

HEALING HANDS



Photo courtesy of Dawn Cogliser, Medical Unit Manager at Options for Southern Oregon

Care Coordination

Over the past decades, care coordination models have emerged as important tools for health care providers working to better serve the needs of people experiencing homelessness. Historically, health care services have been segmented, meaning that a person seeking health care would have to go to one location for their primary care and different sites for mental health care, addiction treatment, specialty care, or other services. This service acquisition process is daunting for anyone, but it is compounded for people experiencing homelessness.

As the Colorado Coalition for the Homeless observes:

People who are homeless—particularly those with trauma history, mental illnesses, and co-occurring substance use disorders—have substantially greater difficulty navigating these complex service systems. Building trust with a mix of unknown care providers, who may not treat them with dignity and respect, often inhibits persons from seeking care. Furthermore, the impact of psychosocial factors on the body is even greater for people in poverty. Populations of low income are less likely than the general public to accept a mental health definition of their problem. If they do accept a referral for mental health services, they encounter much greater difficulty negotiating travel and scheduling.¹

In response to these difficulties, care coordination has emerged as a method for increasing access to comprehensive health care, particularly for vulnerable populations such as people without homes. This issue discusses some of the benefits of care coordination as well as ongoing and emerging challenges for implementation of care coordination initiatives, and then presents several provider case studies that highlight solutions and emerging strategies in care coordination for clients experiencing homelessness.

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Goals and Benefits of Care Coordination

By creating a treatment plan that addresses both physical and mental health conditions and minimizing the need for complicated travel and scheduling arrangements by providing multiple services at single sites, care providers around the country have created innovative programs that are better suited to respond to the unique needs of people dealing with homelessness.

Despite increases in the number of programs and systems seeking to improve care coordination for patients experiencing homelessness, a recent study found that more than 40 definitions for care coordination exist in academic literature. The study noted, however, that there are five common elements amongst all the definitions, specifically that:

- numerous participants are involved in the care coordination process;
- coordination is necessary when clinicians are dependent upon one another to carry out different patient care activities;
- for activities to be coordinated, each clinician must have adequate knowledge about their own and others' roles and available resources;
- clinicians rely on exchange of information to manage all patient care activities;
- integration of care activities has the goal of facilitating appropriate delivery of health care services.

In order to draw these elements together, care providers have developed a variety of approaches, both theoretical and strategic, to increase the effectiveness of care coordination.

Efforts to provide optimum, multifaceted, but cost-effective care to people who utilize significant amounts of health care services are compatible with holistic, patient-centered approaches and ecological health care models that visualize patients at the center of a network of relationships and challenges. A 2011 Institute for Healthcare Improvement publication reported that:

Time and again, teams have come to the realization that the needs that individuals have are not complex—they are remarkably simple, but often numerous. Typical needs may include transportation to appointments, a refrigerator for storing medications, a telephone to communicate with care providers, nourishing food, and a place to call home. Specialty care for people with

diabetes, cancer, or asthma, methadone treatment, mental health treatment, and issues with food security and housing stability are not in and of themselves complex challenges; the complexity arises when the tasks of making connections among multiple care providers and linking each intervention to the individual's overall care plan fall in the lap of the individual alone without effective partnering or support. Likewise, "non-compliance," through this lens, becomes an individual's attempt to navigate significant barriers to care put in place by the system itself. Quite simply, care coordination reframes the complexity as one posed by the care systems, not by the individuals, and offers an elegant solution in the form of individualized, wrap-around planning and supports. When done effectively, care coordination holds the promise of helping individuals take on more and more of their own health-fostering activities over time, freeing the care coordinator to assist others.³

This can also be envisioned as a shift from a "disease state" mentality to a view that encompasses mind, body, and spirit in totality, and recognizes the reality of multiple comorbidities.⁴ A central goal of care coordination is to meet patient needs and preferences in the delivery of high-quality, high-value care.

Ongoing Challenges for Care Coordination

Despite the spread of care coordination as a patient-centered strategy for improving health outcomes and self-sufficiency, a number of challenges still exist for providers designing

and utilizing care coordination. The Colorado Coalition for the Homeless noted in 2013 that there are clinical barriers (for example, sometimes-conflicting paradigms in physical and behavioral health care systems),

programmatic barriers (such as time constraints, lack of training for interdisciplinary care, information sharing challenges, and concerns about client confidentiality and HIPAA regulations), and financial barriers related to funding and billing⁵—though the emphasis on coordinated care in the Medicaid Health Home State Plan Option, established under section 2703 of the Affordable Care Act, may help mitigate some of these financial concerns for some providers.

Other challenges and complications to care coordination differ from place to place, as the geographies of care provision can vary

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Craig C, Eby D, & Whittington, J. Care Coordination Model: Better Care..., 2011

widely. For example, providers seeking to coordinate care in rural areas may have very different challenges than providers based in urban areas. Some providers face difficulties in coordinating care across county lines. These geographic challenges are compounded when working with highly mobile populations. Difficulties may manifest differently in the varying social and economic contexts of communities, within which the relative difficulty of creating care provider networks and community connections can differ.

Though care coordination is designed to be a patient-centered strategy, it can also present challenges for the patient when it is implemented. First, some care providers worry that patients could be “over-coordinated,” or that patients might be required to tell their story many times to multiple care providers, which could result in retraumatization. Moreover, the logistics of care coordination can be complex from the client’s perspective:

Often patients transitioning from one health setting to another are in poor health, recovering from an illness or injury, or have a new diagnosis that requires ongoing self-management. Once discharged from an acute care setting, patients usually assume primary responsibility for following through with discharge instructions, accessing transportation to attend follow-up appointments, and relaying pertinent medical information to their next provider regarding changes to their health status. As such, continuity of care largely rests on patients’ ability to adequately understand and follow through with care coordination and information sharing across settings. For people experiencing homelessness, care transitions are fraught with obstacles often leading to an interruption in care and resulting in higher health care costs from readmissions and duplications in tests and services.⁶

These difficulties in following through may be compounded by issues related to housing, transportation, health literacy, cognitive impairment, and lack of insurance. Acknowledging these difficulties for the client is key to developing care coordination solutions that help clients navigate these complicated transitions.

Solutions and Case Studies

Conscious of these challenges, many programs are coming up with creative care coordination solutions that acknowledge an “interplay of dynamics that are constantly in motion” rather than “singular disease management;” these holistic approaches emphasize that “individuals are composed of interrelated parts” so “when one aspect (physical, emotional, or spiritual) is off-balance, the individual in totality suffers. The care rendered goes beyond the disease condition to include psychosocial, financial, behavioral, and other considerations that can impact an individual’s health.”⁷ Some evolving elements of care coordination include increasing access and ensuring continuity through all stages of care transitions, using intensive case management

and patient outreach, developing community connections, implementing patient-centered care and trauma-informed approaches, and utilizing new technologies to coordinate care.

Increasing Access and Improving Continuity of Care

Care coordination for people experiencing homelessness often takes the form of increasing access to multiple dimensions of health care in a streamlined way. One strategy is to enhance the immediacy of care by offering same-day access; **Drew Grabham** of Oregon Health & Science University’s New Directions program notes that, “There has to be instant access, especially with primary care.” The efficacy of same-day access can be enhanced by offering a variety of services at a single site. For example, **Matt Tillery** of Cherokee Health Systems explains that on-site at clinics, they are able to provide same-day not only primary care and behavioral health services, but also inpatient/outpatient services for alcohol/drug abuse, women’s clinic services, and a crisis stabilization unit (with transportation provided). This minimizes the amount of planning, travelling, and coordinating required of the patient. For clinics that are



CARE COORDINATION
SPECIALISTS MEET WITH A CLIENT

Photo courtesy of Dawn Coglisler, Medical Unit Manager at Options for Southern Oregon

unable to offer this range of services, providing transportation assistance and appointment accompaniment is an important alternative to help clients transfer between care settings.

Programs are also working to utilize and improve care transition models to ensure continuity of access to health care. Care transitions are a subpart of the broader concept of care coordination, designed to ensure that patients and their caregivers are able to understand and use health information and that those patients are able to move seamlessly from one health setting or provider to another.⁸ **Sabrina Edgington**, Director of Special Projects at the National Health Care for the Homeless Council, notes that medical respite is an example of a care transition initiative designed “to provide post-acute care for people who are too sick to be on the streets or in a shelter, but not sick enough to be in the hospital—people being discharged from a hospital who do need ongoing care but not hospital-level care.” Care coordination is an integral part of medical respite programs, Ms. Edgington explains, because “the medical respite team will try to get a brief history from the hospital and then try to help the PCP become aware that their patient has been seen in the hospital in order to get the PCP involved in the medical respite care plan.” Care coordination can also be used to set up other necessary appointments while in respite, coordinate details like transportation, and ensure that “everybody is speaking the same language and working from the care plan.”

One resource that is increasingly utilized to improve access to and continuity of care is the use of community health workers (CHWs) or peer specialists. According to **Julia Dobbins**, Project Manager at the National Health Care for the Homeless Council, a community health worker is “somebody who is basically a peer worker, somebody who is part of the community they’re serving, so their expertise lies in their experience ... and their ability to connect with the community.” Community health workers can “interpret the health care system in a way that helps other people navigate it” and keep others from falling through the gaps of a complicated health care system. Hiring a community health worker, Ms. Dobbins explains, is a strategy for effective care coordination and care transitions: “CHWs can do the warm handoff from the hospital to the health care clinic, help with housing, benefits, [etc.] ... The CHW is an advocate and has more flexibility to be able to go with the client wherever they go.”

Intensive Case Management and Outreach

Intensive case management models have been proven to be successful for work with homeless populations.⁹ It is “a practice modality which, in coordination with the physical health/mental health/chemical dependency treatment of the clients, addresses the problems and needs associated with the condition of homelessness” by coordinating support services with the goal of “1) helping individuals obtain safe, affordable, and permanent housing; 2) assuring access to treatment services; 3) providing crisis assistance; 4) identifying educational and employment options; and 5) developing a social support network.”¹⁰

Core Principles of Case Management Services for People Experiencing Homelessness

- » Assertive and persistent outreach to meet people on their own turf and on their own terms
- » Active assistance to help clients access needed resources
- » Following the client’s own self-directed priorities and timing for services
- » Respecting client autonomy
- » Nurturing trust and a therapeutic working alliance
- » Small caseloads for case management staff

* Source: Morse, G. (1998). A Review of Case Management for People Who Are Homeless: Implications for Practice, Policy, and Research; in HUD and HHS, Practical Lessons: *The 1998 National Symposium on Homelessness Research*, 7-1 to 7-34. <http://aspe.hhs.gov/progsys/homeless/symposium/7-Casemgmt.htm>.

Drew Grabham is an Emergency Department (ED) Transitional Care Social Worker in the New Directions program at Oregon Health & Science University in Portland, Oregon. The New Directions team is composed of emergency room transitional care social workers who utilize an intensive case management model (as opposed to a traditional medical approach that focuses on presenting problems) in working with clients with high levels of ED usage. The team follows clients for 30 to 90 days, through phone calls, street outreach, and other forms of outreach. In addition to discussing health care goals, Mr. Grabham also works with the clients on issues like housing, harm reduction, transportation, social support, advocacy with state services, other community resources, mental health services, and more, in an attempt to “identify what’s actually driving their ED utilization so that we can customize a sustainable plan.” This brand of intensive case management is designed to “help [clients] have a different kind of relationship with health care providers. We care about them and we want to do things differently so that they can do things differently” (for example, connecting with primary care clinics instead of using the ED or 911 for health support). As hospitals and other health care providers continue to expand models of intensive case management, the multifaceted needs of clients may be better understood and treated.

Community Connections

Shelly Uhrig, the Chief Operating Officer of Options for Southern Oregon, an organization that provides a clinic and other services to clients experiencing homelessness, observes that the landscape of care coordination has changed dramatically in recent

years. Options for Southern Oregon, for example, has “become integrated into more settings, which really expands the potential for coordinated care” as they’ve established a presence in every school in the county, Head Start programs, doctors’ offices, and other community sites. This enables them to gather referrals and expand access to services. Due to this increasing capacity for care coordination, they were able to recently coordinate a single plan across counties, despite the logistical challenges. Building community connections, Ms. Uhrig says, is important both for identifying individuals in need of services and for creating collaborative relationships with community partners who can provide needed services.

Drew Grabham acknowledges that there are a number of barriers to this kind of community collaboration, particularly around shortages of resources like time, expertise, and funds. Efforts pay off, though, he says: “We started out meeting in a coffee shop ... and it has grown to a monthly meeting with hospitals, insurance companies, mental health providers, homeless shelters ... Organizations just come and present about who they are and what they can do and how we can work with them, creating this rich source of information.” They also hold regular forums to talk about service improvement and care coordination between agencies. To other service providers looking to build community connections, Mr. Grabham recommends to “not wait to get invited; just get out there and meet people.” As you introduce yourself to people working in relevant fields, hold meetings and forums, and seek out people who can fill the gaps in your organization’s service menu, he says, “natural partners will emerge and you can offer each other support and backup.” **Matt Tillery** agrees: “Just being out in the field, and actually being a presence in the community speaks volumes ... Going to community meetings and committee meetings, making sure that if you serve children you’re in the Head Start meetings, because otherwise you might be left out of the loop, and more importantly other agencies might be left out of the loop of what you’re doing ... We all need to be out there informing how to do this, and making sure that we’re able to change together as needed.”

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Matt Tillery, Cherokee Health Systems

Patient-Centered Care and Trauma-Informed Approaches

Increasingly, researchers and care providers are discovering that “some of the worst health and social problems in our nation can arise as a consequence of adverse childhood experiences.”¹¹ Categorically referred to as Adverse Childhood Experiences (ACE), traumatic early experiences such as abuse, parental mental illness, domestic violence, loss of a parent, and other traumas can have a

long-term impact on an individual’s mental health. Mounting evidence indicates that “unaddressed early childhood trauma is often an unidentified trigger for mental and physical disease, addiction, and disability in the United States. These traumatic experiences are precursors to and strong predictors of homelessness.”¹² Trauma-informed approaches acknowledge these trauma histories and seek to avoid the retraumatization that can occur in health care settings if patients are shamed, criticized, or mistreated. Mr. Grabham emphasizes that service providers can also help integrate clients into health care systems by “thanking them for coming in to the clinic, acknowledging how much effort it took for them to come to an appointment, and recognizing that they’re busy surviving ... It’s a really big deal to come to an appointment, acknowledging that that’s a choice they made. We want to honor that and empower them and help them know they’ll be welcomed at the clinic.”

CareOregon’s Health Resilience Program is built upon a trauma-informed care approach that

supports accountability and responsibility by recognizing the limitations that traumatic experiences have on one’s ability to make decisions, communicate, and process information. Individuals who have experienced trauma may have difficulty trusting authority figures and tend to fare poorly within traditional health care structures. To engage this group, it is critical to develop a workforce that is aware of the effects of trauma and potential behaviors related to past trauma.¹³

Carissa Williams of CareOregon’s Health Resilience Program notes that a trauma-informed, patient-centered approach is particularly important for people dealing with homelessness, since “this population has complex diagnoses, complex social

situations, often high-risk behaviors,” and that care coordination is an important part of the trauma-informed approach, enabling practitioners to “work as a team to define roles and really streamline care ... by stepping back and looking at the big picture for this person, asking: ‘What’s going on for this person, and what’s our role in helping them achieve those goals? What do they need long-term, and how can we put those pieces in place? Would mental health management help other pieces fall into place? What does this person need to connect with sustainable care?’” Questions like these help the care coordination team “create a more holistic picture of the person—not fragmenting them, not just being diagnostic, but really looking at them as a person.” Ms. Williams notes that care providers who seek understanding of a patient’s circumstances are more likely to help the patient engage successfully with their own health care.

Utilizing Technology to Coordinate Care

Trauma-informed approaches also acknowledge that re-telling trauma histories to multiple providers can be retraumatizing for clients. As Ms. Dobbins notes, “We see a lot of frustration with duplication of services, and not communicating those well. Especially in resource-rich cities, one of the issues we have is that clients would have other case workers at different places, and they weren’t communicating with each other about what was happening about the clients.” This scenario places a difficult burden on patients to consistently communicate their own needs to different providers. Though coordinated care may increase this risk in some cases due to the involvement of multiple providers, technology can also be utilized to decrease the risk. Cherokee Health Systems in Tennessee, for example, utilizes a variety of technologies to make information about clients available to a variety of providers. Not only can streamlining technologies make care provision more efficient and productive, but it also removes the burden from the client of recounting complicated and/or painful health histories.

Matt Tillery, Director of Community Services for Cherokee Health Systems, mentions his organization’s use of EHRs and automatic ADT alerts as essential for scheduling and following up with clients, including “verifying if there’s any discrepancy [in care] or if people are following through the tracks.” They also utilize CareMessaging, a text messaging system for clients who have cell phones with limited amounts of minutes, and provide electronic tables for community health workers to take with them during outreach in order to facilitate assessment and communication. At clinics, they use patient dashboards that are accessible by a variety of care providers, including behavioral health consultants, so that the care plan is all in one place. Mr. Tillery adds that IT teams are a crucial part of care coordination efforts: “We all have so many patients that we are trying to see,” he says, “but having a good, creative IT team who finds ways to make it work for people and make it easy for providers to do their job” is essential to the success of the care coordination team as a whole.

Information sharing is more prominent in some states. For example, in Oregon, state money is combined and accessible for coordinated care organizations, which breaks down many of the barriers to care coordination, according to Ms. Uhrig. CareOregon’s Pop and Tell technology is an example of the kind of database tracking tools that can be developed when these barriers are broken down. Across the country, some community-based programs have access to hospitals’ electronic medical records. Ms. Dobbins notes that this kind of access can be complicated if hospitals are worried about HIPAA, so community connections and relationship-building are important for developing these technological collaborations across agencies and sectors. She recommends working to find the right person in the hospital to communicate with: “Often it’s hospital social workers,” she says. “Their job is resources and connecting clients to resources, so that’s the best go-to place for coordinating care or at least the transition of care from the hospital to the client.”

Information That Should Be Provided Across Care

1. Primary diagnoses and major health problems
2. Care plan that includes patient goals and preferences, diagnosis and treatment plan, and community care/service plan (if applicable)
3. Patient’s goals of care, advance directives, and power of attorney
4. Emergency plan and contact number and person
5. Reconciled medication list
6. Follow-up with the patient and/or caregiver within 48 hours after discharge from a setting
7. Identification of, and contact information for, transferring clinician/institution
8. Patient’s cognitive and functional status
9. Test results/pending results and planned interventions
10. Follow-up appointment schedule with contact information
11. Formal and informal caregiver status and contact information
12. Designated community-based care provider, long-term services, and social supports as appropriate.

* Source: U.S. Department of Health and Human Services. (2011). <http://www.healthbi.com/roadmap-care-transitions-readmissions/>

Conclusions

As care coordination teams continue to acknowledge and work through the complexities of care coordination in a complex health care system, they will be able to continuously improve and streamline a trauma-informed, patient-centered approach to health care. **Carissa Williams** notes that in Portland, there are “a lot of different systems trying to figure this piece out”—including outreach workers in the ED, mental health outreach workers, primary care providers, and other homeless services providers—which means there are a lot of people working with one person. But Ms. Williams says that this process is exciting, and notes that it enables the system to be “able to provide so much more support for people.” Because each person only sees “a little piece of someone,” but “working together creates a more holistic picture of the person ... It helps people get better care.”

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