interfaith Center for Public Policy are among the new partners that have signed onto the State’s campaign.

“There are a lot of good things happening in individual communities, but they lack cohesive, organized efforts,” Northup says. The Virginia PCA has been involved in primary care systems development for more than 20 years and has the resources to help, she notes.

PCAs in more than 20 States have expressed interest in being campaign partners. All together, the Bureau hopes to work with 250 communities this year alone. Campaign partners also include such groups as the Robert Wood Johnson Foundation, the Community Development Corporation, and the Coalition for Healthier Cities and Communities.

Campaign materials are available on the Bureau Web site at <http://www.bphc.hrsa.dhhs.gov>. For more information, contact Nora Lynn Buluran at (301) 594-4269 or nbuluran@hrsa.gov. ▲

The Healing Place: Miracles on \$25 a Day

Jay Davidson has seen it many times before—homeless men and women addicted to alcohol and drugs who've given up hope that change is possible. "They have failed the system and the system has failed them," says Davidson, Executive Director of The Healing Place in Louisville, KY, which provides social and medical outreach to homeless substance abusers.

But the miracle of The Healing Place occurs, Davidson says, when men and women "step out in fear one more time." Hope replaces fear and leads to change. The program's success in helping homeless people recover from addiction was recognized by the Bureau of Primary Health Care, which named The Healing Place a winner in the 1998 Models That Work Campaign.

A Full Continuum of Services

Begun in 1989 by the Jefferson County Medical Society Outreach Program, The Healing Place offers a full range of medical and social services that includes overnight shelter, nonmedical detox, a motivational program, long-term recovery, transitional housing, and medical care. With a staff of only six professionals and an annual budget of \$1.5 million, The Healing Place serves 26,000 free meals a month, shelters 400 men and women a night, and provides free medical care to more than 80 people a

week. Costs are \$25 per person per day, and all services are provided free of charge.

The fundamental basis of The Healing Place is a peer-run program that places the responsibility for recovery on the individual. In this respect, it is similar to a social model recovery program, which is based on the Alcoholics Anonymous philosophy of one alcoholic helping another. Expanding on the AA approach, The Healing Place uses an in-depth study of the 12 steps called Recovery Dynamics, developed by the Kelly Foundation of Little Rock, AK. Recovery Dynamics includes 28 classes and written assignments each participant must complete.

A Powerful Chemistry

In one of the more unique aspects of The Healing Place program, people who are in recovery share the same living space with those who are still drinking and using drugs. The Healing Place operates a 120-bed emergency shelter, with 60 beds for people who are still using on the streets, and another 60 beds across the hall for those in the motivational program.

The motivational program is composed of Off the Street I, which offers a guaranteed bed to those willing to begin the recovery process, and Off the Street II, in which participants embark on the study of Recovery Dynamics. The motivational program leads to the long-term recovery

program, which is housed downstairs in the same building. Currently, 65 beds are available to men in recovery. (The Healing Place operates a similar women's shelter with 95 beds, 30 of them for women in recovery). The nonmedical detox center is across the street from the shelter, and a 70-bed transitional housing facility is located next door.

Director of Programs Chris Fajardo was initially opposed to the idea of allowing people who were drinking into the shelter at night. "This went against everything I believed in," says Fajardo, who saw the policy as enabling individuals to remain addicted. Today, he's a strong supporter of this approach.

"There is a powerful chemistry that can only occur when people who have both feet in their addiction live with people who are doing everything in their power to be clean and sober," Fajardo says. People in recovery see the misery of their former drinking buddies as a "reminder of where they came from." Since the facility is client-run, individuals who are not yet in recovery see the success of their peers, who may be serving their food or checking them in for the night.

The Success of the Human Spirit

In addition to mandatory attendance at 12-step meetings, participants in long-term recovery are expected to work 10 to 20 hours a week within the

program and attend three community meetings a week. "These meetings set the tone for everything we do," Fajardo says. The group elects supervisors for community jobs and holds members accountable for their behavior.

If proof is in the numbers, The Healing Place is an unqualified success. Since 1995, more than 62% of men and 64% of women who completed the program have remained abstinent for a year. Many return to jobs and families. The program has been replicated in Lexington, KY, and Athens, GA, and will open soon in Raleigh, NC.

But Davidson also sees success in human terms. "The human spirit comes alive in everyone who comes through here," he says.

For More Information

For more information on The Healing Place, contact Davidson at (502) 584-7844, or visit the program's web site at <http://www.thehealing-place.org>. Information on Recovery Dynamics is available at (800) 245-6428 or <http://www.kellyfdn.com>.

For information on arranging technical assistance to replicate this model, call the Models That Work Campaign at (301) 594-4334 or send e-mail to models@hrsa.dhhs.gov. A strategy transfer guide can be downloaded from the Bureau's web site at <http://www.bphc.hrsa.dhhs.gov/mtw/mtwstg1.htm>. ▲

NEWS FROM THE HCH CLINICIANS' NETWORK

What HCH Clinicians Can Do about Chronic Hepatitis C

Hepatitis C virus (HCV), the most common chronic, blood-borne infection in the United States, is most often transmitted through direct percutaneous exposure to infected blood. Persons with HIV infection or liver disease of other origin are at highest risk for morbidity and mortality associated with chronic HCV. Although few data about hepatitis C in the homeless population are available, HCH clinicians report anecdotally that they are seeing a rapid increase in the number of chronic cases, in part because they are screening more patients. The incidence of chronic HCV infection is apparently higher in practices serving a larger proportion of injecting-drug users or HIV-infected individuals.

No vaccine is yet available to prevent hepatitis C. The most promising antiviral treatment to date is expensive, has toxic side-effects, and is contraindicated for persons actively engaged in substance abuse, as well as for those who have advanced liver disease or other medical conditions including major depressive illness. For these reasons, antiviral therapy is not an option for many homeless people. While more promising alternative treatments are still under investigation, HCH clinicians must rely primarily on the following preventive measures to control the spread of HCV and limit its morbidity in infected patients who are ineligible for antiviral therapy:

Prevent transmission of HCV to uninfected persons.

- Offer risk reduction counseling to illegal drug users and clients engaging in high-risk sexual practices.
- Warn against sharing needles, razors, combs, and toothbrushes.
- Provide bleach kits to sterilize needles and drug paraphernalia.
- Advise infected clients to use latex condoms and to inform sex partners, whether multiple or single, of their risk.

Prevent serious liver and other disease in HCV-infected persons.

- Advise clients to stop drinking; provide access to addictions treatment; after six months of sobriety, refer for antiviral therapy.
- Immunize high-risk clients against hepatitis A and B,

which can increase morbidity and mortality for persons with hepatitis C.

- Consider other causes of liver disease; treat commonly co-occurring medical conditions.

Resources for More Information

HCH Clinicians' Network. "Chronic Hepatitis C: Silent Intruder, Insidious Threat," *Healing Hands* March 1999: 3(2), 1-4; <http://www.nhchc.org/hands/1999/mar/marhands.html>.

CDC. "Recommendations for prevention and control of hepatitis C virus (HCV) infection and HCV-related chronic disease," *MMWR* 1998; 47 (No. RR-19): 3 (1-33): 781/893-3800, ext. 1199; <http://www.cdc.gov/ncidod/diseases/hepatitis/c/>.

NIH. "Management of Hepatitis C": Consensus Conference Statement Online 1997 March 24-26;15 (3):1-41; http://odp.od.nih.gov/consensus/cons/105/105_statement.htm.

Bonkovsky HL. "Other options for treatment of hepatitis C," Hepatitis C Consensus Conference presentation: <http://www.hepnet.com/nih/bonkov.html>.

Moyer LA et al. "Hepatitis C": Part I (Routine serologic testing and diagnosis), Part II (Prevention counseling and medical evaluation), *Am Fam Physician* 1999 Jan 1;59(1):79-88, 91-92; 349-54, 357.

Assn for Professionals in Infection Control & Epidemiology. Position paper: "Hepatitis C exposure in the health care setting," *Am J Infect Control* 1999; 27:54-5. APIC, 1275 K St. NW, Ste 1000, Washington, DC 20036.

McHutchison JG et al. "Interferon alfa-2b alone or in combination with ribavirin as initial treatment for chronic hepatitis C," *N Engl J Med* 1998 Nov 19; 339(21):1485-1492; *Medscape Gastroenterology*, 1999: <http://www.medscape.com>.

Dieterich DT. "What are the potential interactions and clinical management problems of patients who are co-infected with HIV and chronic hepatitis?" 8th Clinical Options in HIV Symposium on Hepatitis & HIV, *Medscape HIV/AIDS* 4(2), 1998.

Thiemal L and Lalazeri J. Double Jeopardy: *The HIV/HCV Co-Infection Handbook*. Community Prescription Service, 800/842-0502.

Hepatitis Foundation International: 800/891-0707; **American Liver Foundation:** 888/443-7222; **National Digestive Diseases Information Clearinghouse:** 301/654-3810.

We're Ready to Hear From You

For more information about this and related clinical topics, visit the National Health Care for the Homeless/HCH Clinicians' Network web site at <http://www.nhchc.org/clinical.html>. To join the Network, call (615) 226-2292 or fill out an application form available at <http://www.nhchc.org/networkform.html>.

Administration Clarifies “Public Charge” Determination

Non-citizens are eligible to receive a wide range of Federal and State health insurance and health care benefits without being considered a “public charge,” according to a proposed rule in the May 26 *Federal Register*. The rule clarifies the circumstances under which non-citizens can receive public benefits without becoming a public charge, a designation that may make them unable to re-enter the country or become a legal permanent resident.

Under the proposed rule, non-cash benefits and special-purpose cash benefits that are not intended for income maintenance are not subject to public charge consideration. In addition to Medicaid and the Children’s Health Insurance Program (CHIP), these benefits include prenatal care, immunizations, testing and treatment of communicable diseases, and emergency medical assistance, among others. The Immigration and Naturalization Service will

adopt the proposed rule until a final rule is published; written comments are due by July 26, 1999.

Recent immigration and welfare reform laws have generated considerable public confusion and concern about whether a non-citizen who is eligible to receive certain Federal, State, or local public benefits might be considered a public charge and subject to deportation. This has prevented legal immigrants from receiving necessary medical care, thereby putting the public health at risk and undermining the government’s policies of increasing access to health care, according to Clinton administration officials.

The text of the proposed rule, a fact sheet, and answers to frequently asked questions are available at the Health Resources and Services Administration web site: <http://www.hrsa.dhhs.gov/pubchg/pcfact.htm>. ▲

USDA Expands Food Program to Homeless Shelters

The U.S. Department of Agriculture (USDA) has expanded the Child and Adult Care Food Program (CACFP) to emergency shelters that serve homeless children and their families. Beginning July 1, 1999, public and private nonprofit organizations that provide residential and food services to homeless children and their families are eligible to participate in this federally funded nutrition assistance program.

Under CACFP, children age 12 and younger, migrant children age 15 and younger, and children with disabilities regardless of age are automatically eligible to receive reimbursable meals and snacks at the emergency shelters where they reside. There are no application forms for parents or guardians to fill out.

To learn more about participating in CACFP, contact the child nutrition staff of the applicable State agency (the education department in most States), or visit the USDA Food and Nutrition Service web site at <http://www.fns.usda.gov/fns>.

A Tapestry of Services (continued)

treatment costs cited by the Alcohol Research Group in Berkeley, CA, revealed that inpatient hospital treatment is at least six times as expensive, and outpatient hospital-based programs are twice as costly, as comparable social model programs.

At Casa Los Arboles, residents participate in mandatory day programming, attend 12-step meetings, and run the program themselves. “We encourage residents to see that with peer support, they can recover on their own, and they can learn to deal with others in a positive way,” Robertson says.

As a stepping stone back to jobs and family relationships, men who complete 6 to 9 months at Casa Los Arboles may live for up to two years at Villa De Paz. This 24-unit apartment building requires that residents have an outside

source of income, which staff can help arrange, and that they continue working on their recovery.

Filling in the Gaps

In an ongoing effort to fill the holes in the cloth, Robertson says Albuquerque HCH is planning additional services, including housing for people who participate in day treatment programs. He advises his colleagues to “go after the services first and find the money later. If you let funding steer you, you’ll develop things you may not want and your clients won’t use,” Robertson says.

For more information on the Albuquerque substance abuse program, contact Robertson at (505) 766-9520. ▲

HCH INFORMATION RESOURCE CENTER CONNECTIONS

Y2K Help for Health Centers

Health centers are becoming increasingly aware of the potential disruptions, shutdowns, and liabilities associated with the Year 2000 (Y2K) computer problem. Grantees need to develop strategies to assess their risk for disruption in health care delivery and/or management. Below are resources to help you understand and correct potential Y2K computer systems problems.

Y2K Resources Home Page

A web site for both the novice and advanced user.

Located at <http://y2k.acf.dhhs.gov>, this web site is sponsored by the Human Services Outreach Sector, Department of Health and Human Services, and provides information about potential computer problems. To respond to both the novice and the advanced computer user, the site is designed along two tracks: "Y2K 101" for non-technical users and "Y2K Solution Center" for experienced users. The site also has two search methods for accessing information, including the *Y2K Information Guide for Human Service Providers*. The guide provides information in the following areas:

- Y2K compliance definitions
- Selected Y2K web sites and resources
- Getting ready for the Year 2000
- Frequently asked questions
- Sample letter for contacting your computer resource provider

Y2K Workbook

A Workbook for Addressing the Year 2000 Bug in Community and Migrant Health Centers. This resource provides a step-by-step approach to reference and document progress in the assessment, renovation, validation, and implementation phases of a

Y2K project. The workbook is available by e-mail or phone (see the Help Desk listing below). It can also be downloaded at the following address: <http://www.bphc.hrsa.gov/chc/newapps/y2kprogram.asp>. The workbook includes project plans and checklists, worksheets, and an awareness briefing that will sharpen your awareness of Y2K implications. Worksheets address the following issues:

- Determine core business areas/processes
- Business processes priorities/Y2K risk
- Y2K priority summary worksheet
- Software inventory
- Biomedical equipment inventory
- Non-biomedical equipment inventory
- Database/archives inventory
- Business interfaces/data exchange inventory
- Systems summary
- Y2K renovation plan
- Renovation tracking
- Design data interface/exchange renovation approach
- Validation phase test plan
- Validation phase test procedures
- Validation phase test results/corrective plan

Y2k Help Desk

Y2K help is only a phone call or e-mail away! The Health Resources and Services Administration has created a Help Desk for questions that Y2K generates for health organizations. The following is the e-mail address: y2kinquiry@acf.dhhs.gov. Be sure to include in your message your name, address, phone number, your organization's name, and the nature of your Y2K-related question. You can also call the Help Desk at these phone numbers: (888) HHS-Y2K1 or (202) 401-7041.

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>

Dr. Gaston Hears Grantees' Concerns

When HCH grantees met with Bureau of Primary Health Care Director Marilyn H. Gaston, M.D., at the recent national HCH conference in Washington D.C., they shared concerns in several key areas. In particular, grantees called for improved access for homeless people to substance abuse services, specialty care, and mainstream services, including other Bureau programs. They also recommended respite services as a humane and cost-effective alternative to hospitalization. Dr. Gaston suggested training for Bureau grantees not well-equipped to work with homeless people and noted that respite services are under consideration for future Bureau budget proposals.

Homeless children and families have significant mental health needs, and all homeless people need dental care, the group told Dr. Gaston. Dr. Gaston noted that mental health services are part of the Bureau's school-based programs, and said the Surgeon General will soon release a report on oral health needs.

Grantees also expressed concern that homeless adults have limited access to immunizations, including those for tetanus, tuberculosis, and Hepatitis B. In addition, the prevalence of Hepatitis C may be more than

50% among homeless people in inner cities (see page 5 for information about Hepatitis C resources).

Dr. Gaston noted that HCH is a "shining example" of the ability to forge successful partnerships and provide truly comprehensive programs. She called on grantees to showcase their accomplishments and to work more closely with their State PCAs and PCOs (see lead story).

RWJ Seeks Community Leaders

The Robert Wood Johnson Community Health Leadership Program (CHLP) honors 10 outstanding individuals each year. CHLP seeks individuals with between 5 and 15 years of service who have the leadership skills to overcome obstacles and find creative ways to bring health care services to communities with unmet needs. Recipients' organizations receive \$100,000, including \$95,000 for program enhancement over a three-year period.

Nominations are due September 16. For a brochure and Letter of Intent form, contact CHLP, 30 Winter St., 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
INFORMATION RESOURCE CENTER

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