All Access to Care and Support

RFP for Coronavirus State and Local Fiscal Recovery Funds

RHA Health Services, Inc

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Application Form

Question Group

Buncombe County requests proposals for projects to help the community recover from and respond to COVID-19 and its negative economic impacts.

Buncombe County has been awarded $50,733,290 in Coronavirus State and Local Fiscal Recovery Funds (Recovery Funding)i, as part of the American Rescue Plan Act. This infusion of federal resources is intended to help turn the tide on the pandemic, address its economic fallout, and lay the foundation for a strong and equitable recovery.

Buncombe County is committed to investing these funds in projects that:

- Align to county strategic plan and community priorities
- Support equitable outcomes for most impacted populations
- Leverage and align with other governmental funding sources
- Make best use of this one-time infusion of resources
- Have a lasting impact

Proposals shall be submitted in accordance with the terms and conditions of this RFP and any addenda issued hereto.

Click here for the full terms and conditions of the RFP

Coronavirus State and Local Fiscal Recovery Funds*

Name of Project.

All Access to Care and Support

Amount of Funds Requested*

$12,011,300.00

Recovery Fund Eligible Category*

Please select one:

Enhance behavioral and mental health services

Brief Project Description*

Provide a short summary of your proposed project.

Providing a single point of entry allows for increased collaboration and care coordination for individuals in crisis. RHA Health Services is proposing to increase the hours of operation for the Behavioral Health Urgent Care (BHUC) to resume walk in crisis services that support adults and children 24/7/365. In addition to increased hours of operation and opening up access to eight observation beds, RHA is also proposing to

increase services and supports that are offered at the BHUC to include access to Primary Care, partnering with Pivot Point for access to low barrier shelters for those individuals experiencing chronic homelessness, initiating the IVC process on site to reduce the administrative tasks and time for Law Enforcement and providing community based medical care. RHA will also be working closely with the Health Department and County to offer COVID 19 vaccinations as well as to be a partner in distributing NARCAN to educate and reduce the risk of overdose in our community.

Project Plan*

Explain how the project will be structured and implemented, including timeframe.

Funding for the All Access to Care and Support Project will increase operating hours of the Behavioral Health Urgent Care (BHUC) to 24/7/365. The staffing pattern for the BHUC to operate 24/7/365 will increase to a total of FTE's. The positions will be filled by Registered Nurses, Clinical Staff, Family Nurse Practitioner/Physicians Assistant and a Psychiatrist on site and on call 24/7. The increase in operating hours will allow individuals in crisis to access the 8 beds available on the BHUC unit 24/7 allowing for a more defined and responsive approach to clinical and medical care as well as coordinated community referrals. Primary Care services will also be available at the BHUC and in the community to vulnerable and marginalized populations who have limited or no access to facility based services. In addition to RHA staff being covered under this proposal, Sheriff's Deputies salaries are being included as part of the partnership and expense to allow for the IVC process to be initiated on site, to provide LEO with a chain of custody, and to increase partnerships with the Sheriff's Department, APD, Buncombe County Jail, and EMS.

The implementation timeframe for this project is solely focused on hiring, the physical structure and equipment needs are already in place to seamlessly move to a 24/7/365 service when we have adequate staffing patterns to do so. Our timeline for being fully staffed to provide 24/7/365 care is no later than December 2021.

During the initial ramp up to 24/7/365 and prior to being fully staffed, RHA BHUC leadership will be focused on community implementation efforts around access and collaboration in an effort to increase community partner knowledge to Law Enforcement, Health Department, Jail Staff, Hospital Staff, local businesses etc. so that these partners know how to access support through the BHUC (see attached PPT for LEO).

The total amount of funds requested include the BHUC's operational costs for a period of five years, our annual budget to operate the BHUC 24/7/365 is $2.5 million a year. At this time RHA receives $550,000 a year from VAYA Health. RHA is requesting the use of Coronavirus state and local fiscal recovery funds to assist in funding the remaining operational balance. With this large financial request RHA is committed to seeking out additional sustainability funds throughout the life of the grant to be able to continue this service long term. RHA will work with local county and city governments, VAYA Health, The Dogwood Foundation in addition to seeking out state funding though NCDHHS and federal funding through SAMSHA to remain operational past the life of the grant. If additional funding streams became available during the life of the grant, the remaining funds above and beyond operational costs could be returned to the County and utilized for other community projects. RHA is committed to working with all community partners to continue this needed and already proven successful program.

Statement of Need*

Describe the need that this project will address. Include data to demonstrate the need, and cite the source of the data.

This request for funding will help decrease the community's dependence on costly and potentially ineffective and/or counter therapeutic services and interventions. The All Access to Care and Supports

Project will provide the community and residents of Buncombe County an alternative to incarceration, emergency department drop offs, IVC initiation and increased vagrancy/chronic homelessness by providing 24/7/365 access to crisis services and care coordination through the BHUC. The BHUC will have increased capacity to provide observation, assessment, intervention, stabilization and safety planning with a referral to the next most appropriate clinical/medical level of care. By providing these wrap around services to individuals experiencing a psychiatric, medical and substance use challenge, the BHUC can help eliminate inappropriate referrals by the community and individuals self presenting to an incompatible level of care. The BHUC's focus is on individuals getting the appropriate treatment, at the appropriate time, and in the appropriate amount.

The following data points will provide some historical information regarding access and usage of the BHUC. The BHUC opened in 2016 operating 24/7/365, the first 12 months of operation, 6/2016-5/2017, 2,374 individuals accessed BHUC services. These numbers continued to increase to include 3,206 individuals served from 6/2017-5/2018. 3,694 individuals were supported from 6/2018 -5/2019. From 6/2019 - 3/2020, the ten month period prior to the BHUC changing operational hours to 8-8 M-F, 2,872 individuals were supported during this timeframe. Since the transition of the BHUC schedule from 24/7 to 12/5, the number of individuals accessing supports dipped dramatically to 2,087 individuals over a time period of 15 months (4/2020-6/2021). Increased hours, access and services clearly show that a coordinated community response to addressing mental health, substance use and medical needs has worked for Buncombe County residents.

Link to COVID-19*

Identify a health or economic harm resulting from or exacerbated by the public health emergency, describe the nature and extent of that harm, and explain how the use of this funding would address such harm.

The COVID-19 pandemic and the resulting economic recession have negatively affected many people's mental health and created new barriers for people already suffering from mental illness and substance use disorders. Individuals newly experiencing mental health or substance use disorders and those who already were diagnosed before the pandemic may have required mental health and substance use services but faced barriers such as, widespread social isolation, access to care, ability to pay, concerns of safety and loneliness, all which result in reduced lifespans and an increased risk of both mental and physical illnesses. History has shown that the mental health impact of disasters outlasts the physical impact, today's elevated mental health needs will continue well beyond the coronavirus outbreak, psychological distress can last up to three years after a disaster. Due to the financial crisis accompanying the pandemic, there are also significant implications for mortality due to feelings of despair, additional deaths due to suicide and alcohol or drug misuse are predicted to occur through 2029.

Funding the All Access to Care and Support project will provide the community and individuals access to services and supports 24/7 that will address whole person care, to include medical and mental health services on site as well as offer community based medical/clinical support several times a week to identified populations at high risk for relapse, non-compliance with medication/treatment and those who are chronically homeless and disenfranchised in Buncombe County. Providing an array of services under one roof with an integrated health team eliminates the challenges of access, increases compliance and coordination of care between providers. Funding the BHUC as a best practice program provides our community with a support service that provides effective and therapeutic interventions to all members of our community for their mental health, substance use and medical needs.

Population Served*

Define the population to be served by this project, including volume and demographic characteristics of those served.

The All Access to Care and Support Project at the BHUC will support Buncombe County residents ages 4 and up that are experiencing a mental health, substance use or developmental disability crisis. These support services will be provided to anyone in Buncombe county regardless of the ability to pay. Since the inception of the Behavioral Health Urgent Care in 2016, the average number of individuals supported monthly was 264 when the facility was operating on a 24/7 basis, with the reduced hours of operation, the average number of individuals supported monthly dropped to 139. Adults served are the largest population being supported at 99%, gender is split at 58% male and 42% female, 34% of the population supported at the BHUC have private insurance, leaving the remaining 66% of individuals being supported through state funds. Beginning July 1, 2021 RHA is in network with three of the Medicaid insurance plans that will allow for increased billing through a crisis and BHUC eligible code for these policy holders, this increased insurance coverage will allow RHA to bill and create revenue streams that have not been available in the past. The populations served with regards to diagnosis are 55% substance use only diagnosis, 27% mental health only diagnosis, 18% co-occurring diagnosis, 1% IDD diagnosis. The timeframes throughout the day when the BHUC was accessed the most when the service was 24/7 were between the hours of noon and midnight accounting for 68% of arrivals to the unit, 55% of the individuals also utilized the observation beds for up to 24 hours.

As an agency we are looking to focus on increasing our partnership with our law enforcement partners, working to make communication and referrals to the BHUC seamless, providing ease of access to the BHUC and eliminating any barriers to long drop off times. These efforts will help to ease any burden on their shifts in supporting MH/SU crisis in the community and offering a seamless solution to care.

Results*

Describe the proposed impact of the project. List at least 3 performance measures that will be tracked and reported. If possible, include baselines and goals for each performance measure.

The proposed impact of the Access to Care and Support project will allow for increased access for community partners and individuals. The BHUC operating 24/7/365 will allow individuals access to medical and clinical assessments and ongoing 24 hour care through the use of the 8 bed observation unit. The BHUC with continued partnership, communication and understanding will increase the number of Law Enforcement drop offs for individuals experiencing a mental health or substance use crisis and provide the initiation of and follow through of an involuntary commitment for an individual that is deemed a harm to themselves or others. With an increase in LEO drop offs to the BHUC, RHA would expect to see a drop off in individuals being booked in the county jail for offenses that were potentially related to a MH or SU diagnosis. In addition LEO will be be granted priority drop offs, with a drop off time less than 15 mins. An IVC initiation can begin at the BHUC alleviating LEO of this time and burden. Access to Medical Care on site at the BHUC will allow for underlying conditions to be identified, treated and appropriate referrals made for follow up care. Partnering with Pivot Point provides the BHUC with opportunities to make referrals to transitional housing for the chronically homeless.

The Performance Measures to be tracked and reported include:

1. The number of Law Enforcement drop offs to the BHUC that result in observation unit access and the rate in which these referrals result in a MH/SU level of care recommendation
2. The number of adults accessing the BHUC in a month that result in a referral to onsite BHUC Medical care and the referral follow up rate to a Primary Care Physician.
3. The number of Law Enforcement Drop Offs to the BHUC that resulted in IVC initiation and the IVC determination.
4. The number of Chronically Homeless individuals accessing the BHUC with a SPMI dx that resulted in a referral to Pivot Point and the referral determination.

Evaluation*

Describe the data collection, analysis, and quality assurance measures you will use to assure ongoing, effective tracking of contract requirements and outcomes.

RHA will work closely with community stakeholders to identify data points that will inform best practice and progress toward desired outcomes as it pertains to the success of this program. A data management report will be developed in collaboration with stakeholders and submitted monthly. Currently RHA provides data to multiple sources with regards to the following data points; access numbers, funding source, referrals to/from community partners, collaborative partner drop offs to BHUC, disposition of referral, time in care at BHUC and time to disposition to appropriate level of care. The following data points are calculated for monthly reports to VAYA Health and Buncombe County. With this request for expansion of hours and services, additional data points will be added to data collection and analysis to include referral to/use of primary care, gender, race, age, referrals/successful linkage to Pivot Point, COVID 19 vaccination numbers, NARCAN distribution and IVC initiations. The additional data collection and analysis will align with the three performance measures outlined in the results section of this application. RHA will regularly evaluate data elements to assess their usefulness in informing key factors of the individuals being served and their interface with the All Access to Care and Support Project. This information will be used to identify trends in service delivery and completion, reduced crisis events, community safety and increased pro social functioning among individuals served. Accurate tracking of program outcomes provides an assessment of the effectiveness of available resources, the costs associated with services and potentially an opportunity to create system wide change. The opportunity to analyze outcome data from services provide by our team in the BHUC as related to our community partnerships (Pivot Point, Law Enforcement, Jail services) provides a mechanism for evaluating the overall system of care and coordination among partners.

Equity Impact*

How will this effort help build toward a just, equitable, and sustainable COVID-19 recovery? How are the root causes and/or disproportionate impacts of inequities addressed?

The pandemic's mental health impact has been pronounced among communities of color who also experienced disproportionately high rates of COVID-19 cases and deaths. Prior to the pandemic, Black and Hispanic people were less likely to receive needed behavioral health services compared to the general population (Kaiser Family Foundation, 2020). To address these disparities in access to care, RHA will be implementing a communication, health literacy and public awareness campaign that will be launched to educate the community about BHUC services and supports that will entail Language Translation, providing materials in translated versions, Culturally Tailored Messages that are presented in a culturally-appropriate manner, establishing communication channels where information is accessible and reaches the Black and Latino communities and developing ongoing partnerships with diverse Community-Based Organizations (CBOs). All efforts are focused on inclusion for both our community partners and the individuals supported.

RHA believes that an organization that prioritizes diversity, equity and inclusion creates an environment that respects and values individual differences along varying dimensions. In addition, inclusive organizations foster cultures that minimize bias and recognize and address systemic inequities. RHA is committed to hiring and retaining staff that are culturally diverse and represent the diversity of Buncombe County, initiating and maintaining engagement with culturally diverse organizations such as faith based communities, health centers, housing developments to increase engagement and comfort in accessing services. Diversifying the engagement and treatment options when supporting people of color, recognizing that different approaches and modalities are significant to successful engagement and recovery. Racial equity and inclusion must focus on transforming our organization to fit all people, who we support, employee and partner with in the community.

Project Partners*

Identify any subcontractors you intend to use for the proposed scope of work. For each subcontractor listed, indicate:
1.) What products and/or services are to be supplied by that subcontractor and;
2.) What percentage of the overall scope of work that subcontractor will perform.

Also, list non-funded key partners critical to project.

Pivot Point will be a subcontractor providing low barrier housing (approximately 30 units) to identified individuals that are chronically homeless. Housing will be available to these individuals for up to 90 days and will be available to individuals with a primary diagnosis of a severe and persistent mental illness. Individuals will be referred to Pivot Point through the BHUC and/or enhanced services teams, such as ACTT, CTI or CST. The low barrier housing option for these identified individuals will provide a point in time for the community supporting this individual to be able to be intentional in coordinating care and promoting recovery efforts and engagement. RHA will be the lead agency that will be overseeing the project, hiring the staff to include QP level case managers, Security and Program Manager oversight 24/7/365 to ensure community safety and program integrity.

RHA has successful working relationships with multiple agencies serving a population in crisis. Partnerships include, VAYA Health, HCA/Mission, Buncombe County Office of the Sheriff, Asheville City Police, JFK ADATC, Jail Diversion/Re-entry services, Adult/Family Drug Treatment courts, NAMIWC, ABCCM, Sunrise Community, Our Voice, Western NC Aids Project, Buncombe County DSS, Helpmate and the NC Harm Reduction Coalition. The continuation of these collaborations will be vital in the success of the All Access to Care and Support Project. In addition to collaborating with community partners, RHA also serves on community workgroups and committees that address the needs of individuals with mental health and substance use disorders which promotes relationship building, mutual understanding of services/supports and cross system collaboration. RHA participates and has leadership involvement in Familiar Faces, Homeless Coalition, Safety Net Providers Group, Buncombe County Crisis Providers Group. Mission Hospital High Utilizer group, and Vaya Regional Leadership team.

Capacity*

Describe the background, experience, and capabilities of your organization or department as it relates to capacity for delivering the proposed project and managing federal funds.

RHA has been a comprehensive MH/SU/DD provider in Buncombe County since 2005. We have partnered with VAYA Health, HCA/Mission, Buncombe County and other collaborative partners throughout this time period. RHA along with their partners have been able to address health disparities in our community, provide support for mental health/substance use needs, identify social determinants and provide ongoing care and support to the most vulnerable individuals. In collaboration with VAYA, HCA/Mission and Buncombe County, RHA received a Crisis Solutions Grant in 2015 to begin operation as a Comprehensive Care Center. This comprehensive model includes supporting individuals that are experiencing a mental health or substance use challenge by providing access to multi tiered levels of care. Crisis services are just one of the many supports offered at RHA, with the Behavioral Health Urgent Care (BHUC) being the walk in option for individuals in crisis. The expansion of hours for this program will again allow individuals 24/7/365 access to services, to include the use of the 8 observation units that historically have been the access point for care coordination that begins with a medical, mental health and substance use assessment, access to a 24 hour observation unit staffed by medical and clinical staff and a case management team to assist with needed referrals to identified levels of care. In addition to these services, the All Access to Care and Support Project will also be expanding into providing primary care at this site as well as community based medical care to reach and support marginalized communities. As part of the primary care role, the COVID 19 vaccination, along with Narcan distribution will be part of the the array of services that will be included in this expanded model of care.

Partnering with Pivot Point will allow the BHUC and enhanced service teams to make referrals to low barrier housing for identified individuals with a severe and persistent mental illness.

Budget*

Provide a detailed project budget including all proposed project revenues and expenditures, including explanations and methodology. For all revenue sources, list the funder and denote whether funds are confirmed or pending. For project expenses, denote all capital vs. operating costs, and reflect which specific expenses are proposed to be funded with one-time Buncombe County Recovery Funds.

Download a copy of the budget form HERE. Complete the form, and upload it using the button below.

Recovery-Funds-budget-template All Access to Care and Support.xlsx

Special Considerations*

Provide any other information that might assist the County in its selection.

Buncombe SLFRF.RFP.Pivot Point-RHA Collaboration.docx

File Attachment Summary

Applicant File Uploads

- Recovery-Funds-budget-template All Access to Care and Support.xlsx
- Buncombe SLFRF.RFP.Pivot Point-RHA Collaboration.docx

Coronavirus State and Local Fiscal Recovery Funds
Proposed Project Budget

Organization Name:	**RHA Health Services**
Project Name:	**All Access to Care and Support**
Amount Requested:	**$8,408,680 (Requesting 5 years of funding) Grant request of $1,681,736 per year for All Access to Care and Support Project)**

Proposed Project Revenue Funder	Amount	Confirmed or Pending?	Notes
Proposed Buncombe COVID Recovery Funds			
State/Federal Non-UCR VAYA Health	$ 550,000.00	Confirmed	Yearly Commitment
Other Private Insurance/Third Party	$ 3,000.00	Pending	Revenue based on assumptions from previous years revenue
Medicaid	$ 75,000.00	Pending	Revenue based on assumptions from previous years revenue and additional revenue expectations due to transformation
List other sources here			
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Total	$ 628,000.00		

Proposed Project Expenses	Proposed Recovery Funds	Other Funds	Total	Capital or Operating Expense?	Notes
Salaries/Wages/Benefits	$ 1,362,769.00	$ 250,000.00	$ 1,612,769.00	Expense	Staff Wages and Benefits for 22.63 FTE's
Contracted Personnel	$ 300,000.00		$ 300,000.00	Expense	Psychiatrist and Physician
Equipment	$ 3,967.00		$ 3,967.00	Expense	IT Maintenance/Support and Repair
Facilty	$ 15,000.00		$ 15,000.00	Expense	Utilites/Communication/Internet/Fax/Postage
Supplies and Materials		$ 43,640.00	$ 43,640.00	Expense	Office Supplies, Janitorial, Linens and Laundry, Client Food Expense
Medical Supplies and Materials		$ 11,860.00	$ 11,860.00	Expense	Prescription Drugs, Drug Tests, Non Prescription Drugs,
Other Supplies and Expenses		$ 300,000.00	$ 300,000.00	Expense	Deputy Expense, Travel Expense for Clients to access Care
Travel		$ 10,000.00	$ 10,000.00	Expense	Staff Travel Reimbursement
Personnel and Recruiting		$ 5,000.00	$ 5,000.00	Expense	Recruitment and training
Marketing and Public Education		$ 7,500.00	$ 7,500.00	Expense	Marketing, culturally relative materials and language translation
List expenses here			$ -		
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Total	$ 2,309,736.00		

Pivot Point/RHA--Collaborative Project Overview

RHA, a Buncombe County based organization, has a significant regional footprint and established reputation for quality, comprehensive, integrated behavioral services for vulnerable populations. Pivot Point offers a **low-barrier, Housing First "bridge" housing model that efficiently, safely, aesthetically, and immediately provides basic, hygienic micro-shelters and robust wrap-around services for chronically homeless adult individuals**. RHA and Pivot Point, two non-profits with a shared mission and vision, are proposing a synergistic collaboration to significantly improve outcomes by facilitating access to behavioral/SUD/IDD and physical health/wellness services for those identified with a qualifying disability in accordance with HUD criteria. Through this arrangement, RHA will serve as the lead agency and subcontract with Pivot Point to establish a continuum of care that combines primary health and wellness, urgent behavioral health services, immediate bridge housing, and a number of other supports…including (but not limited to) training and education for appropriate employment, personal financial management, and independent living; nutrition; peer navigation for established human services; and focused case support to address barriers inherent in many Social Determinants of Health (SDoH). The ultimate **outcome measure of success for Pivot Point will be the throughput of residents to Permanent Supportive Housing in 12 months or less, pending availability.** Residents entering PSH from the bridge housing portal of entry will be able to continue with the supports established while in bridge housing (if they choose).

Amount of Funds Requested from RHA as Lead Agency

$3,602,620 total request for 3 years ($1,200,873 average per year)

Recovery Funding Eligibility Category

The Pivot Point Bridge Housing Project is relevant, directly and indirectly, to many of the Recovery Funding Eligibility Categories through its broad array of wrap-around services. The broad scope of funding impact by the Pivot Point/RHA collaboration is significant to all of the categories listed below:

- Prevent and mitigate COVID-19
- COVID-19 treatment and medical services
- Enhance behavioral and mental health services
- Support local health and safety workforce
- Improve the design and execution of health and public health programs
- Address disparities in public health outcomes

- Assistance to households
- Assistance to unemployed workers
- Improve efficacy of economic relief programs
- Services for disproportionately impacted communities

Nevertheless, RHA and Pivot Point will share **"Enhance behavioral and mental health services"** as our designated Recovery Funding Eligible Category for the purposes of this collaborative application.

Project Description

Pivot Point proposes an innovative, bridge housing solution for chronically homeless adult individuals that offers an immediate, low-barrier (harm reduction based), best practice option that will serve as a model for NC and throughout the nation. Pivot Point strongly embraces the Housing First model to "build lives" in addition to just "roofs overhead". To accomplish this, Pivot Point proposes to build two 15-unit micro shelter villages (total of 30 individual beds) that will be situated on approximately 2 acres of property in the Swannanoa area (property acquisition negotiations are currently underway). Essential wrap-around services will be provided by RHA and a wide array of community partners. The villages will be gender specific and gender identity (LGBTQ/Binary/Trans) accommodating. Pets which are healthy and vaccinated will be accepted after screening by a veterinarian. Micro-shelters will be built upon on mobile platforms that are easily relocatable if needed and can offer flexibility in allocating beds according to each separate village as demand for beds fluctuates. 24/7 on-site non-uniformed security will be retained and secure privacy fencing with controlled access/egress will be maintained. Limited power for lighting and basic needs (battery charging outlets, etc.) will be resourced by solar panels in each village, allowing for off-grid village locations.

Additional services for regular garbage and recycle collection will be provided. Two meals per day will be provided along with semi-weekly services retained by Hope Vibes, a mobile shelter hygiene vendor. On-site access to clean portable bathrooms, resident showers, and laundry machines will be retained.

A comprehensive clinical assessment (CCA) and individual treatment plan will be developed through on-site POS telehealth connectivity using mobile iPads (including pharmacy/medication support) and staffed by RHA. Support services utilizing SOAR resources, Peer Support, Case Support, NCCARE360, Employment and Housing Specialists will be among the array of health/wellness/medical/community services available to residents on an ongoing basis. Regular planning and communication with Vaya as NC Medicaid transformation rolls out will be ongoing. Tailored plan enrollment for this complex need population will be a top priority.

Project Plan

If awarded funding under the Buncombe CSLFRF RFP, Pivot Point will adhere to the program performance standards set forth by the federal Department of Housing and Urban Development Continuum of Care (CoC) [24 CFR 578.7(a)(7)] and monitored by the Balance of State (BoS) CoC.

Program Elements:

I. Access/Eligibility/Process

- Program eligibility, prioritization, and access will be determined through the established NCBoS coordinated assessment system using the VI-SPDAT for triage priority of individuals with the longest histories of homelessness and complex co-occurring issues.
- Policies and procedures for admission, diversion, referral, and discharge will be in place.
- Coordination guidelines for communication and collaboration with emergency shelters, transitional housing programs, essential service providers, homelessness prevention programs, rapid rehousing programs, and permanent supportive housing programs will be adopted.
- Applicants identified as meeting HUD chronically homeless criteria [42 U.S.C 11360(9)] will be eligible for enrollment.
- Applicants with a physical/developmental disability as defined in the DDA Assistance and Bill of Rights Act 2000 will be assessed by a qualified clinical evaluator. Decisions whether to accommodate will be made with consideration given to the physical plant and the qualifications of support staff. Safety of the resident and appropriateness of the services provided will guide the admission decision.
- Development of low barrier enrollment policy and guidelines to include stipulations and review process for exceptions.
- Pivot Point staff will be trained in and participate in the CoC Homelessness Management Information System.

II. New Resident Contract Agreement/Orientation

- Pivot Point resident contract with rights and responsibilities, confidentiality agreement, and release of information consent
- New resident information packet and Pivot Point Village orientation check list
- Resident handbook to include rules and regulations including policies for program disqualification, early exit requests, complaint/grievance resolution
- Resource directory of SDoH supports (e.g., public transportation, food banks, clothing resources, hygiene/laundry services, SOAR contacts, employment resources, financial management advisors, free legal services, etc.)
- Daily resident program schedule/calendar
- Establishment of mailing address and mail center support

- Develop resident file check list and personal information template with plan for secure record storage
- Written philosophy statement regarding adoption and adherence to Housing First and Person-Centered Recovery practices
- Internet and cell phone access and usage guidelines
- Village self-governance/mutual support plan with available community task assignments (as appropriate)

III. Security/Emergency Response Plan

- Comprehensive Fire/Safety/Security Plan delineating emergency response procedures safety resources (e.g., security agency staffing, fire plan, law enforcement support plan, health emergency response plan)
- Policy regarding guest access and sign in
- Privacy fencing and monitored access/egress

IV. Health and Hygiene Support

- Primary healthcare and pharmacy resources with medication security procedures
- Hygiene services support plan (e.g., bathing, toileting, laundry, trash/recycle removal)
- Nutrition food resource support with daily meal plan
- Access to health and needed supports via on-site telemedicine and internet connectivity
- ACTT and Critical Time Intervention services will be delivered as requested and authorized by Vaya Health

V. Case Support/Peer Support/Transition Planning to PSH

- Co-development with resident participation of an individual work plan to achieve transition to PSH within a 6–12-month timeframe
- Assignment of individual RHA case support staff and peer navigators
- Create Life Skills Building curriculum to include basic interpersonal relationship and communication skills and job search capabilities
- Post staffing schedule on a weekly basis
- Schedule routine virtual interdisciplinary/interagency meetings to discuss resident progress and challenges (to include the resident as appropriate)
- Ensure ongoing external communication activities with key stakeholders to nurture relationships, solicit input, and offer feedback

VI. Timeline

- Grant funding awarded 8/31/2021
- Initial funding disbursement schedule established—30 days
- RHA subcontract executed—60 days
- Operations Manager hired—60 days
- Site lease secured/executed—90 days
- Zoning approval received—90 days
- Site preparations complete—90 days
- Furnishings/resident supplies procured—90 days
- Vendor contracts in place—120 days
- HMIS enrollment/training complete—120 days
- Coordinated access system established—120 days
- New staff hires/orientation/training complete—120 days
- Resident applicant assessments initiated—120 days
- Policies and procedures manual complete—150 days
- Form/file templates/orientation materials completed—150 days
- Shelter unit construction complete and on site—180 days
- Resident lease agreements executed—180 days
- Initial resident occupancy begins—180 days
- Wrap-around service supports initiated—180 days

Statement of Need

The chronically homeless are widely recognized as among the highest (and repeated) utilizers of emergent/urgent responders (e.g., law enforcement, EMTs, fire departments, hospital emergency departments, mobile crisis workers, etc.). Yet, these costly interventions fail to address the foundational health and housing needs of many of the most desperate in our society. Unfortunately, this not only is a tremendous (and avoidable) burden on stakeholder agencies and taxpayers, it also feeds a recalcitrant perspective and cynicism regarding human services amongst many long-standing homeless individuals. This can lead to a lack of engagement and compliance with siloed assistance efforts, as well as ongoing high rates of recidivism.

This scenario is steadily reflected in the annual chronic homelessness PIT data for AVL/Buncombe County. While the total number of homeless was slightly down from 2020-2021 by 4%, the number of unsheltered homeless was up by 78% to 116 and the number of chronically homeless went up 40% to 154. The increases were driven to an extent by COVID-19 and the limits on shelter capacity. However, many were driven into chronic homelessness by the impact of the pandemic itself. Nevertheless, the % of chronic homeless individuals has remained fairly level in the years prior to the pandemic at about 20% of the total homeless count. The lack of progress in elevating the numbers placed into Permanent Supportive

Housing has resulted in a continued erosion of HUD CoC ESG funding in spite of the inability to reduce the % of those HUD has classified as chronically homeless in our region.

Emergency shelters continually turn away chronically homeless individuals who are difficult to manage in congregate settings. Landlords are well known to maintain lists of those who have been disruptive and/or destructive to property, therefore refusing to lease affordable housing to the most vulnerable individuals with disabling conditions.

The difficulty in developing capacity for Permanent Supportive Housing can delay access to this option to individuals and families for months, if not years. Bridge housing offers interim, immediate, cost effective housing with timely access to essential health and welfare services.

Link to COVID-19

Chronic homelessness has been present in our community for many years prior to the COVID pandemic. However, the severe physical health, mental health, economic, and family structure/stability system impacts of COVID are far reaching and without significant interventions, will exponentially increase the recurring generational cycles of future homelessness.

Specific links to chronic homelessness include:

- Capacity reduction in emergency shelters for over a year resulting in individuals resorting to living conditions unfit for human habitation
- Substantial increases in domestic violence and crime
- Overwhelming increases in SUD, especially alcohol and opioid abuse
- Lack of viable economic security and jobs with livable wages
- Profound disparities of health and economic disadvantages for people of color
- Public health system and human service capacity limitations and staff burnout from volume of need with few options for assistance

Population Served

This project will offer low barrier bridge housing to the chronically homeless, as defined by the following HUD criteria:

(1) an individual with a disability as defined in section 401(9) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11360(9)) who: (i) lives in a place not meant for human habitation, a safe haven, or in an emergency shelter; and (ii) had been homeless and living as described in (i) continuously for at least 12 months or on at least 4 occasions in the last 3 years, as long as the combined occasions equal at least 12 months and each break in homelessness separating

occasions included at least 7 consecutive nights of not living as described in (i). Stays in institutional care facilities for fewer than 90 days will not constitute a break in homelessness, but rather such stays are included in the 12-month total, as long as the individual was living or residing in a place not meant for human habitation, a safe haven, or an emergency shelter immediately before entering the care facility;

(2) an individual who has been residing in an institutional care facility, including jail, substance abuse or mental health treatment facility, hospital, or other similar facility, for fewer than 90 days and met all of the criteria in paragraph (1) of this definition, before entering that facility.

Results

Outcomes will be routinely measured, reported, and corrective actions will be addressed in team communications and planning to ensure targets are met and exceeded.

Performance indicators will include reduction in urgent/emergent episodic care, reduction in hospitalizations, reduction in law enforcement encounters, improvements in physical and behavioral assessments of health, resident satisfaction with services and engagement, and length of time to PSH placement (12 months or less) with sustained housing stability for the year.

In addition, the following HUD CoC System Performance Measures will be tracked and reported:

- Returns to Homelessness—People that are permanently housed, but end up back on the streets
- Average length of time spent in bridge housing (goal is 9 months)
- Obtain and maintain PSH following Pivot Point bridge housing residency

Evaluation

Pivot Point will gather data from HMIS and a variety of other contact sources in order to track encounters and outcomes. Contract requirements will be outlined in a spreadsheet format with a dashboard summary for reporting. Collaboration with the UNCA Health and Wellness Department will be initiated to tap into the data collection, processing, analysis, and reporting expertise which was extremely valuable to Buncombe County in the development of the current 5 Year Strategic Plan on Homelessness.

Equity Impact

The following is an excerpt from a May 18, 2021 ACT article by Joel Burgess entitled **Asheville homelessness down overall, but unsheltered and 'chronic' homelessness is up**:

"The 2021 data reflect a dramatic decrease in the number of people in shelters and transitional housing, and a corresponding increase in the number of people who are unsheltered," said the report by Interim Community and Economic Development Director Nikki Reid and Homeless Services System Performance Lead Emily Ball.

In one section, Reid and Ball talk about "the elephant in the room": that "30% of people identified in the 2021 count were Black, Indigenous and People of Color," a reflection of city government's recent focus on discrimination and equity. The staffers attributed the disparity to "systemic racism."

Asheville is 11.2% African American, while the whole county, including Asheville and other municipalities, is only 6.3% Black, according to 2019 U.S. Census data that does not include information on race from the 2020 census that has not yet been released."

The proposed impact of this project will be tracked and measured in the near term through objective performance indicators. However, the true impact of the initiative, especially to disproportionately impacted people of color and historically underserved neighborhoods in our community must be measured of years, if not generations. The root causes of inequities are socially, politically, economically, and educationally woven into the fabric of our culture. Only acknowledgement of the issues and enlightened leadership offering innovative solutions will avoid a future of expanding homelessness from the lingering effects of the COVID-19 pandemic, both locally and throughout the world.

Project Partners

In addition to working with RHA as our lead agency, we are fortunate to have the following organizations supporting our efforts:

- Redline Design Group—Architectural firm based in Charlotte, NC (pro bono)
- Barringer Construction—Full-service construction firm based in Charlotte, NC (pro bono)
- Diego Schemel—Affordable Housing Real Estate Developer based in Asheville, NC (property lease still under negotiation)
- Hope Vibes—Charlotte, NC based non-profit provider of mobile hygiene services for vulnerable individuals and families (10-15% of service expenditure)

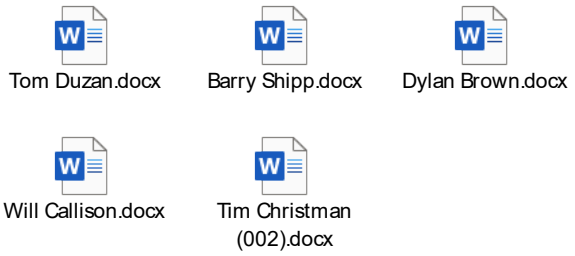
- Axis Incorporated—Security staffing agency recently contracted to provide housing security at the Red Roof Inn (15-20% of service expenditure)

Capacity

Pivot Point will benefit from the full support of RHA in the delivery of this initiative, including its corporate expertise and guidance from its Asheville headquarters. As a key contracting provider for Vaya Health, RHA has an excellent track record for a full continuum of BH/SUD/IDD services in our community and throughout our state. It will play a major role as a large, fully integrated healthcare system provider which will play a significant role in NC Medicaid transformation and management of complex need populations through the Tailored Plans. RHA has been awarded numerous grants over the years by major public and private funding organizations. It will be a reliable steward of the Buncombe CSLFRF resources, and maximize the potential for achievement of measurable outcomes, while ensuring financial sustainability through billable services to meet the needs of the chronically homeless.

While a newcomer to the arena of bridge housing, Pivot Point has quickly established credibility in the Charlotte area for offering an innovative and fresh new approach to the long standing and quickly expanding presence of homeless residing in encampments and on the streets. Our board brings together years of expertise in community healthcare management, architectural design, marquis construction projects throughout NC, and over 20 years of homeless outreach service from our visionary founder, who is a proud Navy veteran and a man of color who has lived experience with homelessness and a passion for elevating lives from out of a hopeless abyss to the dignity that accompanies recovery, resilience, self-sufficiency and productivity.

The bios below give a snapshot of our Pivot Point Board Executive Committee and its capability to provide the strong, caring leadership necessary to blaze new trails in Buncombe County that lead to lasting solutions to put chronic homelessness behind us so that more resources can be devoted to enhancing the fullness of life that many of us are privileged to enjoy in WNC.



Proposed Budget and Total Funding Requested for 3 Years of Operation

Copy of Will Callison
Recovery-Funds-budg