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Subseries:

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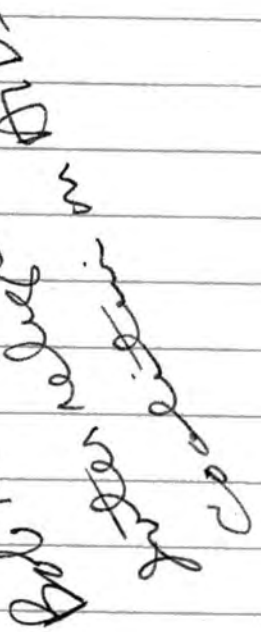
Folder Title:
Meeting with National Coalition for the Homeless Board 10/17/93

Stack:	Row:	Section:	Shelf:	Position:
S	66	5	4	3

Chuck Snyder
NCC - Push (PUSH)
1510 Ardsley Av
Winston-Salem N.C.
27103



(1)

Christine Byrd
Jesus House / 1335 N. Sheridan
OKC., OK.

* TB client being dropped off at Shelter informing client Shelter as long as they take medication its under control

* Problem: Shelter are under staffed when you have as many as 5 to 6 client monitors of medication is a hard task,

* As recent as 2 wks ago OKC. City Council passed ordinance that allows @ private business @ home owners to refuse housing or employment to HIV

and AID clients

Problem: The amount of public housing ~~o~~ that is low to client with HIV-AID with waiting list is lengthy and late.

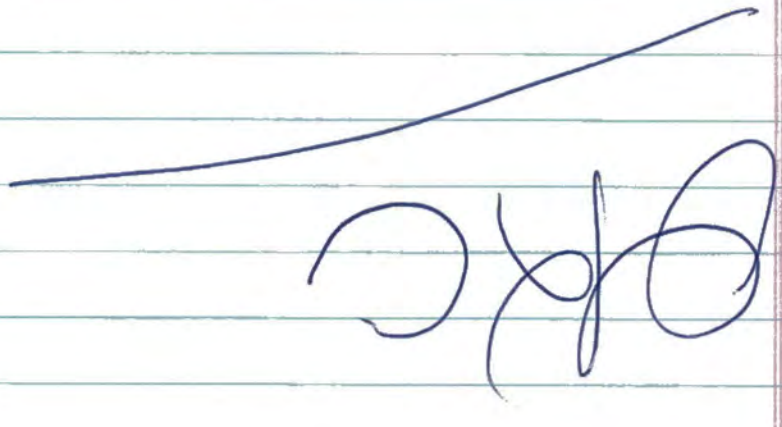
Problem: Ryan White Funding

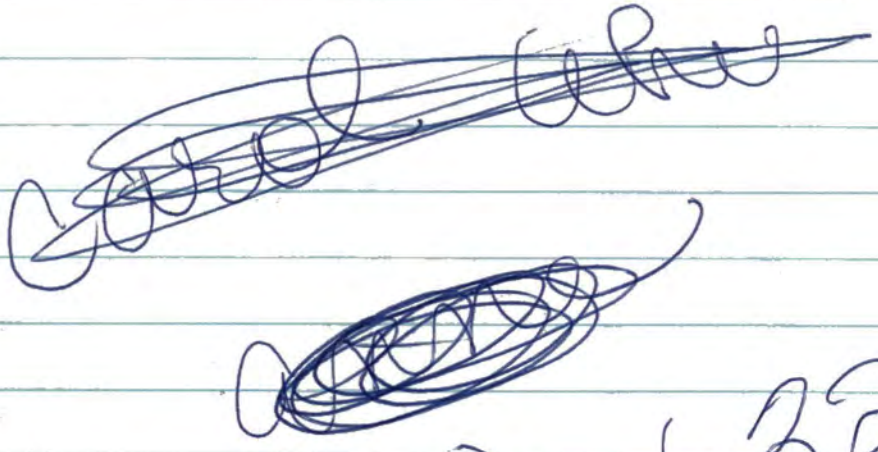
In previous year OK. City Health Department has handle and dispense funds. This year because administrative cost and outreach they will not do so.
The money sit and client who ~~m~~ need it just wait.

Problem: Homeless are fastest growing HIV-AID population but no housing mechanism partner with comprehensive care available

[3]

Problem Youth (12-17) fastest growing homeless population with HIV-AID By state law if they are unaccompanied not allow to live or stay in shelter. / So as an end to a mean they prostitute to live in flop house. to further spread the virus ans. Funding program to the problem of youth shelter housing need and also care.





(202) 632-1090

LAS VEGAS METROPOLITAN POLICE DEPARTMENT

JOHN MORAN, SHERIFF
C.A.L.E.A. ACCREDITED

A. LEIJA, #2020
OFFICER, (H.E.L.P. TEAM)
HOMELESS EVALUATION LIAISON PROGRAM
NORTHEAST AREA COMMAND

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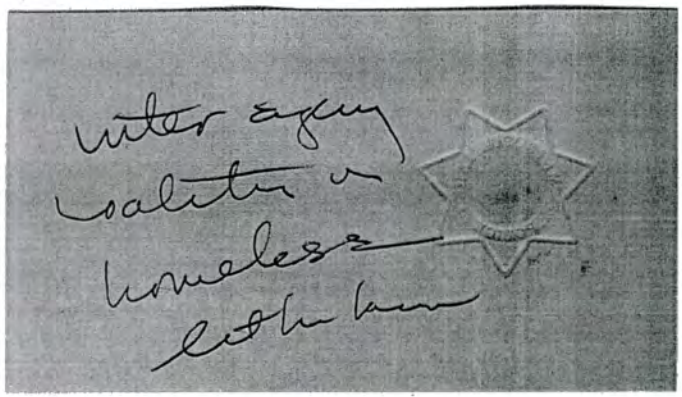

THE COMMUNITY HOUSING PARTNERSHIP

P.O. BOX 25312
Phoenix, AZ 85002
(602) 253-6905

LOUISA STARK, Ph.D.
PRESIDENT

Health Care Issues

National Coalition for the Homeless

DAWN SYDNEY
Policy Analyst

1612 K Street NW #1004 • Washington, DC 20006
Phone 202-775-1322 • Fax 202-775-1316

Questions/concerns —

- Shelter as "discharge planning"
  Ryan White - needs requirement for work on homeless —
  interagency council on homelessness —
  being eliminated ?
  joint RFP's
  need guidance on interagency for Ryan White councils -

- how AIDS plays out
  how things are discussed —
  economic factors / crack cocaine —
  #'s to white gay organizations
  recipients as measures of success —

Pres / Exec. Order - no dumping from hosp to street?
—

LA - TB housing ? #'s example for special needs —

HUD - Oklahoma City ordinance - discriminatory

Illinois - increase in unaccompanied youth overseas —
how does this fit in AIDS budget —

Arizona - severely mentally ill & HIV -

Minnesota - continuum of housing -
congregate sites / scattered sites

Homeless or HIV/AIDS

HIV as a lens or window on societal problems

3 groups

1) Those discriminated against who thus become homeless

2) Those whose illness costs them jobs/resources who become homeless

3) Those who are already homeless who become HIV+

Housing - as service / as legal issue

Key agency HUD, not HHS

Shift in policy focus from HHS to whole Administration

Mtg tomorrow @ HUD -

National Coalition for the Homeless

SEP 30 1993

September 15, 1993

Ms. Kristine Gebbie
National AIDS Policy Coordinator
750 17th Street, N.W.
Washington, D.C. 20303

Dear Ms. Gebbie

I am extremely pleased that you have accepted our invitation to speak at the semi-annual board meeting of the National Coalition for the Homeless. I am writing to confirm that you will be speaking Sunday afternoon, October 17, at 4 pm. The meeting is being held at the Days Inn Downtown, located at 1201 K Street, N.W. here in Washington, D.C.

We would like you discuss current issues related to AIDS particularly as they affect poor and homeless people. We will be in touch with Ben Merrill regarding specific priorities we would like you to discuss. It would be great if you could speak for 20 to 30 minutes and answer questions for about 30 minutes. We promise to get you out by 5:00 p.m.

For your information, NCH's board consists of 63 individuals from 40 states. They are homeless and formerly homeless people, advocates, service providers, and academics. This year, in addition to our board, we have invited representatives from state coalitions who are not on our board to join us for the Sunday and Monday sessions of our meeting, and a new national group concerned about welfare reform and employment issues, the GA Working Group, will be holding their national meeting in conjunction with ours. Thus, we hope to have a diverse audience of about 100 people who are deeply concerned about the needs of low income persons.

Again, we are very pleased that you are going to join us. Please, do not hesitate to call me if you have any questions.

Sincerely,

Fred Karnas, Jr.
Executive Director

1612 K Street, NW, #1004, Washington, DC 20006 • 202-775-1322 • Fax 202-775-1316

for file

[16] From: Ben Merrill 10/12/93 8:19PM (2616 bytes: 46 ln)
To: Kristine Gebbie, Timothy Fox
Subject: 10/18 9am Coalition for the Homeless Board Meeting
---------- Message Contents ----------

This is a large board, 72 people. They come from all walks of life. The staff people say that it is a circus at times. They will be respectful but will ask some hard questions.

You should announce that the administration obtained a record $ 156M for sheltering the homeless with AIDS. But that this group is just a small part of the homeless problem in America.

Mention that the Secretary of HUD is a chief supporter of you and your programs and that he has asked "How can we help."

Indicate that you are aware of the problems with the AFFORDABLE HOUSING ACT which provides funds for a variety of services to the homeless including housing persons with AIDS and that you will work to RESOLVE the dispute within HUD as to whether HIV+=AIDS. We resolved that issue 5 years ago and it is time that HUD caught up with reality.

Second, that you are aware of the SHELTER PLUS CARE PROGRAM which targets the mentally ill, substance abusers, and PWA's and that although it is a rental assistance program, you will work to STREAMLINE the availability of funds for persons who are in need.

Third, that you know that more can be done with SECTION 8 housing and that the stories of people being expelled from Section 8 housing because of their HIV status is no different than people in Vedor, Texas discriminating against blacks, and that you expect Roberta Achtenberg to act throughout section 8 projects just like she and the Secretary of HUD acted in Vedor--seized the projects from the administrators if they don't stop discriminating against people no matter what their status.

Fourth, you understand the long, slow, laborious and confusing application for funding under 3(b) funding of Ryan White; and that you will work to speed up the distribution of funds to communities that have had applications languishing in the Department waiting for approval.

[I have asked Tim to give you additional points and background on this since he just returned from the Housing Confernece in Chicago.]

DRAFT

Direction of HUD Homeless Programs

Objectives:

1. Provide motivation for communities to develop holistic, coordinated systems to effectively attack homelessness. This is the Continuum of Care approach which consists of three components -- (1) Intake/Assessment; (2) Transitional/Rehabilitative services; (3) Permanent housing (with services as needed).

2. Ensure that a continuum of care plan is developed and implemented through an inclusive process that involves not-for-profits, homeless individuals, private foundations and businesses and government agencies. This plan should be a part of the affordable housing strategy and economic development strategy -- not a totally separate system.

3. Provide funds in a manner to fill gaps in continuum of care plans and existing infrastructure.

4. Provide continuity of funding for communities to enable them to plan intelligently to put in place all of the components of a continuum of care approach.

5. Distribute available funds on the basis of relative need and effort rather than grantsmanship.

6. Greatly simplify the process of making Federal funds available to help meet the needs of homeless families and individuals, while holding grantees responsible for achieving results in moving persons from homelessness to residential stability.

Design Issues:

1. What manner of consolidation would best address these objectives? Formula block grant? Competitive block grant?

2. How can we ensure that under a consolidated grant funds will continue to reach not-for-profit organizations?

3. How can we ensure balance in continuum of care plans (e.g., that permanent housing will be available for persons when they are ready to move on from transitional housing)?

4. Who should be eligible to receive assistance? How encompassing should the term "homeless" be?

5. What activities should be eligible? To what extent should homeless prevention activities be eligible?

Illinois Coalition to End Homelessness

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522 East Monroe, Suite 304 • Springfield, Illinois 62705-1472 • (217)788-8060 FAX (217)544-0067

Joseph P. Clary
Executive Director

Advocacy • Education • Justice

CHICAGO COALITION FOR THE HOMELESS

LES BROWN
Program Policy Coordinator

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ALONE AFTER DARK:

A Survey of Homeless Youth in Chicago

The Chicago Coalition for the Homeless

National Health Care
for the Homeless Council, Inc.

John N. Lozier
Executive Director

Post Office Box 68019 • Nashville, TN 37206-8019
Telephone: (615) 386-0302 • FAX: (615) 385-2157

National Health Care
for the Homeless Council, Inc.

Post Office Box 68019 • Nashville, TN 37206-8019 • Telephone: (615) 386-0302 • FAX: (615) 385-2157

Meeting the Needs of the Homeless Poor: Principles for Health Care Reform

A significant measure of any reform of the health care system will be that reform's impact on the neediest Americans--those who lack the most basic necessities, such as housing and income. Their severely limited access to the current system results in untreated illnesses, prolonging their personal economic woes and ultimately driving up the overall costs of the health care system.

Effective reform of the health care system will address not only the financing of care, but also the delivery system to provide that care. Strong emphasis must be placed on health education, prevention and primary care in order to reduce the need for costly utilization of specialty and tertiary services and thus to achieve cost savings in the long run. Additional, comprehensive benefits (as described below) are also necessary to improve the health status of impoverished populations.

Health care reform should draw together the separate funding streams now supporting primary care, substance abuse and mental health services, eliminating bureaucratic obstacles to providing comprehensive services to people with multiple needs.

Experienced providers of health and social services for homeless people suggest the following principles to shape a health care system most responsive to the serious health needs of the homeless poor.

1. Universal coverage must apply to all Americans equally. Poor people must be able to present themselves to health care providers with the same assurance of adequate health insurance coverage as anyone else, lest they continue to be turned away by large numbers of providers.

2. Access to care must be assured, regardless of presenting problem(s), residency, economic status, location, language, culture, or provider attitude. The current system of community clinics, homeless and migrant health care projects, public health clinics and public hospitals must be preserved and expanded in order to provide primary care effectively to hard-to-reach populations. For homeless people and other population groups, aggressive outreach and on-site health care delivery efforts are required.

3. Comprehensive benefits must be provided. Health problems are inter-related, and must be addressed comprehensively. In addition to primary, specialty and tertiary medical care, any basic benefits package must provide dental care and treatment for substance abuse and mental illness, which lead to and exacerbate other health conditions. Expansion of the current substance abuse and mental health treatment systems will be required to adequately address the need. Building on the important, albeit underfunded, legacy of the McKinney Act, housing must be seen as an integral part of the continuum of health care, not only for homeless people but for the mentally disabled, those in recovery from substance abuse and people with HIV disease. There must also be provision for social casework services to address social problems (such as lack of housing, food or income) that adversely affect physical health.

In the long term, these principles will be satisfied by a single-payer system that will provide comprehensive care, will simplify funding mechanisms for providers, and will make special accommodations for access by socially and economically marginalized Americans. In the near term, as the nation and the states experiment with managed care/managed competition systems, the following additional principles must be considered:

4. Medical case management in a managed care system must be designed to assure easy access to all needed services, rather than acting as a gatekeeper whose role is to limit costs through limiting access. Effective health care for the most marginalized Americans requires the elimination of barriers, not the erection of barriers.

5. Public health efforts designed to halt the spread of communicable diseases must be preserved and strengthened. A vigorous public health system is desperately needed to reverse the course of tuberculosis and HIV disease in particular.

6. Adverse selection which excludes certain persons must be prevented. Managed care providers might seek to avoid enrollment of homeless or poor persons because their complex medical problems are costly and because their presence in health care facilities might offend more 'desirable' patients. Alternatively, providers in a capitated system might seek large enrollments by aggressively marketing to homeless and poor people, while erecting barriers to prevent utilization of services. Such practices have been observed in managed care experiments, and careful regulation and oversight are required.

7. Enrollment must be facilitated for marginalized persons. Enrollment at the point of service and at shelters, welfare offices, etc., must be available, while marketing abuses must be guarded against. Impartial assistance in understanding options must be provided at such sites.

8. Immediate disenrollment, or immediate transfer to another plan, or other arrangements for payment must be facilitated so that health services can be provided for transient persons who require care in places other than where they enrolled.

Preservation and expansion of targeted, grant-funded homeless health care services will be necessary during at least the early implementation of managed care/managed competition. Effective homeless health care requires outreach, substance abuse, mental health and social work services that may not be included in managed care plans, and securing homeless persons' participation in managed care will be a difficult challenge. During a transition period of several years, demonstration programs should be established to test the effectiveness of various relationships between homeless health care projects and managed care providers. Although these targeted services must stand somewhat apart from the mainstream managed care system, they must not become an inferior level in a two-tiered system of care, but must supplement basic benefit packages with services that meet the complex needs of homeless persons.

March 1, 1993

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EXECUTIVE SUMMARY

Proceedings:

Health Care & Homelessness:

The Policy Context

An exploration of National Health Care Reform and other issues affecting the health of homeless Americans

From a May 8, 1993, symposium sponsored by:

The National Health Care for the Homeless Council

The National Association of Community Health Centers

The National Coalition for the Homeless

The Caucus on Homelessness in "official relations" with the American Public Health Association

Comic Relief