Executive Summary

The Appalachian Regional Coalition on Homelessness (ARCH) proposes to develop an AmeriCorps program serving in Carter, Greene, Hancock, Hawkins, Johnson, Sullivan, Unicoi and Washington Counties, Tennessee, that will focus on the CNCS focus areas of Economic Opportunity, Healthy Futures and Veteran and Military Families. The CNCS investment of $74,419 will be matched with $27,620 in public and private funding. No AmeriCorps members will be needed to execute this plan.

Rationale and Approach/Program Design

1. Need

The Appalachian Regional Coalition on Homelessness (ARCH) was established in 2003 by the U.S. Department of Housing and Urban Development (HUD) as the designated local planning body, Collaborative Applicant and Homeless Management Information System (HMIS) Lead Reporting Agency for the Appalachian Regional Coalition on Homelessness Continuum of Care (CoC) service providers located in the First Congressional District of Tennessee consisting of Carter, Greene, Hancock, Hawkins, Johnson, Sullivan, Unicoi and Washington Counties, TN.

In 2009, the McKinney-Vento Homeless Assistance Act (Act) was amended by the Homeless Emergency Assistance and Rapid Transition to Housing Act (HEARTH Act), which consolidated three separate HUD homeless assistance programs (Supportive Housing Program (SHP), Shelter Plus Care program, and Section 8 Moderate Rehabilitation Single Room Occupancy program) into a single grant program, known as the Continuum of Care (CoC) Program. Additionally, the Emergency Shelter Grants Program was revised and renamed the Emergency Solutions Grants (ESG) Program. The amended Act also codified into law the CoC planning process, a longstanding part of HUD CoC application process to assist persons experiencing homelessness by providing greater coordination in response to their needs. A critical aspect of the amended Act is a focus on viewing the local homeless response as a coordinated system of homeless assistance options as opposed to homeless assistance programs and funding sources that operate independently in a community. The Act also requires CoCs measure their performance (in HMIS) as a Coordinated System in addition to analyzing performance by specific projects or types. To be considered homeless, a person must be sleeping in a place not meant for human habitation (i.e., living on the streets) or in an emergency shelter. Chronic homelessness is defined as an unaccompanied homeless individual with a disabling condition who has either been continuously homeless for one year or more or has had at least four episodes of
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homelessness during the past 3 years. An episode is a separate, distinct, and sustained stay on the streets or in an emergency homeless shelter. Disabilities, at least as they relate to homelessness, often include serious mental illness, substance abuse problems, and HIV/AIDS (Burt et al., 2004).

Provisions in the CoC Program interim rule at 24 CFR 578.7(a)(8) require CoCs to design a Coordinated Entry (CE) System that is easy for people to access, that identifies and assesses their needs, and that people with the greatest needs receive priority for any type of housing and homeless assistance available in the CoC, including Permanent Supportive Housing (PSH), Rapid Rehousing (RRH), and other interventions as rapidly as possible, while connecting them to mainstream programs. Mainstream means not targeted specifically to people experiencing homelessness. Examples include: economic assistance programs (i.e., Temporary Assistance for Needy Families (TANF), Supplemental Security Income (SSI)/Social Security Disability Insurance (SSDI), emergency assistance, Medicaid, public housing and Housing Choice Vouchers, workforce services, food support, etc.). The CE process is linked to street outreach efforts so that people sleeping on the streets are prioritized for assistance in the same manner as any other person assessed through the CE process. The CE process ensures client immediate needs, such as housing, are assessed and addressed quickly first (Housed First), and continue to be regularly assessed for ongoing service needs through case management. Furthermore, all people in the CoC geographic area must have fair and equal access to the CE process, regardless of where or how they present for services, meaning people can easily access the CE process, and the process for accessing help must be well known.

ARCH implemented its Coordinated Appalachian Resource Extension or CARE CE System in a phased approach, focusing first on establishing CE Access Points at four sites most frequented by the homeless in the three major Cities in ARCH CoC, Johnson City, Kingsport and Bristol, then staffed sites with Assessment Specialists. ARCH office in Johnson City is the primary CE Access Point for the large homeless Veteran population with mental health, substance use disorders, and psychiatric history (85% average between 2010-2015) who are exiting the Healthcare for Homeless Veterans (HCHV) Program from the James H. Quillen, Veterans Affairs (VA) Medical Center (VAMC), located just a few blocks from the ARCH office. Veterans are referred from VAMC to ARCH where the CE Assessment Specialist screens for eligibility, performs assessment to determine need, assists Veterans obtain housing through housing search assistance and immediately refers to wraparound services and move in funds (Supportive Services for Veteran Families (SSVF) RRH funds, coupled with HUD-VA
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Supportive Housing (HUD-VASH) PSH). Wrap-around service delivery is a team-based, collaborative case management approach, which is a point-of-delivery, rather than a system-level, approach to coordination of primary, mental, behavioral health services, substance abuse treatment, peer support, and other services specifically associated with the homeless population. It is a philosophy of care with defined planning process used to build constructive relationships and support networks among the homeless with emotional or behavioral disabilities.

A second Assessment Specialist is staffed at East Tennessee State University (ETSU) Johnson City Downtown Day Center (JCDDC), a Community-based mental and primary healthcare clinic where the homeless population are referred for the aforementioned wraparound services including HIV testing. As CoC HMIS Lead Agency, ARCH is required to perform an annual Point-in-Time (PIT) Count of the homeless and report these findings to HUD. The 2016 PIT demonstrated a drastic increase in homeless unaccompanied youth (age 18-25), from 0 in 2015 to 25 in 2016 who are IV-drug users, and who regularly present to JCDDC for services. HUD defines this population as youth who do not qualify as homeless under other categories but who are homeless under other federal statutes, including the Runaway & Homeless Youth Act, who have not had their own place with a lease, ownership interest or occupancy agreement in the last 60 days; have moved two or more times in the last 60 days; and can be expected to have continued housing instability because of a disability, substance use addiction, history of domestic violence or child abuse, or two or more barriers to employment.

The third CE Assessment Specialist is located at the Salvation Army shelter in Kingsport, as it provides CE accessibility to the general homeless population and is also the location of ARCH VA Per Diem (VAPD) Grant for homeless Veterans, a Transitional Housing (TH) program (limited to 24 months with intensive case management). Using the CE System, homeless Veterans from VAMC HCHV Programs (Domiciliary, Intensive Work Therapy Programs, etc.) are referred to the Assessment Specialist in Kingsport for assessment and VAPD TH placement.

The fourth Access Point is located at the Salvation Army in Bristol where homeless Veterans, unaccompanied youth, individuals and families from both Bristol, TN and Bristol, VA present to the CE Assessment Specialist for access to housing, mainstream and wraparound services.
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The second phase of implementation of the CE System will focus on providing fair and equal access to the outlying counties by placing Assessment Specialists at the Upper East Tennessee Human Development Agency (UETHDA), Community Action Partner (CAP) or Neighborhood Service Centers as they are commonly known, located in each of the eight Counties, which are well known to rural families seeking assistance. The partnership with the Neighborhood Service Centers will provide a portal for CE and subsequent housing and wraparound services in the outlying areas. There are no additional resources available to ARCH to staff these positions through any other State or Federal agency. Without AmeriCorps member assistance, ARCH is unable to provide accessibility, subsequent housing and wraparound services to rural target populations. ARCH CoC area, with two of eight counties designated as distressed (having twice the national poverty level and twice the national unemployment rate), is underserved by AmeriCorps.

Mental illness, co-occurring disorders and/or IV drug use are the underlying causes of homelessness; if not addressed with necessary housing and wraparound treatment, this vulnerable population will experience recurrent episodes of homelessness and exacerbation of behavioral and health issues.

2. Evidence-Based Intervention

In recent years, the United States Interagency Council on Homelessness (USICH) and HUD have identified rapid re-housing (RRH) as a critical strategy to meeting the national goal of ending family homelessness by 2020 (USICH 2013). As noted in a recent update of Opening Doors, the federal plan to end homelessness, US Department of Health and Human Services (HHHS), HUD, the US Department of Veterans Affairs (VA), and USICH have joined forces to promote expansion of rapid re-housing as a part of community coordinated systems (emphasis on coordinated systems) . . . (USICH 2013). Rapid re-housing, an intervention that helps homeless families exit shelters and get back into permanent housing quickly, provides short-term help with housing expenses (e.g., rent arrears, ongoing rent assistance, moving costs) and case management focused on housing stability . . . The emphasis on rapid re-housing represents a significant shift in the response to family homelessness toward a Housing First philosophy (Cunningham, Gillespie and Anderson, Rapid Re-housing, What the Research Says, Urban Institute, June 2015).

The Housing First Model was first studied in Randomized Controlled Trial (RCT) Housing First, Consumer Choice, and Harm Reduction for Homeless Individuals with a Dual Diagnosis, by Sam
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Tsemberis, PhD, Leyla Gulcur, PhD, and Maria Nakae, BA, published in the American Journal of Public Health, April 2004, Vol. 94, No. 4. The results demonstrated homeless clients served in CoCs using the Housing First model exhibited lower rates of homelessness; obtained housing earlier, remained stably housed (first group sustained approximately 80% housing retention rate), and reported higher perceived choice. Once settled in housing, families receive time-limited, transitional in home case management services whose primary aim is to connect families with mainstream programs that can meet their needs (Einbinder & Tull 2005). In addition to housing stability, other important outcomes for Housing First programs are reductions in the frequency and severity of psychiatric symptoms, the use of drugs and alcohol, the level of impairment related to substance use, as well as positive changes in client income and self-sufficiency.

The premise of Housing First approach is that clients who are rehoused and stabilized as rapidly as possible through a (CE) process that provides immediate referral, housing search assistance and move in funds, achieve housing stability and are better prepared to address their mental illness and substance-related issues. Housing First provides the homeless accessible, effective, coordinated permanent supportive housing and peer recovery support with service integration and delivery using an Assertive Community Treatment (ACT) team approach. ACT consists of social workers, nurses, psychiatrists, vocational and substance abuse counselors, peer counselors and mental, behavioral and primary health professionals. The ACT Team consists of a lead agency who acts as the coordinator and connects clients to other team members for wraparound services (mental, primary, behavioral, substance abuse, peer support, SSI/SSDI Outreach Access and Recovery (SOAR) rapid attainment of SSI/SSDI benefits), and collaborative case management. The Housing First Model implements supportive services that facilitate housing first, then treat and manage mental health and substance abuse disorders. This model has been experimentally tested and demonstrated increased stability in housing of homeless, greater engagement with services and service providers, and better retention in treatment programs (Morse, 2004).

In 2016, ARCH, partnered with East Tennessee State University (ETSU) Johnson City Downtown Day Center (JCDDC), to develop a Housing First Evidence-Based Proposal (EBP) for submission to SAMHSA Cooperative Agreement to Benefit Homeless Individuals (CABHI) Grant. ARCH was awarded the CABHI grant in July 2016 and began September 30th to implement the following Housing First goals: 1) reduce barriers to obtaining permanent housing for Veteran and non-Veteran
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homeless individuals; 2) Reduce barriers to access mental health and substance use services for Veteran and non-Veteran homeless individuals. 3) Increase the accessibility of education, screening and if necessary, treatment, for Sexually Transmitted Diseases amongst CABHI consumers at the Johnson City Downtown Day Center; 4) Implement an ACT Team (with ARCH as Lead Agency) with JCDDC delivering medication support; psychosocial treatment; community living skills; health promotion; family involvement; housing assistance; employment or SSI/SSDI as appropriate; and Crisis Services to include Crisis Stabilization Unit, Calm Center, and Crisis Hotline.

ARCH will maintain fidelity in planning Housing First EBP as the lead (connecting or coordinating) agency, collaboratively providing housing case management and referral to JCDDC for mental health, peer support, behavioral health, substance abuse treatment, and ongoing case management. Specifically, a plan for AmeriCorps members to assist with carrying out the following four basic EBPs of Housing First will:

1. Provide a process for the direct, or nearly direct, placement of targeted homeless and chronically homeless Veterans, individuals and unaccompanied youth into permanent housing. Even though the initial housing placement may be transitional in nature, i.e. the VAPD Program, the Housing First model ensures the client is housed permanently through the use of available PSH funds. Eight AmeriCorps members will be ideally suited as Assessment Specialists at CAP Neighborhood Service Centers and one each at ARCH, JCDDC, Bristol and Kingsport Salvation Army at CE Access Sites. Members with backgrounds or seeking Bachelor of Social Work (BSW) and Masters in Social Work (MSW) degrees, Human Services, Psychology, Nursing or Public and Allied Health, will be ideally suited to assess this target population. Assessment Specialists will be thoroughly trained in the use of the HMIS standardized screening tool, HMIS data standards entry, and Vulnerability Index-Service Prioritization Data Assessment Tool (VI-SPDAT), the assessment used to determine targeted population housing and primary, mental and behavioral health needs. Based on assessment results, Assessment Specialists will refer target population to JCDDC for mental health, substance abuse treatment, and peer support, employing the ACT Team Wraparound Philosophy of Housing First. Members will be trained in utilization and update of ARCH Caspio Database, a dynamic list of area RRH, PSH and mainstream providers and their available services, criteria, and eligibility requirements; this Database also includes Landlords, which will ensure Assessment Specialists directly refer target populations to landlords who have available, appropriate units. Assessment Specialists will
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be introduced to and trained in making connections to Temporary Assistance for Needy Families (TANF), Survivors Supplemental Insurance (SSI) and Social Security Disability Insurance (SSDI), emergency assistance, Medicaid, public housing and Housing Choice Vouchers, workforce services, food support, and other mainstream benefits. Additionally, members will be trained in HUD and VA PSH housing case management procedures to assist tenants secure and maintain public benefits and entitlements by helping with paperwork; obtaining required documentation; escorting tenants to appointments; advocating on their behalf with relevant public agencies; and assessing the impact of earned income on benefits (annual recertification for all PSH and subsidized housing).

2. While supportive services are to be offered and made readily available, the program does not require participation in these services to remain in housing. Once in housing, a low demand approach accommodates client alcohol and substance use, so that relapse will not result in the client losing housing (Marlatt and Tapert, 1993). If s/he chooses not to move forward with an assessment of needed mental health and substance abuse services, then Assessment Specialist will offer housing assistance only services. Assessment Specialists will be trained in Motivation Interviewing techniques to ensure fidelity to this EBP.

3. The use of assertive outreach to engage and offer housing to homeless people with mental illness who are reluctant to enter shelters or engage in services. ARCH Outreach Director leads the Outreach Team in conducting weekly outreach to areas frequented by the homeless population to engage and refer to housing homeless assistance agencies, and ensure they have government phones, food, blankets, etc. An AmeriCorps member, most suitably a Veteran due to the large Veteran encampments in and around the VAMC area in Johnson City, with a background in Public and Allied Health or BSW and/or seeking a MSW degree, will be well suited to be trained as a mobile Assessment Specialist to perform Screening Intake and VI-SPDAT in HMIS on I-Pad, and in appropriate Motivational Interviewing and Critical Time Intervention techniques for this particularly vulnerable population. One FTE AmeriCorps member with a Marketing, Communications or Public Relations background, will be suited to train and assist in appropriate development of HUD-eligible marketing strategies (which) include informational flyers left at service sites and public locations, announcements during CoC or other coalition meetings, and educating mainstream service providers (https://www.hudexchange.info/resource/4427/coordinated-entry-policy-brief), to inform street homeless of access site locations and hours, toll-free number (1-844-989-CARE); he/she will also
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maintain contact with the target population through social media, i.e. Facebook, Twitter, and ARCH webpage, which the homeless access on government-issued phones.

4. The continued effort to provide ongoing case management, even if they leave housing. One FTE AmeriCorps member, with a background in or studying Social Work is well-suited for placement at JCDDC as ACT Care Manager, who will be thoroughly trained to lead and coordinate the activities of the ACT Team and be primarily responsible for establishing and maintaining a therapeutic relationship with a consumer on a continuing basis, whether the consumer is in the hospital, in the community or involved with other agencies. In addition, the Care Manager will be the team member responsible for being knowledgeable about consumer life, circumstances, goals and desires. The care manager develops and collaborates with the consumer to write the person-centered treatment plan; ensures that changes are made as the consumer needs change; and advocates for the consumer.

ARCH is a Housing Opportunities for Persons with AIDS (HOPWA) subgrantee, which is a PSH housing program for clients with documented diagnosis of HIV. ARCH HOPWA Coordinator will encourage target populations with HIV diagnosis and IV drug users to attend HIV/STD awareness classes and consent to semiannual HIV testing at ETSU JCDDC. One FTE AmeriCorps member recruited from East TN State University Dept. of Public and Allied Health or School of Nursing will be well suited to be trained to assist HOPWA Coordinator to implement annual HIV/STD community awareness and connect target population with Ryan White Program on a continual basis.

3. Planning Process/Timeline:
ARCH, Lead Agency for the CoC, Executive Director, Anne Cooper, will be the Program Director and will lead the planning process. In 2016, ARCH was awarded Substance Abuse and Mental Health Services Administration (SAMHSA) Cooperative Agreement to Benefit Homeless Individuals (CABHI) grant, with Housing First EBP as proposed in this AmeriCorps planning grant. The CABHI grant requires the formulation of a Steering Committee to facilitate the implementation of the CABHI Housing First model, and this Committee will also lead the AmeriCorps Planning effort.

0-3 Months: Steering Committee will assist the Project Director to formulate a job description for the recruitment of an AmeriCorps Program Development Coordinator to be hired immediately. Steering Committee will perform need analysis of CoC for possible partner sites, and plan a recruitment strategy for AmeriCorps members. ARCH Board Chair, Dr. Susan Grover, ETSU College of Nursing,
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will lead the recruitment initiative by establishing subcommittees for different departments, i.e. Social Work, Psychology, Public Health, etc. The Steering Committee will meet bi-monthly.

3-6 Months: Program Director will pursue partnerships and develop Memorandum of Agreement (MOA) and renew Facility Use Agreements (FUA) already in place with Salvation Armies, and establish relationship to develop FUA and MOA with Neighborhood Service Center for ARCH AmeriCorps placement. Program Director will network with CoC partners to assess need for AmeriCorps. Program Director and Finance Director will review Financial Policies and Procedures, draw request forms, time sheet and consult with Auditor to set up AmeriCorps chart of Accounts. Outreach Director will plan and implement Public Relations, Fund Raising Plan, present to Board and begin to spearhead an AmeriCorps Awareness Campaign at various events.

6-9 Months: Project Director will assist and oversee AmeriCorps Development Coordinator to formulate a Human Resource System specific to AmeriCorps Program Policies, specifically Employee Handbook, Job Descriptions, staff orientation and training, staff retention, member responsibilities, volunteer policies, and asset management policies. Homeless Programs Director will articulate step-by-step, written job-specific procedures for AmeriCorps positions. Project Director and AmeriCorps Development Coordinator will attend Human Resource Training to ensure compliance with Federal and State employment laws to develop eligible AmeriCorps benefits package, and compensation, in addition to seeking Technical Assistance for preparation for the AmeriCorps program. AmeriCorps Development Coordinator will develop AmeriCorps Training Modules on Disaster Preparedness, Workplace Safety, Winter Safety, OSHA requirements, Cyber Security, and Employment In-Service, Fire Safety, etc.

9-12 Months: ARCH Homeless Programs Director (certified SOAR trainer) will have developed and present annual SOAR training, Critical Time Intervention, Motivational Interviewing, Trauma Informed Care, VI-SPDAT, PSH and RR Training, and assist HMIS Systems Administrator with annual HMIS training. Outreach Director will recruit PIT Volunteers and organize annual PIT training and outreach. Steering Committee will hold AmeriCorps recruitment fair.

How Planning Period will be used to Develop Necessary Components. ARCH Homeless Programs Director, Outreach Director, and Housing Navigator will continue to liaise with the VAMC Homeless Programs and SSVF, and other RRH and PSH Service providers to refine the flow of the ACT Team Wraparound Service Model referral process and service delivery connection. HMIS Systems Administrator will add participating agencies contact information for email notification of referral via
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HMIS with special attention paid to Release of Information and HIPPA. Homeless Programs Director will design and implement referral forms among the different agencies (ACT Team) for various services and develop Excel spreadsheet to record outcomes that cannot be captured in HMIS, i.e. VAPD Veterans in Transitional Housing referred to Peer Support meetings. Schedule for Peer Support meetings will be established as well as transportation to and from, coordinated with Outreach Director. A Triage format with scheduled intake, VI-SPDAT, and Housing Case Management will be designed with established dates and times across the various CE sites, as well as schedules established for JCCDC wraparound services, particularly clinical. HIV-STD risk awareness and HIV testing will be incentivized with condoms (HOPWA-funded), and tracking mechanism (Excel spreadsheet) devised as all non-HMIS Program specific activities must be recorded.

Development of Theory of Change/Logic model. ARCH will implement the Housing First model with fidelity by following both evidence-based intervention practices with the addition of HUD requirements for PSH programs within the CoC. Expected outcomes are 1) greater consumer choice; 2) lower rates of homelessness; 3) increased number placed into housing; 4) lowered rate of substance abuse; 5) reduced episodes of psychiatric episodes; and, 5) Increased duration of stay (housing stability) with the addition of wrap-around services (SOAR, VA Disability, Peer Support, Mental Health, Substance Abuse Treatment.) Concurrently, the connection to permanent housing for clients with mental illnesses, will provide the necessary stable environment to increase attendance at substance abuse treatment/meetings and maintain mental health appointments. 6) ETSU will provide known IV drug using consumers of the Day Center with HIV screenings. ARCH Coordinated Access/HOPWA Coordinator will assist clients with HOPWA application and recertification process. Expected outcome is increased number of HIV-positive population housed and increased number of tests performed with decreased number of positives.

Member Selection and Training Plan. The AmeriCorps Development Coordinator will immediately begin to implement a member selection and training plan under the direction of the Project Director.

Member Supervision Plan. ARCH will utilize CNCS Toolkit for Supervisors in order to provide clear expectations and goal setting for members; continue regular check-ins, reviews, and communication; develop coaching of members, and perform useful evaluations. ARCH Program Director will complete and follow Core Competencies Modules for Planning and Documentation (Welcome new members;
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Handbook 101; Demystifying Projects, Plans and VADs, Checklist for Member Files, and Time Sheets/Time Away Forms); Creating Effective Members (coaching, communicating and problem solving); Monitoring and Evaluating members (setting goals and expectations, ongoing monitoring, and performing evaluations); and Working with Host Sites.

Commitment to AmeriCorps Identity. If awarded, ARCH will identify as an AmeriCorps Program and incorporate the AmeriCorps logo and ARCH logo which will be prominently displayed on all printed material, letterhead, business cards, website, Facebook, etc. AmeriCorps members will wear the AmeriCorps logo daily on provided shirts. AmeriCorps members will create and deliver elevator speeches.

Compliance and Accountability. ARCH will comply with AmeriCorps rules and regulations including those related to prohibited and unallowable activities at grantee, subgrantee and service site locations. ARCH performs regular monitoring of all grants to ensure compliance with all federal and state grants. ARCH provides written standards to the CoC to ensure overall compliance with grant guidelines. ARCH holds all funding agencies harmless from accountability and maintains professional and general liability insurance at all ancillary sites.

Securing Match Support for the Program. ARCH has HUD and CABHI grants which allow matching; additionally, ARCH charges 2% participation fee to all HMIS users for licensure, administration, training and hosting of the database. This amounts to approximately $53,000 annually. Other resources include rent from ARCH-owned building, approximately $32,000 annually.

Assessing Fidelity, Outcomes and any New Outcomes: ARCH HMIS Systems Administrator will establish a minimum set of standards and expectations in terms of the quality expected of projects and will adapt HMIS as necessary to capture the following outcomes achieved in previous Pathways to Housing EBP evaluation: 1) greater consumer choice over time; 2) (a) lower rate of homelessness; (b) achieved and sustain greater residential stability; 3) lower rate of substance use on exit than prior to entry (modified from Pathways measure, which compared usage to that of control group; 4) client participation in fewer substance-abuse treatments over time (than the control group i.e., because substance abuse treatment is not a precondition for the Housing First model, it was expected that there would be a lower rate of service utilization for the experimental group). HMIS will modify this
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to increased number of treatment sessions attended as this is a key component of ACT application; (5) rate of psychiatric symptoms exhibited similar to or lower than those of the control group (will be modified to reduced episodes of psychiatric symptoms, based on case management file). And, new outcomes anticipated: 7) an increase in the number of clients entering Peer Recovery Support with correlating decrease in drug-related arrests and decrease in re-incarceration; and 8) an increase in the number of HIV tests performed with decreased number of positives.

Organizational Capability

ARCH currently administers six federal grants: HUD Homeless Information Management Information (HMIS) grant; HUD CoC Planning Grant; HUD Permanent Supportive Housing Grant; HUD Emergency Solutions Grant (ESG); VA Grant Per Diem (ARCH is Grantee of VA Per Diem Grant with MOU in place with Salvation Army of Kingsport); and CABHI Grantee with contracts in place with subcontractors ETSU Day Center, Insight Alliance, and Evaluator. ARCH was a $2M awardee of Supportive Services for Veterans and Families (SSVF) Grant from 2012-2016, and has acted as an AmeriCorps host site since 2014; AmeriCorps member still performs Veteran Intakes. The Ex. Dir. established, planned, supervised and managed four ARCH offices, including one in Woodstock, VA, and 3 in Tennessee, with 22 employees, including the AmeriCorps member and various partner agency employees through staffing MOAs, and designed facility use MOAs. ARCH ensures financial compliance by tracking spending of all budget line items with every subcontractor draw request, specifically correlation of hours and activities; enforces operating line-itemed Budget Addendum Requests. Subcontractor Management Plan, Financial Management Plan, Communication Plan, and Outreach Plan are in place. HMIS Administrator provides quarterly Data Quality reports and Annual Performance Reports are provided to CoC organizations and used for training purposes to improve quality of delivery. As Collaborative Applicant, ARCH provides Systems Performance Measure Report to CoC Steering & Ranking Committee, who formulate scoring criteria for annual CoC- application process. Applicants are scored based on rank.

Cost Effectiveness and Budget Adequacy

ARCH proposes to hire a full-time Program Development Coordinator, who will begin to develop the AmeriCorps Program immediately upon award notice. Under the direction of the Executive Director/Project Director, s/he will coordinate and communicate the AmeriCorps Program to inform recruitment partners and local stakeholders/service providers within the CoC. The Program Development Coordinator will research, develop and execute a timeline for training, and assist
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Program Director to implement necessary management mechanisms, and policies and procedures to immediately place members upon FY18 award. HMIS Systems Administrator will build and monitor appropriate reporting module, HMIS training, HMIS software integration and data quality standards. This is HUD-funded and eligible for match; 20% FTE @ $50,470 = $10,094/yr plus $3,146 fringe = $13,240. Program Development Coordinator, 100% FTE @ $43,000/yr. plus $8,689 fringe = $53,689; Prog. Dir 10% FTE = $7,242 + $2,034 fringe = $9,036. Total salary and fringe = $75,965.

Travel in company vehicle to mandatory meeting in Washington DC and vicinity total: Gas $219; 2 staff members X $600 lodging (3 nights) = $1,200 plus $69 per diem X 2 staff X 3 days = $414. Total = $219 + 1,200 + $414 = $1,833. ARCH owns a vehicle; it is more economical and quicker to drive than fly from TN to Washington, D.C. and in the area.

Supplies necessary to operate the AmeriCorps program include office supplies $396 and two AmeriCorps shirts each for Program Development Coordinator and Outreach Director, plus setup fee. HMIS module fee to capture EBP components and Caspio software for CE billed at 6% usage rate determined by $75,000 Americorp funding)/$1,157,744 total annual funding (less contractors).

Evaluator, funded under CABHI grant at $45/hour X 200 hours = $9,000; 10% CSNS performing evaluation = $900; 90% CABHI = $8,100.

Communications calculated at actual cost per employee allocation; Program Development Coordinator 100%, Project Director 10% of cost of I-pad and I-phone data fee and VOIP line fee. Internet service calculated at 6% overall use allocation. Space calculated at 160 sf X $1.15 X 12 = $2,208 X .10 (Prog. Dir) = $221; 160 sf x $1.15 X 12 = $2,208/yr (Prog. Coord.); HMIS Systems Adm. 160 sf X 1.15 sf X 12 = $2,208 X .20 FTE = $442; Util.$15,800 yr X 6% use allocation = $948. Total: $221 + $2,208 + $442 + 948 = $3,819

In addition to HMIS ($113,170); Planning ($46,603); HOPWA ($32,631); CABHI (ARCH portion is $189,728); VA Per Diem Grant (administrative up to $34,000 based on bed days); ESG ($150,000), and was recently awarded additional CoC-funded $43,498 HMIS grant and $93,583 Permanent Supportive Housing grant. ARCH has never been delinquent on federal debt.

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Short Description of Theory of Change

The Housing First Model implements supportive services that facilitate housing first, then provide treatment and management of mental health and substance abuse disorders. The Housing First Model posits that providing a person housing first stabilizes them and creates a foundation on which the process of recovery can begin. Housing First entails providing chronically homeless populations accessible, effective, coordinated permanent supportive housing and peer recovery support with service integration and delivery using an Assertive Community Treatment (ACT) team approach.

Outcomes of Interest

Expected outcomes of the Housing First Model are 1) removal of barriers to entry resulting in greater consumer choice; Coordinated Entry will ensure clients are not screened out of housing if they chose not to participate in behavioral or mental health or substance abuse treatment; clients will be rapidly rehoused through the Coordinated Entry process by connecting them to rapid rehousing providers (or utilizing ARCH rapid rehousing funding) to the housing situation of their choice; 2) decreased time spent on the streets; 3) decreased rates of homelessness through the use of both rapid rehousing and assertive outreach; 4) increased number placed into housing; 4) lowered rate of substance abuse; 4) reduced episodes of psychiatric episodes; and, 5) with the addition of wrap-around services (SOAR, VA Disability), increased duration of stay (sustainability); 6) connection to immediate permanent housing for clients with mental illnesses, using a harm reduction model whereby clients are not prevented from entering or lose their housing if using, will provide the necessary stable environment to promote attendance at substance abuse treatment/meetings and maintain mental health appointments; 7) an increase in the number of clients entering Peer Recovery Support with correlating decrease in drug-related arrests and decrease in re-incarceration; and 8) an increase in the number of HIV tests performed with decreased number of positives.

Research Questions to be Addressed

The following Pathways Housing First Model research questions will be addressed:
1) What effect will the removal of barriers to entry have on the ability of consumers to have a choice in housing over time? 2) (a) what effect will providing no barriers to entry through a Coordinated Entry process and providing rapid entry to housing have on the rate of homelessness? (b) Will clients
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sustain greater residential stability? c) Will there be a reduction in repeated episodes of homelessness? 3) Will the connection to wraparound services and stable housing result in a decrease in substance use? 4) Will following a harm reduction model whereby clients are not required to attend substance abuse treatment result in an increase or decrease in peer support and substance abuse attendance? 5) What effect will stable permanent housing with wraparound mental health services have on client exhibition of psychiatric symptoms and HIV symptoms? 6) How effective is assertive outreach coupled in getting street homeless off the street and into housing?

Study Components
The Outcome Study Design will be utilized as it includes qualitative and quantitative collection data, which, ARCH, as Homeless Management Information System (HMIS) Lead, collects for all service providers in the CoC. The Outcome Study Design components will include review of program documents and records; review of administrative data; interviews of focus groups; and direct observation. Thematic analysis of interview transcripts using IBM SPSS Statistics 23 and Qualtrics will be used to evaluate client interviews regarding consumer choice, Colorado Symptom Index (for psychiatric symptoms), and substance abuse Treatment Services Interview. Coding and thematic analysis will be used to document review of Coordinated Entry intake forms and screening assessments (Vulnerability-Index, Service-Prioritization Data Assessment); referral forms to Providers; exit/entry /re-entry data reports, and case notes extracted from HMIS; review of member activity logs, outreach logs, and referral logs to analyze immediacy of housing delivery, status and tenure; and, review of Drug and Alcohol Follow-Back Calendar to evaluate substance abuse usage. Evaluator will perform on-site interviews of JCDDC staff quarterly and will utilize Thematic Analysis of the interview transcripts to review fidelity to service delivery method.

The Cooperative Agreement to Benefit Homeless Individuals (CABHI) grant, funded under the Substance Abuse and Mental Health Administration Services (SAMHSA), provides the basis for the implementation of the Housing First Evidence-Based Practice (EBP) Model and integration with the AmeriCorps Housing First Program. An Evaluator is required for CABHI and has been retained. Request for Qualifications was published in the local newspaper and to the Continuum of Care with the following requirements: Evaluator must be PhD level and an expert in the field of behavioral health treatment, research and evaluation and will analyze collected data and report using the
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Government Performance Reporting Act (GPRA) Center for Substance Abuse Treatment (CSAT) Collection Tool. He/She must be experienced in behavioral health treatment, research and evaluation, and knowledgeable about the targeted homeless populations. Evaluator will be paid at $45 per hour. Dependent upon contract start date, the first six (6) months of the project is for a maximum total of $3,000. The maximum pricing per year for this project is $9,000. Further submission requirements were listed. The CABHI Steering Committee used an unbiased review process to rank submissions, and Dr. Joy Drinnon, PhD, Milligan College Department of Psychology, was chosen. Dr. Drinnon will act as evaluator for the AmeriCorps extenuation of the CABHI Housing First Evidence Based Practice. Ten percent ($900) of her reimbursement is applied to CNCS share; the other ninety percent ($8,100) is provided through CABHI.

Amendment Justification

N/A

Clarification Summary

As Collaborative Applicant of the Appalachian Regional Coalition on Homelessness Continuum of Care (ARCH CoC), ARCH is responsible for performing an annual HUD-mandated point-in-time count of the homeless in its 8-county service area (Carter, Greene, Hancock, Hawkins, Johnson, Unicoi, Sullivan and Washington Counties). According to the 2017 annual Point-in-Time (PIT) Count, there were 442 homeless persons in ARCH CoC during a single 24-hour period beginning at noon on January 24, 2017 and ending at noon on January 25, 2017. One-hundred-eighty-six adults with no children, including 41 Veterans were in emergency shelters and 118 adults with no children were unsheltered (street homeless.) Of the unsheltered adults, 46% reported a serious mental illness (SMI); 31% a substance use disorder (SUD); 1% with HIV/AIDS, and 53% were victims of Domestic Violence. SMI and SUD are the major underlying causes of homelessness for all populations, which increases exponentially among the Homeless Veteran population. Annually, 81% of Veterans in the VAMC Homeless Programs reported alcohol and drug use with psychiatric history (co-occurring disorder or COD) and 70% reported a history of incarceration. Drug use in Tennessee, specifically opioid, is the highest in the nation. According to the Tennessee Department of Mental Health and Substance Abuse Services, the largest age group with Opioid treatment in calendar year 2014 was 12-17 years old; on average, 14 of every 10,000 children between the ages of 12-17 enter treatment for Opioids in Tennessee, and in Washington, Sullivan and Johnson Counties, that rate is 78 of every 10,000. Approximately 75% of these youth are homeless runaways. Heroin, a cheaper form of opioid,
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has become the drug of choice among the unaccompanied youth (18-24) population. Prevalent SMI and SUD among the homeless population has had a negative effect on all of the communities burdening law enforcement, emergency rooms, drug courts (including Veteran Drug Court), probation, mental health clinics, health departments, EMS, and human service organizations. The drug-addicted population has become a health hazard to the public at large. For example, IV-drug users have been banned from public libraries as they were injecting and disposing used needles in the trash; they are now back on the streets, congregating in abandoned buildings, parking lots, day centers, soup kitchens, etc., putting the general population at risk for spreading HIV, Hepatitis and sexually transmitted diseases. Law enforcement has been forced to staff special task forces to deal with not only vagrancy but resulting criminal drug activity. Emergency rooms have become clogged with the homeless, in and out, repeatedly, as EMS and law enforcement have no other recourse. ARCH Outreach Staff recently spent two weeks trying to get one homeless person off the streets. Due to extreme mental illness, he was evicted from the Salvation Army and was roaming the streets, behaving erratically. The police could not take him to jail as he was not harming himself or anyone else; and in order to admit to mental health in-patient facility, the Crisis Stabilization Unit had to evaluate him at the ER; however, a person must be willing to go of his own accord. After assessed by Crisis Stabilization, it was determined he was not grossly psychotic, and he was released. He was subsequently back on the street a few hours later and the cycle began again the next day. The shelters, who traditionally have served the homeless, are overwhelmed as well. Shelters do not staff licensed clinical staff and are therefore not equipped to handle drug related psychotic outbursts or overdoses. Consequently, chronically homeless with SUD won't go to the shelter. The school systems are burdened with the fall-out from children of homeless parents, many who are children themselves, including behavioral outbursts, drop-out rates and youth in the juvenile justice system. In summary, there is a dire need for the development of a Crisis Response System using the Coordinated Entry System as the access point in ARCH CoC to prevent negative outcomes associated with homelessness and accompanying SMI, COD and SUD.

Continuation Changes

N/A

Grant Characteristics