⇒ Broader piece is

t.a. to provide state-of-art info on dealing w/ dual diagnosed

HHS { HC for Homeless
HIDS
SAMSHA

+

HUD ⇒ meeting

= have to have HIV, and then can have S.A., M. illness problem
= not a single pot of $ → but brings together HOPWA + RWhite people + 2) if succ'ful in HOPWA will be part of HHS evaluation (continuing it if succ'ful under RWhite)

HEALTH RESOURCES AND SERVICES ADMINISTRATION

Bureau of Health Resources Development
Special Projects of National Significance (SPNS)

FY 1996 Competition:
Integrated Service Delivery Models
and
The HIV Multiple Diagnoses Initiative

(A Collaboration between the Departments of Health and Human Services and Housing and Urban Development)

The Health Resources and Services Administration is accepting applications for fiscal year (FY) 1996 grants addressing integrated service delivery for persons with HIV disease. The SPNS program is designed to demonstrate and evaluate innovative and potentially replicable HIV service delivery models. Applicants must respond to <u>one of the two categories</u> of grants: (a) Integrated Service Delivery Models or (b) The HIV Multiple Diagnoses Initiative. Key items include:

- **Due Date** — May 28, 1996.
- **Notification of Intent to Apply** — Applicants are encouraged to contact the Grants Management Office in writing of their intent to apply. Notification should be received by March 29, 1996.
- **Funds** — These grants are subject to the appropriation of funds.
- **Grant Size** — Given a continuing resolution and the absence of FY 1996 appropriations for the Ryan White CARE Act programs, available funding for these grants cannot be estimated.
- **Project Period** — Applicants <u>may</u> apply for project periods of up to 5 years.
- **Eligibility** — Grants may be awarded to public and non-profit entities.
- **Activities** — Grants will support the development and evaluation of models of care.

Applications will be accepted that propose to demonstrate and evaluate:

<u>Category A - Models of Integrated Service Delivery for Persons with HIV Disease</u>. The formal linkage and integration of mental health, substance abuse treatment, rehabilitation and/or other critical HIV services with HIV ambulatory medical care (such as primary medical care and/or home/health care) in new or existing projects. Projects may provide comprehensive services to people with HIV disease in locations or facilities or clinics that serve only people with HIV disease or those that also care for people who do not have HIV disease. Applicants for this category must address <u>one</u> of the following sub-categories:

(1) Coordinated delivery of HIV health and support services to specified transient, homeless, migrant, immigrant or mobile populations to ensure the delivery of a comprehensive continuum of care throughout the course of HIV infection and disease;
(2) Delivery of comprehensive health and support services to Native Americans (e.g. American Indians, Alaskan Natives or Native Hawaiians) through a network of providers experienced in caring for Native American communities; or
(3) Development of an integrated system of HIV ambulatory medical care services for an unserved or underserved population group that is experiencing a significant barrier(s) to care (e.g., ethnic and language minorities, visually or hearing impaired communities, the severely and persistently mentally ill, rural communities, or <u>others</u>) that improves access to and retention in the health care delivery system.

<u>Category B - The Multiple Diagnoses Initiative</u>. This initiative, a collaborative effort between the Departments of Health and Human Services and Housing and Urban Development (HUD), is designed to develop and evaluate programs for the integration of medical, substance abuse, mental health services and other support services with housing assistance for homeless persons with HIV/AIDS and a serious mental illness and/or alcohol or substance abuse problems. The collaboration targets "on the street" homeless persons who currently do not have a place to live. This would include an innovative strategy for developing an integrated system of outreach, needs assessment, comprehensive health and other support services and various types of transitional and permanent housing which has the potential for replication. Related assistance is being provided under the Special Projects of National Significance component of HUD's Housing Opportunities for Persons with AIDS (HOPWA) program.

- **Review Criteria**

Factor	Criteria
(1) Justification of Need (15 points)	Adequacy of demonstrated knowledge of the local HIV service delivery system and the of the justification of need within the community and target population for the proposed integration model. The extent to which the applicant's justification of need goes beyond documenting the existence of an available population in need of HIV services and describes what is innovative about the proposed model, how this model will be of benefit to the population in need, and its potential to advance knowledge in the HIV service delivery field. The adequacy of the discussion about whether or not this or similar models have been evaluated in published literature or reports. The extent to which the applicant identifies past/existing/future systemic or programmatic issues that have contributed to a fragmented service delivery system and how this model will develop a more integrated system of care.
(2) Description of Proposed HIV Service Integration Model (25 points)	The extent of the feasibility and clarity of the description, appropriateness, innovative quality, and potential for evaluation, replication and dissemination of the proposed model. The amount of emphasis given to the definitive integration of services to ensure the delivery of a comprehensive spectrum of care to persons with HIV disease. The extent to which the identification of providers and services integrated by the model is described. The adequacy of the discussion of the rationale for the selection of providers and services integrated by the proposed model.
(3) Description of Program Plan (20 points)	Comprehensiveness of the program plan as described in clearly stated goals, time-limited and measurable objectives for each goal, activities directly related to each objective, and a time line that shows the schedule of activities and production of materials that corresponds to milestones stated in the objectives and program evaluation. The extent to which the applicant demonstrates access to the proposed target population. The feasibility of the description of a process for maintaining client confidentiality throughout the project period.
(4) Description of Evaluation Plan (20 points)	Thoroughness, feasibility and appropriateness of the project's evaluation design from a methodological and statistical perspective. The extent to which the design of the evaluation allows a generalized conclusion regarding the outcomes of the integration model and its suitability for replication. The adequacy of the plan to assess HIV-related health outcomes among the population serviced and followed, and the anticipated outcome impact from a systems level perspective.
(5) Description of Dissemination (10 points)	The extent to which the applicant demonstrates past involvement with disseminating information about HIV service delivery by describing dissemination activities to date (e.g., presenting and publishing findings through reports and papers, training, or technical assistance). The adequacy and feasibility of the preliminary dissemination plan.
(6) Description of Organizational Capacity (10 points	Competency of the applicant organization in terms of fiscal, program management, and evaluation, as evidenced by (a) the consistency between the proposed level of effort and the budget justification; (b) skill level and time commitment required in the personnel specifications for program and evaluation staff; the adequacy of resources proposed to conduct a quality evaluation of the project and dissemination of the project's findings; (d) the qualifications and experience of the proposed evaluation staff; and (e) appropriate confidential handling of clients' medical, social service, and epidemiological data. Extent of documentation demonstrating current and proposed coordination, formal collaboration, and specific linkages with related medical, health and support service activities within the project's catchment area.

- **Application Information**

  - Grant application materials and fiscal issues related to awarding of grants: Mr. Neal Meyerson, Grants Management Branch, Bureau of Health Resources Development, Health Resources and Services Administration, 5600 Fishers Lane, Room 7-15, Rockville, MD, 20857. Telephone: 301 443-2280; FAX 301 594-6096.

  - Additional technical information: SPNS Branch, Office of Science and Epidemiology, Bureau of Health Resources Development, Health Resources and Services Administration, 5600 Fishers Lane, Room 7A-07, Rockville, MD 20857. Telephone: 301 443-3744; FAX: 301 594-2511.

DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT

Office of the Assistant Secretary for
Community Planning and Development

Housing Opportunities for Persons with AIDS
HIV Multiple-Diagnoses Initiative

SUMMARY: HUD published a notice in the Federal Register on February 28, 1996 that announces the availability of approximately $7,000,000 in funds for an initiative for multiply-diagnosed homeless persons who are living with HIV/AIDS and have chronic alcohol and/or other drug abuse problems and/or serious mental illness. The funds will be allocated by competition for housing assistance and supportive services under the Housing Opportunities for Persons with AIDS (HOPWA) program for Grants for Special Projects of National Significance -- HIV Multiple-Diagnoses Initiative.

This new feature of the 1996 competition responds to recommendations expressed during the 1995 White House Conference on HIV and AIDS, to recommendations to HUD by residents and providers of HIV/AIDS housing, and to recommendations and a survey of priority unmet needs of homeless providers and advocates cited in Priority: Home! The Federal Plan to Break the Cycle of Homelessness, issued by the Interagency Council on the Homeless in March, 1994. The HIV Multiple-Diagnoses Initiative is a collaborative effort between HUD and the Department of Health and Human Services to establish, evaluate and disseminate information on model programs to provide the integration of health care and other supportive services with housing assistance for eligible persons. The initiative targets assistance to homeless persons who often have complex needs and for whom service systems are often least developed.

The announced HOPWA assistance is being offered in conjunction with related assistance being announced under the Special Projects of National Significance component of the Ryan White CARE Act under Department of Health and Human Services notices. HHS funds will support the development and evaluation of programs for the integration of medical, substance abuse, and mental health services in residential facilities or home health care agencies. Additionally, HHS will fund an Evaluation Technical Assistance Center which will undertake national and multi-site evaluations of the Special Projects of National Significance, including grants for Housing for Homeless Persons with HIV/AIDS and Substance Abuse and/or Mental Illness. In addition, the Center will provide for assessment and technical support for projects selected under this initiative for HUD projects that request program development support.

The HUD notice contains information concerning eligible applicants, the funding available, the application package, its processing, the selection of applications, and may be obtained as noted below. The notice was published on February 28, 1996, 61 FR 7664.

The notice also provides funds for two other categories of assistance: (1) grants for Special Projects of National Significance which, due to their innovative nature or their potential for replication, are likely to serve as effective models in addressing the needs of eligible persons; and (2) grants for Projects which are part of Long-term Comprehensive Strategies for providing housing and related services for eligible persons in areas that are not eligible for HOPWA formula allocations. Including the funds reserved for the HIV-Multiple Diagnoses Initiative, the HOPWA notice announced up to $17.1 million for award under the 1996 competition.

ELIGIBLE APPLICANTS AND SCHEDULE OF COMPETITIONS IN 1996:

Category	Special Projects of National Significance	Special Projects of National Significance -- HIV Multiple-Diagnoses Initiative	Projects which are part of Long-term Comprehensive Strategies for providing housing and related services
Eligible Applicants	States Local Governments Non-profit Organizations	States Local Governments Non-profit Organizations	States and Local Governments in areas that are not eligible for Formula allocations
Approximate funding *	$17.1 million (approximately $7 million reserved for SPNS-HIV MDI) * estimate pending appropriations		
Maximum Award Per Applicant	$1,000,000 for program activities, and 100,000 for administrative costs, and, if applicable, 100,000 for program development support of SPNS-HIV MDI projects		
Where to obtain application packages	Contact the Community Connections information center at 1-800-998-9999 or by internet at gopher://amcom.aspensys.com:75/11/funding for the application package and supplemental information. You can also purchase, for a nominal fee, a video that walks you through the application package and provides general background that can be useful in preparing your application. The fee for the video may be waived in cases of financial hardship.		
Applications due to HUD Headquarters in Washington DC	May 21, 1996 Midnight Eastern Time		

HEALTH RESOURCES AND SERVICES ADMINISTRATION
Bureau of Health Resources Development
Special Projects of National Significance (SPNS)

FY 1996 Competition:
SPNS Evaluation Technical Assistance Center

The Health Resources and Services Administration is accepting applications for fiscal year (FY) 1996 Grants for the Special Projects of National Significance (SPNS) Evaluation Technical Assistance Center (The Center). The SPNS program endeavors to advance knowledge and skills in HIV services delivery by stimulating the design of innovative models of care. SPNS accomplishes its purpose through funding the technical support and evaluation of innovative and potentially replicable HIV service delivery models. Key items under this competition include:

- **Due Date** — April 29, 1996.
- **Notification of Intent to Apply** — Applicants are encouraged to contact the grants office in writing of their intent to apply. Notification should be received by March 29, 1996.
- **Funds** — This grant program is subject to the appropriation of funds.
- **Grant Size** — Given a continuing resolution and the absence of FY 1996 appropriations for the Ryan White CARE Act programs, the amount of available funding for the grant cannot be estimated.
- **Project Period** — Applicants must apply for a five-year project period.
- **Activities** — The Center will provide technical assistance and support for the program evaluation studies of three SPNS grantee groups: 1) Models of Integrated Service Delivery for Persons with HIV Disease, 2) HIV Multiple Diagnoses Initiative (a collaborative effort between the Departments of Health and Human Services and Housing and Urban Development) and 3) Health Care Services Demonstration Models for HIV Infected Youth. The Center will work with the grantees in the planning phase to: 1) provide advice regarding the evaluation personnel needs at the project level; 2) develop criteria for compatible computer equipment; 3) recommend cross-cutting outcome measures; 4) develop model data collection formats that can be used by grantees at their discretion; 5) provide assistance in the development, preparation and dissemination of evaluation results and findings; and 6) develop and coordinate the implementation of any multi-site evaluations within groups of similar projects.
- **Eligibility** — Grants may be awarded to public and non-profit entities.

- **Rating Criteria**

Factor	Criteria
(1) Professional Qualifications of Personnel (15 points)	Qualifications of the project director, existing staff, proposed staff and/or consultants in (a) the design and direction of national and multi-site health services models evaluation and/or research, (b) the dissemination of progress reports and final results of completed studies, the provision of technical assistance on both qualitative and quantitative evaluation techniques, and in (d) the development of various types of dissemination products.
(2) Organizational Capacity (20 points)	Proficiency of applicant's administrative, fiscal and professional management in the use of grant funds and personnel resources as evidenced in (a) the appropriateness of the proposed budget for the entire project period, (b) proposed staffing patterns during various phases, e.g., planning, start up, implementation, analysis and reporting of the project's operations, proposed apportionment of existing facilities and information management resources, and (d) justification(s) for additional space and equipment if requested.
(3) Implementation Plan (25 points)	Comprehensiveness of applicant's plan for implementing national and multi-site evaluation studies as evidenced by (a) the relevancy of the goals and objectives for measuring progress and achievement of completion of the evaluation studies, (b) the feasibility of the projected timeline, capability of meeting the needs of the Federal government through production of timely reports and providing assistance in managing the meetings of the three groups of grantees, and (d) meeting the needs of the grantees through the provision of ongoing technical assistance, designing efficient measurement tools, and the initiation/receipt of continuous support in their data collection process.
(4) Management Information Systems (MIS) and Procedures (20 points)	Capacity of the applicant's MIS hardware and software to manage the scope of the proposed project; the professional expertise of the MIS staff in programming, maintaining data set(s), implementing the applicant organization's quality control policies and in providing technical assistance to the grantees; the adequacy of the applicant's plan for providing technical assistance to grantees and coordinating grantee project evaluations; and the feasibility of the policies and procedures utilized to ensure reliable and confidential management of the data set(s).
(5) Dissemination Activities (20 points)	Thoroughness of means for addressing and assessing the knowledge and skills needed within the field of HIV/AIDS health services delivery; creativity and timeliness of approaches for the dissemination of "lessons learned" and "best practices"; the release of various types of dissemination products that describe unique and cross-cutting operational issues; and capability to assist grantees in preparation of reports, releases to local media, training curricula, manual development and consultant services for replication of grantee service delivery models.

- **Application Information**

  - Grant application materials and fiscal issues related to awarding of the grant:

    Mr. Neal Meyerson, Grants Management Branch, Bureau of Health Resources Development, Health Resources and Services Administration, 5600 Fishers Lane, Room 7-15, Rockville, MD, 20857. Telephone: 301 443-2280; FAX: 301 594-6096.

  - Additional technical information:

    SPNS Branch, Office of Science and Epidemiology, Bureau of Health Resources Development, Health Resources and Services Administration, 5600 Fishers Lane, Room 7A-07, Rockville, MD 20857. Telephone: 301 443-3744; FAX 301 594-2511.

The ACCESS Demonstration Program

Center for Mental Health Services
Substance Abuse and Mental Health Services Administration
U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

ACCESS (Access to Community Care and Effective Services and Supports) is a five-year demonstration program launched by the Center for Mental Health Services in 1993.

The long-term goal of this initiative is to foster enduring partnerships that will improve the integration of existing Federal, State, local and voluntary service systems to homeless persons with serious mental illnesses, particularly those with co-occurring alcohol or other substance use disorders. The more immediate goal of the program is to identify promising approaches to systems integration and to evaluate their effectiveness in providing services to these individuals.

Nine States receive between $1.7 and $2 million per year to fund both an experimental and a comparison site. Both sites in each State receive funds to provide enhanced outreach and case management services for the target population. The experimental sites receive additional funds to implement innovative systems integration strategies.

All ACCESS sites participate in a formal evaluation that documents changes in local systems of care and the impact of systems integration on client outcomes.

The States and localities receiving funds are:

- Bridgeport and New Haven, CT;
- Sedgwick and Shawnee counties, KS;
- Mecklenburg and Wake counties, NC;
- St. Louis and Kansas City, MO;
- Austin and Fort Worth, TX;
- Richmond and Hampton/Newport News, VA;
- two communities in Chicago, IL;
- two communities in Philadelphia, PA; and
- two communities in Seattle, WA.

Preliminary Lessons

1. The time between first outreach and enrollment in case management is shorter than originally thought.

2. Communities need to identify their local systems integration priorities.

3. Interagency coalitions are key to effective systems integration.

4. An Interagency Management Information System is an important tool for systems integration.

5. Technical Assistance helps projects make mid-course corrections.

6. The use of a formal evaluation design allows documentation of changes in local systems and the impact of these changes on client outcomes.

UNITED TATE DEPART E T OF CO E CE
Bureau of the Census
Washington, DC 20233-0001

Handout 1

List of NSHAPC Sampled PSUs

List of 28 Self-Representing PSUs in Metropolitan Statistical Areas

MSA	MSA Name
520	Atlanta, GA
720	Baltimore, MD
1120	Boston, MA--NH
1600	Chicago, IL
1680	Cleveland--Lorain--Elyria, OH
1920	Dallas, TX
2080	Denver, CO
2160	Detroit, MI
3360	Houston, TX
3760	Kansas City, MO--KS
4480	Los Angeles--Long Beach, CA
5000	Miami, FL
5120	Minneapolis--St Paul, MN--WI
5380	Nassau--Suffolk, NY
5600	New York, NY
5640	Newark, NJ
5775	Oakland, CA
5945	Orange County, CA
6160	Philadelphia, PA--NJ
6200	Phoenix--Mesa, AZ
6280	Pittsburgh, PA
6780	Riverside--San Bernardino, CA
7040	St. Louis, MO--IL
7320	San Diego, CA
7360	San Francisco, CA
7600	Seattle--Bellevue--Everett, WA
8280	Tampa--St. Petersburg--Clearwater, FL
8840	Washington, DC--MD--VA--WV

List of 24 Non-Self-Representing Sampled PSUs in Metropolitan Statistical Areas

MSA	MSA Name
730	Bangor, ME
875	Bergen--Passaic, NJ
1000	Birmingham, AL
1080	Boise City, ID
1150	Bremerton, WA
2190	Dover, DE
2340	Enid, OK
3480	Indianapolis, IN
3520	Jackson, MI
3800	Kenosha, WI
4100	Las Cruces, NM
4360	Lincoln, NE
4900	Melbourne--Titusville--Palm Bay, FL
5720	Norfolk--Virginia Beach--Newport News, VA--NC
5880	Oklahoma City, OK
6690	Redding, CA
6920	Sacramento, CA
7160	Salt Lake City--Ogden, UT
7520	Savannah, GA
7680	Shreveport--Bossier City, LA
8000	Springfield, MA
8680	Utica--Rome, NY
9280	York, PA
9320	Youngstown--Warren, OH

List of Sampled Counties in 24 Non-MSA PSUs

PSU	County
1	Lassen County, CA
1	Modoc County, CA
2	Chester town, CT
2	Deep River town, CT
2	Essex town, CT
2	Lyme town, CT
2	Westbrook town, CT
3	Bradford County, FL
3	Columbia County, FL
3	Dixie County, FL
3	Hamilton County, FL
3	Lafayette County, FL
3	Madison County, FL
3	Suwannee County, FL
3	Taylor County, FL
3	Union County, FL
4	Crisp County, GA
4	Dooly County, GA
4	Macon County, GA
4	Marion County, GA
4	Schley County, GA
4	Sumter County, GA
4	Taylor County, GA
4	Webster County, GA
5	Christian County, IL
5	Clay County, IL
5	Effingham County, IL
5	Fayette County, IL
5	Montgomery County, IL
5	Moultrie County, IL
5	Shelby County, IL
6	Buena Vista County, IA
6	Clay County, IA
6	Dickinson County, IA
6	Emmet County, IA
6	O'Brien County, IA
6	Osceola County, IA
6	Palo Alto County, IA
6	Pocahontas County, IA
7	Bath County, KY
7	Menifee County, KY
7	Montgomery County, KY
7	Morgan County, KY
7	Rowan County, KY
8	Union Parish, LA
9	Caldwell County, MO
9	Daviess County, MO
9	Grundy County, MO
9	Harrison County, MO
9	Linn County, MO
9	Livingston County, MO
9	Mercer County, MO
9	Putnam County, MO
9	Sullivan County, MO
10	Hall County, NE
10	Hamilton County, NE
10	Merrick County, NE
11	Esmeralda County, NV
11	Mineral County, NV
12	Chaves County, NM
12	Lea County, NM
13	Cibola County, NM
13	McKinley County, NM
14	Iredell County, NC
15	Hancock County, OH
15	Hardin County, OH
15	Putnam County, OH
15	Wyandot County, OH
16	Haskell County, OK
16	Latimer County, OK
16	Le Flore County, OK
16	Pittsburg County, OK
17	Douglas County, OR
18	Bedford County, PA
18	Fulton County, PA
18	Huntingdon County, PA
18	Juniata County, PA
18	Mifflin County, PA
19	Abbeville County, SC
19	Greenwood County, SC
19	Laurens County, SC
19	McCormick County, SC
19	Newberry County, SC
19	Saluda County, SC
20	Houston County, TN
20	Humphreys County, TN
20	Stewart County, TN
21	Aransas County, TX
21	Bee County, TX
21	Live Oak County, TX
21	Refugio County, TX
22	Accomack County, VA
22	Northampton County, VA
23	Burnett County, WI
23	Clark County, WI
23	Rusk County, WI
23	Sawyer County, WI
23	Taylor County, WI
23	Washburn County, WI
24	Johnson County, WY
24	Sheridan County, WY

NSHAPC-104
(2-23-96)

Handout 2

Interagency Council on the Homeless

February 1996

OVERVIEW

NATIONAL SURVEY OF HOMELESS ASSISTANCE PROVIDERS AND CLIENTS

The **National Survey of Homeless Assistance Providers and Clients** ("survey") is designed to provide up-to-date information about the providers of homeless assistance and the characteristics of homeless persons who use services. The survey, which is being conducted by the Census Bureau, is being co-sponsored by 12 Federal agencies[1] under the auspices of the Interagency Council on the Homeless. The survey will involve a statistical sample of 76 geographic areas consisting of metropolitan and nonmetropolitan areas. It is being carried out between October 1995 and November 1996.

The last nationwide survey, which was conducted in 1987 by the Urban Institute, used a similar methodology. However, it relied on a smaller sample, did not include nonmetropolitan areas, and did not collect information on as comprehensive a basis as the new survey will. Since the 1987 study, no significant national studies have been conducted to produce information on the characteristics of persons participating in homeless assistance programs.

The new survey includes a wider variety of locations than the 1987 study in order to more accurately and fully reflect the characteristics of homeless people who use services nationwide. The 76 geographic areas to be included in the national sample will be comprised of the 28 largest metropolitan areas, 24 randomly selected medium and small metropolitan areas, and another 24 randomly selected nonmetropolitan areas (small cities and rural areas).

The survey will provide up-to-date information about the providers of homeless assistance, the characteristics of the homeless population who use services, and how this population has changed since the 1987 Urban Institute Study in metropolitan areas. This information is critical for developing effective public policy to help break the cycle of homelessness.

For example, the survey will:

1. Provide information on the types of programs and services (e.g., housing, food assistance, health care) available to homeless persons in both metropolitan and nonmetropolitan areas, including population groups primarily served (e.g., veterans, people with mental illness); days of operation; occupancy levels; and sources of funding.

2. Provide a comprehensive profile of the homeless population who use services and allow us to compare characteristics of this population with the findings of the 1987 study.

3. Collect additional information related to prevalence of drug use, mental illness, HIV/AIDS, tuberculosis, and previous episodes of homelessness.

4. Provide information on issues not addressed by the last national study in 1987 such as: What are the triggering events that precipitate homelessness? Where were homeless people living before they became homeless?

---

[1]The 12 Federal agency sponsors include the Departments of Housing and Urban Development, Health and Human Services, Veterans Affairs, Agriculture, Commerce, Education, Energy, Justice, Labor, and Transportation as well as the Social Security Administration and the Federal Emergency Management Agency.

The national survey is being conducted in two phases. The first phase of the survey – the "provider survey" – will be conducted from October 1995 through March 1996. It will involve telephone interviews and a mail survey of assistance providers in 76 areas. Included will be programs specifically targeted to homeless people (e.g., shelters, soup kitchens, and outreach programs), as well as providers of "mainstream" assistance programs which offer programs targeted to homeless persons. The purpose of this survey of service providers is to identify the types of programs and services available to homeless persons in metropolitan and nonmetropolitan areas and assess emerging continuums of care.

The second phase of the survey – the "client survey" – will be conducted from mid-October to mid- November 1996. It will include interviews with a sample of persons in emergency shelters, soup kitchens, outreach programs, drop-in centers, and other locations where assistance is provided. Interviews will take place over a four-week period in order to obtain a representative sample. In addition to providing data on characteristics of the portion of the homeless population who use services, this phase of the survey will identify population subgroups and help determine their use of various types of assistance programs. It will also collect limited comparative data on housed persons with very low incomes who also rely on soup kitchens and other emergency assistance.

The client survey will produce data on client characteristics at the national level only. The sample size is not large enough to produce estimates of client characteristics at the regional or local levels, nor is it designed to produce a count of homeless people.

A pretest of the survey was conducted in April 1995 in Atlanta, Georgia; Pittsburgh, Pennsylvania; and a rural county outside Pittsburgh. The results of the pretest were used to refine the design of the full national survey.

For additional information on the design and implementation of the survey or for other questions of a technical nature, contact Annetta Clark, Population Division, Room 2320, Building 3, U.S. Bureau of the Census, Washington, D.C. 20233, (301) 457–2378 [Fax: (301) 457–2644]. For all other questions, contact the Interagency Council on the Homeless at (202) 708–1480 [Fax: (202) 708–3672].

Handout 3
March 1996

SURVEY MILESTONE DATES

• Select Survey Sample Areas	July - Aug 95
• Acquire Files of Service Providers	June - Oct 95
• Develop List of Service Providers in Each Sample Area	July - Oct 95

PHASE 1: Provider Survey

• Conduct Telephone Interviews with Homeless Assistance Providers in Sample Area	Oct 95 - Mar 96
• Homeless Assistance Providers Review List of Providers	Oct 95 - Feb 96
• Mail Detailed Program Questionnaires to a Sample of Providers	Mar - May 96

PHASE 2: Client Survey

• Select Providers to Participate in Phase 2	Aug 96
• Contact Providers Selected to Participate	Sept - Oct 96
• Conduct Personal Visit Interviews with a Sample of Clients Using Services	Oct - Nov 96

Handout 4

PROVIDER QUESTIONNAIRE - TELEPHONE INTERVIEW
CORE ITEMS ASKED OF ALL PROVIDERS
Survey Design as of September 12, 1995

1. Verify that direct programs and services are offered at this address.

2. Ask which programs are offered at this address:

   Emergency shelters, transitional housing, permanent housing for homeless people, soup kitchen or meal distribution, food pantry, mobile food program, physical health care program, mental health care program, alcohol or other drug program, HIV/AIDS program, drop-in center, migrant housing used in the off season to house homeless people, voucher arrangements, and other programs not listed.

CORE ITEMS ASKED OF ALL PROVIDERS ABOUT EACH PROGRAM
(estimates for February 1996)

1. Days the program is operated in February

2. Number of single-parent families served; percent of these that are homeless; percent that are female-headed

3. Number of two-parent families served; percent of these that are homeless

4. Number of youth and children in families that are served

5. Number of adults without children served; percent of these that are homeless; percent that are women

6. Number of unaccompanied youths served; percent of these that are homeless; percent that are female.

7. Number of unaccompanied children served; percent of these that are homeless; percent that are female.

8. Type of program (i.e., private, non-profit, public, private for profit).

9. Source of funding (i.e., private funding, donations, government funding, other).

10. How most clients enter program (e.g., referrals, outreach, walk-ins)

11. Population groups served (e.g., victims of domestic violence, runaway or homeless youth, people with mental health problems, people with drug or alcohol problems, veterans)

12. Contact person for the program.

DETAILED ITEMS ABOUT PROGRAMS AND SERVICES ASKED OF SAMPLE OF 5,000 PROVIDERS (Excluding Food Providers)
Survey Design as of September 12, 1995

1. Services offered by program type (e.g., basic assistance, life skills, case management, housing search, education, employment, general health care, HIV/AIDs services, substance abuse services, mental health care services, child care, domestic violence counseling, legal assistance, veterans special services, transportation services, and other services).

For housing programs only, we ask:

2. Capacity of the program to shelter unaccompanied persons and families.

3. Estimated level of occupancy by season.

4. Approximate number of eligible people turned away when operating at full capacity, by season.

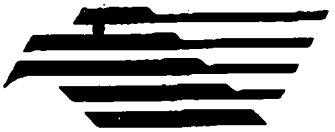
5. Reasons for excess demand for the program when capacity is full.

6. Reasons for lower demand for the program when capacity is less than filled.

7. Destination of persons served when they left the program.

EXAMPLES OF DATA TO BE COLLECTED DURING THE CLIENT SURVEY

- Current Living Condition
- Residential History (Housing type)
- Use of Services
- Childhood Experiences, such as time spent in foster home or group homes as a child
- Demographics
- Information about the respondent's children
- Employment
- Sources of Income and Service Use
- Veteran Status
- Information about the respondent's physical and mental health
- Victimization
- Food intake



Interagency Council on the Homeless

June 28, 1996

MEMORANDUM TO: SEE LIST BELOW

FROM: FRED KARNAS, JR.
ACTING EXECUTIVE DIRECTOR

SUBJECT: JULY 15 MEETING TO DISCUSS INITIATIVES FOR HOMELESS PEOPLE WITH MULTIPLE DIAGNOSES

This is to remind you that the next meeting of the Working Group on Homeless People with Multiple Diagnoses is scheduled for Monday, July 15, 1996 at 10:00 a.m. in Room 8202 of the HUD Building. The purpose of this meeting will be to continue the discussion that we began at our initial meeting on May 16 on ways to improve assistance to homeless people with multiple diagnoses involving mental illness, alcohol and other drug abuse, AIDS, and other serious health problems.

Attached for your information and review is a summary of our last meeting on May 16, 1996. Please call me at (202) 708-0614, ext. 4621, if you have questions.

Attachment

ADDRESSEES:

Araceli Ruano, WH/VP
Molly Brostrom, WH/DPC
Susanne Stoiber, HHS/ASPE
Harriet McCombs, HHS/ASPE
Mary Ellen O'Connell, HHS/ASPE
Michael Shoag, HHS/ASPE
Barbara Garcia, SAMHSA
Bernie Aarons, CMHS
Michael English, CMHS — facilitator
Walter Leginski, CMHS
Lynn Aronson, CMHS/HPB
Fran Randolph, CMHS/HPB
Emily Miller, CMHS/HPB
Jean Hochron, HRSA/BPHC — Health Care for the Homeless
Barney Singer, HRSA/SPNS
Hector Sanchez, SAMHSA/CSAT
Donald Streater, SAMHSA/CSAT
Vivian Smith, SAMHSA/CSAP

David Mactas, CSAT
Ciro Sumaya, HRSA
Joan Holloway, HRSA
Joe O'Neill, HRSA
Elaine Johnson, CSAP
Jacquie Lawing, HUD
Maggie Taylor, HUD
David Pollack, HUD
Ada Deer, Interior
Bernita Joyce, Interior
Mike Feinberg, USDA/RHS
Mary Anne Keefe, USDA
Michael Fishman, USDA
Gary Bickel, USDA
Maureen Kennedy, USDA/RECD
John Pentecost, USDA/RECD
Kay Goss, FEMA
Carol Coleman, FEMA
Paul Hancock, DOJ
Ken Zimmerman, DOJ
Paul Robertson, DOL
Ray Uhalde, DOL
Robert Litman, DOL
Carolyn Colvin, SSA
Cassandra Wilkins, SSA
Pat Betch, SSA
Paula Laird, SSA
Tom Gloss, SSA
Marsha Martin, VA

SUMMARY

HOMELESS PERSONS WITH MULTIPLE DIAGNOSES WORKING GROUP MEETING

Thursday, May 16, 1996
Room 7202, HUD Building

Following introductions, Fred Karnas opened the meeting by noting that this working group of the Interagency Council is being established in accordance with the interest expressed by Secretary Cisneros and Secretary Shalala at the last full Council meeting in identifying additional short- and long-term actions that could be undertaken to assist homeless persons with multiple diagnoses. HUD and HHS will co-chair the working group.

It was agreed that the working definition of "multiple diagnoses" encompasses a broad classification of conditions including severe mental illness, alcohol and other drug abuse, HIV/AIDS, tuberculosis, and other serious related health conditions such as diabetes.

Agency representatives discussed current activities and other initiatives:

--Maggie Taylor and David Pollack of HUD (202/708-4300) described the current Continuum-of-Care NOFA and its language emphasizing the need to serve homeless people with multiple diagnoses. HUD offers a number of technical assistance resources, including a "college of experts" who are available to provide technical assistance on issues involving homelessness, affordable housing, and community and economic development and consultations staffed by the Corporation for Supportive Housing and the National Coalition for the Homeless. HUD and HHS are also collaborating on funding for model projects involving HIV/AIDS and other diagnoses.

--Barney Singer of HRSA/HHS (301/443-3592) described special projects of national significance for HIV/AIDs and related efforts, including a grantee evaluation center, support for integrated service delivery models, and programs for HIV-affected youths and adoloscents.

--Hector Sanchez of SAMSHA/CSAT described the recently issued request for proposals that was jointly issued with CMHS for homelessness prevention among persons with mental illness and/or substance abuse problems. Approximately 16 cooperative agreements are expected to be signed as a result of this national competition. June 10 is the deadline for applications. Call Mr. Sanchez (301/443-7508) or Larry Rickards of CMHS (301/443-3706) for additional information.

--Fran Randolph of CMHS's Homeless Programs Branch (301/443-

3706) reported on additional interim findings of the five-year ACCESS demonstration that were not specifically addressed during the presentation before the full Council. ACCESS is designed to test various models of service integration in 18 communities in 9 states. Following are some of the interim findings regarding process:

--Many communities currently lack the skills to create integrated-services continuums of care.

--Broader representation from mainstream agencies is essential.

--Leadership is needed at the state level to address barriers, not just at the project level.

--There is a role for the Federal government in providing technical assistance; technical assistance can have a significant impact.

--Marsha Martin of VA (202/273-6284) emphasized that VA is the only Federal agency that is literally running a direct service system for homeless people through inpatient and outpatient care in its hospitals. VA's Grant and Per Diem Program for Homeless Veterans provides a vehicle for community partnerships and for networking with care providers in the broader community. VA is working to educate providers that eligibility for its services is restricted to veterans who meet certain conditions, and that not all persons with military service qualify. VA is co-sponsoring conferences later this year in Dallas and Chicago to strengthen its ties with other homeless service providers and the outside community. Because VA is moving to more of an outpatient model for substance abuse treatment, it wants to develop additional vehicles outside of its current system. Ms. Martin encouraged CSAT and CMHS to use VA as an information resource because of its extensive experience with the multiple-diagnosis population. She noted that VA field contacts sponsor at least one general meeting a year that could be used for information dissemination. VA facilities have a teleconferencing capacities that could be used as well.

--Tom Gloss of the Social Security Administration's Office of Disability (410/965-3987) summarized recent changes in Social Security law that will affect the benefits of persons whose primary disability is alcoholism or drug abuse. He encouraged agency representatives to call him directly if they have questions. He noted that SSA could use the assistance of other agencies in getting documentation of disability and in recruiting representative payees to expand the number of eligible persons served under SSA programs.

Following these presentations, it was agreed that short-term first steps would be (1) to coordinate technical assistance materials and (2) to improve communications on the lessons learned to date, with greater use of the ICH network of State homeless contacts. Suggestions for possible longer term efforts included:

--Coordinating program evaluation.

--Sponsoring t/a conferences to promote the development of a continuum of care for this population at the local level.

--Expanding the "Stand Down" concept for homeless people with multiple disabilities.

--Identifying ways to improve coordination of Federal, state and local programs, especially mainstream programs such as Medicaid. (It was recommended that HCFA be invited to send a representative to the next meeting.)

--Redesigning the McKinney programs to require a match of housing dollars with service dollars from mainstream programs. →

--Requiring states to pool funds across departments to address barriers to service integration.

--Rotating Federal staff among various Federal agencies to enable them to become more familiar with programs that provide benefits or other assistance that are related to their own programs.

--Developing a strategic plan under the auspices of the Interagency Council on the Homeless to address the needs of those with multiple diagnoses.

--Considering targeting all Federal homeless assistance funds in a given fiscal year to persons with multiple diagnoses. Set-aside

--Identifying additional Federal resources that are currently available to help the multiple-diagnosis population. e.g. resource guide

The next meeting of the group was tentatively set for Tuesday, June 25 at 2:00 p.m. Fred Karnas will send a reminder notice confirming the time and location of the meeting. He will also prepare a draft list of known technical assistance resources and will identify next steps for the two short-term actions before the next meeting.

CMHS → Best Practices in discharge planning

DPC Plan

1. Accomplishments

- Homelessness. Helped to secure funding for National Census Bureau Survey of the needs and characteristics of the homeless. Survey will be completed this year, with analysis beginning [~~date~~] shortly thereafter.

- Veterans. Worked with OMB, VA, DoD, and HHS to introduce legislation to establish pilot projects to test Medicare reimbursement at VA and DoD facilities.

[Drug Conference -- I assume Dennis included in his]

2. Future Objectives

- Homelessness. Work with Interagency Council on the Homeless on federal responses to homeless people with multiple diagnoses. including part. focus on improving

- [Elizabeth -- should I put in anything on Substance Abuse?]

- Veterans [keep previous bullet; add:] Continue to work with OMB and agencies on establishing pilot projects for Medicare Subvention at VA and DoD health care facilities.

- Social Security. Work with NEC and OMB on response to Social Security Advisory Commission recommendations due in December. [probably should be something about working on establishing Commission, but I haven't been involved yet -- I understand Gene and Laura are putting together ideas...?]

- Seniors. work with AoA and other agencies on developing initiatives (outside of health care) to deal with aging demographics. to address needs of P's aged pop

November 14, 1996

MEMORANDUM TO MOLLY BROSTORM
DENNIS BURKE
DIANE REGAS
PATSY FLEMING
DIANA FORTUNA
CHRIS JENNINGS
JEFF LEVI
STEVE WARNATH
PAUL WEINSTEIN
LYN HOGAN
JEANINE SMARTT
LEANNE SHIMABUKURO
SANDY BUBLICK-MAX
MIKE COHEN

FROM: Jeremy Ben-Ami
Elizabeth Drye

SUBJECT: Report on DPC Accomplishments and Long Range Plans

Carol has been asked to prepare a report listing DPC's accomplishments in 1996 and future plans. We need your input for a first draft of that report by **COB Friday, November 15.** We will follow the format of our previous report (attached), with minor modifications. Specifically, please list:

I. Accomplishments in 1996 (e.g. workgroups, legislation, conferences we have chaired or co-chaired and/or participated in). **Please describe in 1-2 sentences.** Please sort by:

(a) DPC staff accomplishments.

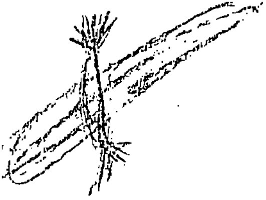
(b) Council accomplishments (e.g. accomplishments of working groups on the homeless, veterans, Native Americans...)

II. Future Objectives. **Please describe issues you will be working on in 1-2 sentences and indicate our specific objective, timing and lead DPC staff. Please use the same format used in our previous report** (see attached for examples). Please sort by:

(a) Concrete Objectives.
(1) Legislative.
(2) Non-legislative.

(b) Ongoing Management.

Please save your items on the I:\DPC\DATA directory by COB Friday as DPCPLAN.[your initials], and send Jeremy and me an e-mail letting us know you're done. Call me or Jeremy if you have any questions. Thanks.



IBA: $70/day | 4 months →

- Work w/HUD to add PH African leg (that maintains patching for a commit to lowest inc)

Accl's

Homelessness:

= Helped to secure intra agency funding for national Census Bureau study of needs + char's of homeless,

Survey timeline

Veterans:

Medicare Subv for VA + DoD

will continue to work w/OMB + agencies

NPG

Seniors

Soc Sec

DOMESTIC POLICY COUNCIL
Long Range Plan (June – December 1995)

I. MISSION

The Domestic Policy Council assists the President and White House senior staff in shaping and articulating the administration's domestic agenda. The DPC develops administration positions consistent with key Presidential themes (community, opportunity, and responsibility) and in furtherance of key commitments such as, for instance, reforming welfare, reforming government, and empowering families through opportunity.

In addition to shaping policy and message, the DPC coordinates legislative initiatives, monitors implementation of initiatives already enacted, addresses critical issues as they arise, and coordinates across agencies on policy matters.

II. KEY ACTIVITIES

To achieve these broad goals, DPC staff perform a range of functions across issues:

- o provide a mechanism for decision making – serving as a "fair broker" among agencies and offices within the administration. In many cases, the DPC chairs or co–chairs working groups or processes designed to develop administration policy.

- o review speeches, testimony and other public statements of administration positions to ensure consistency in policy.

- o monitor the implementation of key Presidential initiatives.

- o act as trouble–shooters on issues of immediate importance such as, for instance, negotiations over the California Medicaid claim or health and welfare waivers.

- o coordinate among agencies addressing similar problems and serving similar constituencies. We have working groups on issues and groups from veterans to the homeless, from Native Americans to the disabled.

- o analyze policy proposals by agencies, the Hill, states, and/or outside groups.

- o Supply basic information –– fact sheets, talking points, issue briefs, questions and answers –– on policy issues to the President and other White House offices and staff.

- o Develop options for Presidential events. Serve as staff contact for events, help draft speeches, and coordinate production of appropriate materials.

III. SPECIFIC ISSUES

On the domestic agenda for the next six months, some issues lend themselves to concrete, clear objectives, while others will be appropriate for ongoing management and monitoring. This section presents key concrete objectives where appropriate and then indicates those issues where the DPC will be involved in ongoing monitoring and management.

A. Concrete Objectives

1. *Legislative* Four critical legislative priorities will involve substantial commitments of time by DPC staff:

Farm Bill The DPC co-chaired the effort to develop the administration's position on the Farm Bill. Objective/Timing: Pass and sign a farm bill reauthorization by the end of the year. Lead DPC Staff: Brian Burke/Marion Berry.

Immigration The DPC chairs the Interagency Working Group that developed the administration's immigration legislation and is addressing ongoing issues such as development of the work verification pilots and the administration's position on legal immigration. The DPC holds weekly meetings of a White House Core Group on Immigration to coordinate administration work on the issue. Objective: Pass immigration legislation that the President can sign this year. Timeframe: Legislation should begin to move through Congress shortly. Lead DPC Staff: Steve Warnath.

Lifelong Learning Secure passage of legislation reshaping education and training programs for youth and adults which reflects the President's principles: empowering individuals, providing states with flexibility, and building on School to Work. Timeframe: House Committee has acted on the Careers Act, and legislation is moving to the House floor soon. Lead DPC Staff: Jeremy Ben-Ami/Mike Schmidt.

Welfare Reform Objective: Work toward passing a bill that the President can sign that fulfills his pledge to end welfare as we know it. In the alternative, position the President as fighting for true welfare reform. The DPC is the lead White House office in developing the administration's position on welfare reform. Timeframe: Senate action expected in early summer. Presidential decision and negotiations with Congress to follow. Lead DPC Staff: Bruce Reed.

Other We will be involved with several other legislative items:

- Ensuring funding for the Community Development Bank and Financial Institutions (CDFI) Fund, so the program can start in this fiscal year. Timeframe: By end of FY95. Lead DPC Staff: Paul Weinstein.

- Defending against efforts to weaken environmental protections and working toward sensible regulatory reform. Lead DPC Staff: Regulatory Reform – Michael Waldman/Paul Weinstein; Environmental legislation – Brian Burke.

- o Work with HUD to pass and implement reinvention proposal. Lead DPC Staff: Molly Brostrom/Paul Weinstein.

- o Work toward Presidential signing of Line Item Veto legislation. Timeframe: By the fall. Lead DPC Staff: Paul Weinstein.

- o Legislation giving states greater flexibility, including the Local Flexibility and Empowerment Act. Lead DPC Staff: Paul Weinstein.

- o Reauthorization of Ryan White CARE Act. Lead DPC Staff: Patsy Fleming.

2. *Non-Legislative*

AIDS (1) Convene President's HIV/AIDS Advisory Council; (2) Complete Report to the President on the epidemic and adolescents. Timeframe: (1) November 15; (2) October 15. Lead DPC Staff: Patsy Fleming.

"Common Ground" Conference Help coordinate meeting of leaders from around the country to discuss divisions in the country and the healing process. Ensure follow-up activity to Conference. Timeframe: Conference scheduled for July 6. Lead DPC Staff: Jeremy Ben-Ami/Gaynor McCown/Mickey Levitan.

Disability The DPC, together with OMB, has established a National Disability Policy Review. The Review is examining all aspects of federal policy affecting persons with disabilities and is developing recommendations. Objectives: (1) Develop short-, medium-, and long-term recommendations for a national disability policy; (2) ensure appropriate recognition of 5th Anniversary of Americans with Disabilities Act. Timeframe: (1) Initial recommendations should be ready within six months; (2) July 1995. Lead DPC Staff: Diana Fortuna.

Homelessness Objectives (1) Coordinate development and publication of update on implementation of Interagency Council on the Homeless' "Federal Plan to Break the Cycle of Homelessness; (2) work with Council and the Census Bureau to move forward a proposed national study of the needs and characteristics of the homeless. Timeframes: (1) Publish update by December 1995. (2) Agree to funding of survey and begin work by summer 1995. Lead DPC Staff: Molly Brostrom.

Lobby Reform Objective: Inject the President forcefully into the public debate as a reformer of politics and government. Release our lobby reform proposals; take unilateral actions as appropriate; reiterate positions in speeches and events; if appropriate, work with lawmakers to enact legislation. Timeframe: By the fall, the President should be positioned as a leader on this issue. Lead DPC Staff: Michael Waldman.

Regulatory Reform Objective: Work with other offices on legislative, policy and communications strategy for regulatory reform. Produce a record of regulatory reform

that can be used as "inoculation" if the President is forced to veto GOP legislation. Timeframe: By the fall, establish record of achievement. Lead DPC Staff: Michael Waldman/Paul Weinstein.

Teen Pregnancy The DPC is taking the lead on implementing the President's pledge to start a National Campaign Against Teen Pregnancy. Objectives: (1) Announce formation of a private sector group that will lead the National Campaign. (2) Produce in cooperation with the Advertising Council a Public Service Advertising campaign to raise awareness about the problems and potential solutions. Timeframe: National Campaign should be announced within one month. PSA should be released by late summer, early fall. Lead DPC Staff: Jeremy Ben-Ami/Janet Abrams.

B. Ongoing Management

Comprehensive Services for Children and Families Many DPC agencies are responsible for services and programs for children and families. There are vehicles for coordinating such efforts within the administration including the Community Empowerment Board and the President's Prevention Council, but the DPC tries to help coordinate among all of these efforts. Objective: Coordinate agency initiatives, reduce fragmentation of services, and encourage comprehensive strategies that emphasize families and communities. Timeframe: Ongoing. Lead DPC Staff: Gaynor McCown.

Crime The DPC is the lead White House Office in dealing with implementation of the 1994 Crime Bill and other policy issues that arise in criminal justice. The DPC hosts weekly meetings to monitor crime bill implementation. Objectives: (1) Pass two terrorism bills currently before the House and Senate; (2) Protect key crime bill components -- 100,000 cops, assault weapons ban, prevention programs, etc. -- from being repealed; (3) Protect crime bill fund during budget/appropriations process. Timeframe: Ongoing. Lead DPC Staff: Bruce Reed.

Drugs Objectives: (1) Develop national response to changing attitudes on drug use - using bully pulpit, preserving the Safe and Drug Free Schools program and prevention programs in the Crime Bill; (2) Develop the Administration's drug enforcement profile. Use the 100,000 cops and federal law enforcement to show Administration's commitment to keeping drugs off the street.

Empowerment Zones/Enterprise Communities -- Objective: As Vice Chair of the Community Empowerment Board, DPC will be working to ensure that this critical Presidential initiative is properly implemented. Timeframe: Ongoing and immediate. Lead DPC Staff: Paul Weinstein/Gaynor McCown.

Environmental Issues The DPC works closely with CEQ and EPA on environmental policy - specifically to ensure that the environmental agenda is integrated into the broader domestic agenda. Objective: Our objective in all these efforts is to position the administration as fighting to defend public health protections as they come under extreme attack. Lead Staff: Brian Burke.

Health Care The DPC, together with the NEC, co-chairs the ongoing process of developing Administration health care policy. Objectives: Fulfill President's commitment to continue to move toward real reform and protect health care programs during the budget debate. Timeframe: Issue will continue on front burner throughout budget debate. Lead DPC Staff: Chris Jennings/Jennifer Klein.

Lifelong Learning Implementation and defense of the President's Lifelong Learning Agenda will continue to be a key focus of Presidential and Administration activity over the next six months. DPC has worked closely with NEC, OMB and the Departments on the development and passage of most components of the Lifelong Learning Agenda. Objectives: Defend investments and signature initiatives such as Direct Lending, School to Work and Head Start from attack; ensure implementation. Timeframe: Ongoing. Lead DPC Staff: Gaynor McCown/Mike Schmidt.

Native Americans Work with the Department of the Interior to ensure a smooth transition of policy review and formulation to the DPC Working Group on Native American and Alaska Native Affairs. Lead DPC Staff: Mike Schmidt.

Seniors Develop a coordinated strategy with other White House offices and Cabinet agencies for follow up to the White House Conference on Aging and additional outreach to key seniors groups. Lead DPC Staff: Molly Brostrom.

Social Security DPC will work closely with NEC and OMB to respond to the long range recommendations of the Social Security Advisory Commission due out this fall. Lead DPC Staff: Molly Brostrom.

State/Local Initiatives The DPC has been working closely with the National Performance Review and other offices in their outreach to State and local governments who want to establish more effective working relationships with the federal government. A primary example of these efforts is the interagency agreement reached with the state of Oregon. We will be focusing on implementing performance partnerships, program consolidation and legislative initiatives to enhance local flexibility. Timeframe: Ongoing. Lead DPC Staff: Paul Weinstein, Gaynor McCown.

Veterans DPC co-chairs the Interagency Veterans Policy Group which will continue to provide a forum for ongoing dialogue with veterans organizations and for encouraging interagency coordination. Lead DPC Staff: Molly Brostrom.

Waivers: Health and Welfare The DPC continues to oversee the implementation of the President's directive that states be given broad authority and flexibility to administer Medicaid, AFDC, and other federal entitlements through the waiver process. Objective: Work with agencies and states to ensure President's intentions are carried out. Timeframe: Ongoing. Lead DPC Staff: Diana Fortuna.

E X E C U T I V E O F F I C E O F T H E P R E S I D E N T

13-Nov-1996 02:32pm

TO: Jill Pizzuto

FROM: Carol H. Rasco
Domestic Policy Council

CC: Claudia M. Rayford-Williams
CC: Christopher C. Jennings FYI
CC: Molly Brostrom FYI

SUBJECT: Ray Scott

Ray Scott is the former Human Services Commissioner in Arkansas, once worked for Sen. Pryor. He called this a.m. to tell me that a physician and a nurse in LR who have opened a health clinic as part of University of Ark. Medical Campus are looking at setting up an aging research center as part of the clinic, want to meet with some of us. I declined setting a meeting as early as Monday and told him we needed to do some joint planning for the meeting in advance with which he agreed.

They would probably like to come in early December for a 1 1/2 hour discussion. I told him to get Jill options on dates asap. Then once we have a date finalized I am asking Molly to work with the person(s) we will designate in Arkansas to set up this brainstorming session. I told him the Ark. folks should prepare a list of bullet points as to features of a center about which they have thought, Molly can look at that and work with various folks to determine just whom we should invite to this session/discussion...perhaps AOA, NIAA, HHS, etc., etc. There may even be other departments we should invite, can see when we have the list. The physician (Dr. Lipschitz) and nurse (Dr. Beverly) are both well known thoughout the country in aging policy circles, and on top of that she's been my friend from Arkansas County since Girl Scout days!!!!!!! He is very interesting individual, is from South Africa, does incredible research.

Next steps:

Ray Scott or someone from medical group will call Jill with options as to dates.

Once a date is set Molly should work with group in LR on setting up the topics, invitation list to meeting. I'll be happy to take a look at this step.

Meeting

E X E C U T I V E O F F I C E O F T H E P R E S I D E N T

13-Nov-1996 08:28pm

TO: Carol H. Rasco

FROM: Christopher C. Jennings
Domestic Policy Council

CC: Jill Pizzuto
CC: Claudia M. Rayford-Williams
CC: Molly Brostrom FYI

SUBJECT: RE: Ray Scott

FYI, I have heard about this. Sen. Pryor has been spending a lot of time trying to push funding for this center. I can't remember the source, but it is likely to come out of a large trust from someone who has Arkansas and Oklahoma roots. Bob Butler, former NIA director, is very much involved too. Can't remember much else, but I agree with you, Carol, these are good and committed people...

cj

7/15 ICH Multiple Dx Meeting

1- HUD/HHS - HIV/AIDS Multiple Dx Initiative
- paper being developed → will help guide devlpt of Conf.

2- PATH

3- Best practices piece → Health Care for the Homeless -
- includes focus on multi-dx'd

4- PNS/Ryan White - Hopwa Eval. Ctr

5- College of experts (in conj'n w/ HUD Cont-of-Care)

6- CDC Publications (e.g. TB)

7- HCH Resource Ctr

8- NRC (HMI)

HCH → need to re-generate info dissemination
↓'d apps for ppl @ state/local level to come together
⇒ looking @ ICH web page (in conj'n w/ newsletter + bulletin board)
Centralizing

HHS ⇒ TA Initiative
- Conference / Dissem strategies (web page)
- Resource guide
- Eval Coord / Dissem
- other ?

HUD ⇒ Revisit Priority Home & develop sub-plan for MD
- Discharge planning

DPC ⇒ Look @ Fed / State Coordination w/ respect to fed'l funding
- SSA, HCFA
- blended funding e.g. SUPER NOFA

HHS ⇒ Stand Up

*Site Visits

Interagency Council on the Homeless

Interagency Council on the Homeless
Working Group on Homelessness and Multiple Diagnoses

AGENDA

July 15, 1996

I. Introductions

II. Update on Short Term Actions

- Identification of TA resources for homeless persons with multiple diagnoses
- Use of ICH network of dissemination

III. Clarification of and additions to Long Term Activities Identified at last meeting

- Status of Discharge Planning Working Group

IV. Identification of 4 long term priorities

V. Creation of committees to develop background for each priority

- Define the proposal
- Identify barriers and opportunities
- Estimate costs (financial, personnel, etc.)
- Estimate timeline
- Recommend Agency for leadership

VI. Set next meeting

451 Seventh Street, S.W. ● Suite 7274 ● Washington, D.C. 20410-0000 ● (202) 708-1480