July 16, 2020

Dear Colleague:

I am pleased to share with you our *Phase 2 Report, 24/7 Continuous Access Drop-In Center* year-end final report recently submitted to the New York City Department of Health and Mental Health.

Like all of us, in this last quarter of the fiscal year, we conducted our work within the nebulous shadow of COVID-19. I am proud to report that not only was St. Ann’s Corner of Harm Reduction (SACHR) able to adapt and provide critical services during the pandemic, but SACHR was also able to innovate and to continue data collection and essential reporting about the future of harm reduction and community.

Our continuing work is a testament to the organization’s strength and adaptability, implemented by a team of courageous and committed professionals, supported by a far-sighted board of directors, an embracing community of partners, including individual donors, foundations, City and State agencies, and, by the participant members of our programs.

Sincerely yours,

Joyce Rivera

Joyce A. Rivera, ABD, MA
Founder/CEO

Attachment
ACKNOWLEDGEMENTS

This feasibility study for a Bronx 24/7 Continuous Access Drop In Center was funded by the New York City Department of Health and Mental Hygiene. The authors appreciate the close collaboration with multiple City offices and agencies in conducting this feasibility study, especially from the Office of the Mayor, the New York City Council, and the New York City Department of Health and Mental Hygiene. We also appreciate the support and leadership of Councilmember Rafael Salamanca, Jr. (Council District 17) and Councilmember Diana Ayala (Council District 8).

This report represents the voices, ideas, and commitment of thought partners throughout New York City. We are grateful to the community leaders, stakeholders, and SACHR participants that have shaped this report and the future of public health in New York City.

DISCLAIMER

The substance and findings of this work are dedicated to the public. St. Ann’s Corner of Harm Reduction and its subcontractors are responsible for the accuracy of opinions, statements, primary data, and interpretations contained in this publication and these do not necessarily reflect the views of New York City government of any SACHR partners or funders.

RECOMMENDED CITATION

Phase 2: Bronx 24/7 Continuous Access Drop In Center
St. Ann’s Corner of Harm Reduction – Bronx, New York
This report was submitted to the New York City Department of Health and Mental Hygiene, July 15, 2020

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24/7 CONTINUOUS ACCESS DROP-IN CENTER PROGRAM

COMMUNITY PARTNERS & STAKEHOLDERS

The authors of the Feasibility Study for the Continuous Access Drop In Center are grateful to the following organizations and affiliations for their guidance during the stakeholder engagement process:

1. Bronx Pride Festival, Inc.
2. 161st Street Business Improvement District
3. Acacia Network
4. Affinity Health Plan
5. AQC Architects
6. BBRG, LLC
7. Boogie Down Pride
8. BOOM! Health
9. Bronx Muslim Center
10. BronxCare
11. Concern Citizens of Community Board
12. Destination Tomorrow
13. Fordham Gospel Mission
14. Harlem United
15. Harm Reduction Coalition
16. Health and Hospitals Corporation – Lincoln Hospital
17. Holyrood Church/Iglesia Santa Cruz
18. Immaculate Conception Catholic Church
19. ISJ Development Group
20. La Iglesia De Dios
21. Masjid al wadud
22. MetroPlus
23. Mott Haven Merchants Association
24. Mott Haven Reformed Church
25. New York Police Department
26. Nos Quedamos
27. NYC BID Association
28. Office of Assemblymember Carmen Arroyo
29. Office of Congressman Jose E. Serrano
30. Office of Councilmember Diana Ayala
31. Office of Councilmember Rafael Salamanca, Jr.
32. Office of Senator Gustavo Rivera
33. Office of the Bronx District Attorney
34. South Bronx Alliance
35. South Bronx Overall Economic Development Corporation
36. Southern Boulevard Business Improvement District
37. St. Jerome’s Church
38. Take Back the HUB
39. The Bronx Borough President’s LGBT Taskforce
40. The Bronx Chamber of Commerce
41. The Bronx LGBTQ Caucus
42. The Bronx Private Industry Council
43. The HIV League
44. Third Avenue Business Improvement District
45. VIP Services
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EXECUTIVE SUMMARY

This report documents and describes St. Ann’s Corner of Harm Reduction’s (SACHR) efforts to create a harm reduction-based 24/7 Continuous Access Drop-In program in the South Bronx, the CADI program.

This report presents findings from the second phase of a multi-year study and implementation process commissioned by New York City. This was a rapid, mixed-methods assessment that took place from July 2019 through July 2020. SACHR’s model for service provision, methods of evaluation, and community engagement process were adapted in March 2020 at the onset of the Coronavirus (COVID-19) pandemic. The impact of COVID-19 has been noted in the report as SACHR explores the meaning of having continuous access to care pre and post pandemic.

SACHR provided a deeper continuation of programming and evaluation to create a 24/7 CADI Center and front end community engagement to design approaches that dispel stigma and address community concerns that often accompany sitting drop-in centers. The implementation program is incremental by design and evaluates programs and services offered while also creating meaningful mechanisms for community engagement and neighborhood development.

Phase 2 of the CADI Program worked with existing and new program participants to provide an outlook into existing and new services, the system capacity to deliver services effectively, gaps in capacity and staffing, and participant and stakeholder experiences with the existing approach and guidance for future planning scenarios.

The idea of a drop-in center is not a new one; indeed, the history of 24-hour drop-in programs in New York City is not one that provides great optimism about the long-term success of such programs. SACHR, however, is a harm reduction program whose guiding philosophy and principles have led to the development of an approach that is different from the institutional actors who have typically worked on the front lines of “managing” at-risk populations that they see as “dangerous.” From their perspective, “clients” are not people with whom they seek to develop long-lasting or meaningful relationships; no, they are to be feared, scanned for weapons, and processed as quickly as possible along a conveyor belt to “recovery.” SACHR offers an alternative path forward; always meeting an individual where they are at.

The concept of creating a 24/7 Continuous Access Drop-In Center during a pandemic turned models on their head and forced the question of equitable service distribution as the primary driver of dialogue and accelerated SACHR’s plans to enhance telemedicine, decrease the digital divide among staff and participants, and rethink tools of evaluation and community engagement. Amid the devastation of COVID-19, SACHR did not panic amid crisis – rather the organization adapted and minimized disparities where possible while charting a new course for the future of harm reduction and how continuous access care is implemented.

METHODOLOGY // EQUITY & ECONOMIC IMPACT

The decision to suggest a multi-year planning and implementation program to the NYCDMH RFP for a 24-hour facility reflects a nuanced understanding of the community as organic and interdependent; where the voices of the renter class (new and old), the owner class (new and old), the merchant class, and the discredited class (the poor) can be harmonized into a respectful co-existence.

As outlined in the Phase 1 Feasibility Study, the phase 2 methodology using an economic impact and equity lens would:

• Continue Phase 1 service provision with continuous access hours and programs;
• Selection and development of the site with the consideration and advisement of community stakeholders;
• Broadened linkages to anchor health institutions to reduce reliance on emergency rooms for nonemergency events;
• Program strategy that is centered around the person, their quality of life, and community based equity strategies.

BACKGROUND

Equity and neighborhood wealth are intrinsic to equitable public health outcomes.

Over the last 20 years, The Bronx has seen record economic growth and unprecedented levels of public and private investment. Both population and job growth in the borough have outpaced New York City during this time. The Bronx’s population has grown by 26% since 1980, compared to 22% citywide and the borough has seen a 27% increase in job growth since 2010 compared to 20% citywide. While the borough has grown, so too have levels of investment in real estate. Since 2009, $18.9 billion has been invested in development, leading to the addition of 36,000 housing units and the creation of commercial hubs for established and emerging industries. Additionally, over 50% of the more than 45,000 new housing units built in The Bronx since 2009 are affordable units. Over 115,000 more Bronx residents are working today than in May of 2009.

Pre-COVID-19, the New York State Department of Labor reports that The Bronx’s current unemployment rate is 5.4%, down from a reported 14.1% in 2009. Pre-COVID-19, we have even seen The Bronx’s unemployment rate dipped as low as 5%, the lowest unemployment number The Bronx has ever seen. The Bronx is on a trajectory of growth and economic opportunity that will continue to make the borough more competitive locally and globally for the foreseeable future.

This record of economic growth has not touched everyone. In many cases, it has left behind large swaths of community residents, largely communities of color. As the tale of two cities continues to widen, organizations like SACHR must not only build and provide comprehensive community based public health programs, but we must also continue to address disparities which have only been highlighted with recent events.

For the purposes of the Continuous Access Program SACHR has focused on the South Bronx’s 149th Street and Third Avenue – the HUB. The Hub in the Bronx is a bustling shopping destination for many Bronx residents. It is also the center for opioid and substance overdoses in the Bronx and New York City. The immediately surrounding neighborhood – a community of color with 67% Hispanic and 29% black residents – has a 46% poverty rate, one of the highest rates in the city. The borough’s COVID case rate is higher than the citywide average, and its unemployment rate increased from 4.9% to 16.5% between January and April 2020.

The 2020 COVID-19 pandemic and the murder of George Floyd highlighted racial injustices and widening disparities in our communities of color – the very communities that SACHR has served for over thirty years. In deploying programs and services to participants, not only is SACHR addressing public health challenges, but has now shifted the paradigm to address the digital divide, equitable access to telehealth, remote ordering for harm reduction kits for participants, online counseling and socializing programs, syringe exchange programs, and adapted buprenorphine partnerships with institutions like BronxCare. The events of March 2020, compounded already several health disparities with the perfect storm of lack of resources and infrastructure for our communities.
Of compelling importance is how we transform the differences most deeply embedded in structural racism that so perniciously inflicts disproportionate disparities on some members of our population to the detriment of all. More and more we ask, and are asked, how our outcomes reduce the disproportionate burden placed by racial disparities. Yet we struggle with translating these policies and protocols into practice; into action, as the divide based on racial inequities widens across all social and economic sectors.

Our neighborhoods were already challenged by systemic racism and lack of resources compounded with public health issues, COVID-19 underscored how disenfranchised the Bronx really is. Health disparities and comorbidities associated with metabolic syndromes, such as obesity, hypertension, and cardiovascular disease, are all well documented as contributing to the health burden of racial and ethnic minorities. This compounded by gross income disparities, food insecurity, housing insecurity and lack of infrastructure like technology has made the call for equitable continuous access to services even more important and timely.

COVID-19 morality has impacted all races, but statistics show a disproportionate mortality rate among African Americans and Hispanic/Latin Americans. For African Americans, the mortality rate is at least 2-fold higher than any other racial group in the United States, and notably, mortality rates are lowest among Caucasian Americans. The disproportionate mortality rates among African Americans compared with other racial/ethnic groups remained consistent, despite the region of the United States in which patients with COVID-19 lived and despite the percentages of African Americans residing in each state.

In a presentation during the American Association for Cancer Research (AACR) Virtual Annual Meeting II, Lisa A. Newman, MD, MPH, FACS, FASCO, director, Interdisciplinary Breast Oncology Program, and medical director and founder, International Center for the Study of Cancer, Weil Cornell Medicine/New York Presbyterian Hospital Network, reported on public health disparities in New York City (NYC), the known United States epicenter of the COVID-19 pandemic.

Since March 11, 2020, citizens of NYC from all racial backgrounds have been succumbing to COVID-19–related illnesses. In the beginning of April 2020, COVID-19–related deaths peaked in NYC with 590 occurring in a single day (April 7, 2020). The curve began to flatten in early June, during which time NYC saw the first day without any COVID-19–related deaths (June 4, 2020). Since the start of the pandemic (June 10, 2020 cutoff), 17,203 COVID-19 deaths have been reported in NYC, accounting for 15% to 19% of all the COVID-19–related deaths in the country. In terms of race, the highest number of COVID-19–related deaths occurred in the African American population.

According to 2020 study released by the American Association for Cancer Research, an age-adjusted case rate per 100,000 people, 335 African Americans with COVID-19 were not hospitalized, 271 were hospitalized but did not die, and 92 died from complications of COVID-19. Morality in the Hispanic/Latino population was also high. There were 271 individuals who identified as Hispanic or Latino with COVID-19 who were not hospitalized, while 198 were hospitalized but lived, and 74 died due to COVID-19–related complications.

Among Caucasian Americans, there were 190 per 100,000 people with COVID-19 who were not hospitalized, 114 who were hospitalized and did not die, and 45 deaths. Asian Americans in NYC had the lowest rates, with 95 diagnosed with COVID-19 and not hospitalized, 82 had a non-fatal hospitalization, and 34 died.

Homing in on why COVID-19–related mortality rates are so high among minorities, Newman said, “African Americans, Hispanics, and Latinos were hit so hard by COVID in NYC, and many of these reasons are related to sociodemographics and exposure to viral load. These minority population subsets account disproportionately for our essential workers that kept the city going during the shutdown, such as hospital workers and employees of transportation and public service systems.”

“African Americans and Hispanic/Latino individuals are more likely to share multigenerational homes or to live in the housing environments that are less well equipped to comply with social distancing policies. Also, importantly,
these minority population subsets are more likely to receive their health care in safety-net hospitals that are financially and resource-constrained."

The impact of these racial and ethnic patterns across NYC neighborhoods is that the poorer neighborhoods with the most African Americans and Hispanics/Latinos have the highest COVID-19 death rates, while predominantly Caucasian and wealthy communities, like Staten Island, have the lowest COVID-19 mortality rates.

The Bronx faces unique challenges, ones not envisioned when SACHR and similar organizations first formed to combat injection-related HIV in the late ‘80s and early ‘90’s. The Bronx faces pressures of gentrification, along with deepening and entrenching poverty. As upscale housing displaces older tenement buildings and more upwardly mobile professionals move into these communities, the apartments in poorer, Bronx neighborhoods become densely packed illegal single-room occupancy units harboring misery and higher risk conditions.

These disparities are only exacerbated when examining the lack of human agency and empathy in the current medical model and its impact on participants and public health outcomes.

The SACHR model that was pioneered more than 30 years ago has allowed us to evolve and successfully challenge contemporary problems that afflict our neighborhood. One approach that SACHR has embarked upon is the implementation of a harm-reduction-led Continuous Access Drop-In (CADI) center for residents of the South Bronx, one that takes into account disparities highlighted by recent events and responds with proactive solutions based on human agency and empathy.

IMPLEMENTATION // ENGAGEMENT + EXPANDED SERVICES

In the last quarter of FY 2020, COVID-19 expressed itself in unprecedented impact upon the health and well-being upon the Bronx, NYC and beyond. Governor Cuomo responded by closing all businesses but those considered “essential”. The services and resources provided by St. Ann’s Corner of Harm Reduction are considered ‘essential’ and standard in-person or congregate care models needed to adapt to reflect the new normal of the public health landscape.

Executive Management responded by creating and successfully launching several new initiatives with long-term, beyond COVID-19 impact for the well-being and success of agency programs. SACHR adapted systems and structures to ensure participants received stable care centered with human agency while focusing on:

- Emotional Wellness Support to Staff
- Telehealth
- Grab & Go Meals
- Grab & Go Drug User Health resources, including MAT and Feminine Kits
- Adaptive continuous care with technology
- On-line ordering - The Warehouse 6. Electronic Health Record (TREAT)
- Funding
- Community engagement
- Continuous care implementation and real estate risk mitigation
- Evaluation

In light of COVID-19, SACHR adapted its services in order to align with federal, state, and local health & safety regulations, while still providing some services to the community. SACHR suspended services related to congregate meals, groups, and most in-person services. Our meal services became the central point of operations, with ancillary services such as syringe access, mobile syringe outreach, light case management, short intakes, clothing donations, and testing (as needed). We shifted to ‘grab & go’ for meals and syringe access services. We were able to provide personal protective equipment to not only staff, but to participants as well.
The following serves as a highlight of operations during COVID-19, from 3/16/2020 to 6/14/2020. Since COVID-19, we have received food donations and were able to ‘double’ and ‘triple’ meals from May and ongoing. Since the beginning of COVID-19 through 6/14/2020, SACHR has distributed approximately 6,324 meals to participants – this is an average of approximately 490 meals per week.

Through grants and donations, SACHR has been able to continue to alleviate the food insecurity of the South Bronx Community. In April, SACHR expanded hours as a response to the need of basic needs – hours operation extended Monday through Friday 8am – 8pm (including Tuesdays & Thursdays). This allowed for providing participants with ongoing meal service, instead of ‘scheduled’ meals (e.g., breakfast 9am-11am; lunch 1pm-3pm), as well as the productivity required to accept donations, sort and organize items, update inventories, and plan for impactful distribution to the community.

Personal protective equipment (PPE) including disposable face masks, gloves, and hand sanitizer were difficult to secure during the onset of COVID-19 due to inventory shortages nationwide. SACHR was able to secure some donations, as well as warehouse pricing for the majority of PPE distributed to participants. Having supplies of PPE on-hand has provided a sense of security and safety for staff, as well as participants.

SACHR has navigated through challenges brought on by COVID-19 by adapting to telemedicine. We have been able to provide bupe services to participants on a steady basis via telemedicine calls facilitated by Case Management, as follows:

It is important to note, there was a gap in Behavioral Health Program Manager from end of February until mid-May. SACHR hired an LCSW/SIFI to assume the role of Behavioral Health Program Manager on 5/18/2020, as well as a Social Worker who started on 6/1/2020. With the new Behavioral Health team, beginning June 2020, we started capturing totals of mental health counseling and psychosocial assessments conducted by the LCSW – weekly averages are approximately 20 counseling sessions and 3 psychosocial assessments provided to participants.

SACHR has also established a Telehealth Sub-committee who worked on framework guidelines in order to navigate around face-to-face behavioral health via telephone. We will be in the process of rolling out the telehealth services with a target of July 2020. The telehealth initiative is grounded on the foundation put forth by the Executive Management Team, and namely the Office Manager, to secure cellular phones to participants paid for
by SACHR, as well as the equipment needed for staff to carry out telehealth sessions. The Office Manager and IT Consultant have been instrumental in providing laptops to select staff who provide telehealth counseling services as well.

The Behavioral Health Program Manager and the Compliance Officer will work together to spearhead future Home & Community Based Services, including Medicaid initiatives, in the near future. In order to prepare for this, we began hosting Corporate Compliance training to staff. Through COVID-19, we have been able to enroll 73 new participants through a ‘short intake’ process.

SACHR currently has 39 staff, soon to be 40 (Medical Doctor), including 6 staffers who have been on furlough since the onset COVID-19. Staff training is maintained via an Excel spreadsheet for employee date of hire, performance evaluation due date, as well as annual internal mandatory trainings. A New Employee Orientation curriculum has been established; though, with the onset of COVID-19, has not been held in the anticipated monthly cohort (e.g., first & second Wednesday of each month).

Since the onset of COVID-19, it has been difficult to facilitate group trainings. Therefore, trainings have been split into smaller groups to align with social distancing. The aim has been to have staff trained on a topic every other week or so, in order to reach the ultimate goal of 100% training compliance.

A detailed report can be found in the Appendix.

**Real Estate Implementation**

The prior section reviewed program implementation for both participants and staff; however, a central component of the Continuous Access Drop – In Center focused on real estate feasibility and economic impact of a physical center. St. Ann’s Corner of Harm Reduction (SACHR) partnered with the Third Avenue Business Improvement District to lead stakeholder engagement and community and economic development analysis. In the Phase 1 Feasibility Report, three scenarios were presented based on economic considerations:

- **Scenario 1 – co-habitation with Lincoln Hospital**, 234 East 149th Street Bronx, NY with a dedicated point of entry for CADI services. The proximity to emergency room services made this scenario appealing, as SACHR could provide harm reduction services, ambulatory care, and triage for the hospital which services the majority of overdose and substance use emergencies.
  - **Given Health and Hospitals restructuring, financial stress, and the COVID-19 crisis this scenario was out on hold permanently.**

- **Scenario 2 – long-term incubation at a leased location in proximity to Lincoln Hospital**. This scenario is the most likely to be implemented. Three locations were considered using this scenario and two letters of intent were released to property owners.
  - **2739 Third Avenue, Bronx, NY**
    - This is the ideal site for the CADI Center as it dovetails the medical model with the SACHR and CADI model of human agency. The site is currently master leased to BronxCare with twenty years negotiated into their new lease (effective May 2020). SACHR would occupy roughly 6,000 sf of ground floor space under the LOI sent to BronxCare in early March.
Due to the COVID-19 pandemic real estate transactions have been placed on hold. In light of this reality, SACHR has taken the opportunity to strengthen relationships with BronxCare in the areas of counseling and buprenorphine programs.

While BronxCare is the master lease holder the property owner must sign off on any subleases. At the time this report was draft BronxCare indicated that their lease renewal for a 20 year extension was finalized, but awaiting a signature from the property owner. Once that lease is fully executed BronxCare indicated that it would welcome a partnership with SACHR's CADI program.

BronxCare has partnered with SACHR at its Westchester Ave location to offer buprenorphine and potentially collaborate on shared mental health services in accordance with the CADI program hours.

SACHR intends to resume negotiation with BronxCare in August 2020.

2825 Third Avenue, Bronx, NY

This is an ADA compliant second floor space overlooking Roberto Clemente Plaza in the HUB. It is 3 blocks from Health and Hospital's Lincoln Hospital. This site was home to the Diabetes Relief Center of America and is pre-fit out for a 24/7 Continuous Access Drop In Center public health facing operation. The space provides 6,000 sf of space inclusive of kitchenette, shower rooms, and restrooms, while also accommodating testing rooms, staff offices, and an enormous open space for programming and rest.
Elidex Realty is the owner of 2825 Third Avenue. Elidex received a nonbinding letter of intent from SACHR in late March. This property is currently in a holding pattern as the 2nd floor space is being used for emergency operations associated with the COVID-19 pandemic. The property owner has assured us that he is willing to move forward after the pandemic subsides.

2825 Third Avenue is the Plan B site. The BronxCare location represents the best synergy for SACHR program implementation and ground floor access.

- **Scenario 3** – Building a full-scale, 13 story mixed use development of which the Care Center occupies 2 floors.
  - This scenario is not moving forward as the identified City-owned property has not been released for development. The identified site is located at 149th Street and is owned by New York City Department of Transportation. The RFP is expected to be released by the NYC Economic Development Corporation. The estimated cost of this development pre-COVID19 was at $91 million.

**Economic Impact**

An economic revival that fails to address the policy basis for the inequities endured in the Bronx will sow greater displacement, marginalization, and no improvement in social, health or economic indicators. In states like New York, policies developed through the inclusion of all community stakeholders have a binding effect that is positively transformative. This effect is usually seen under conditions of constructed crisis.

A central component or the program’s success is a phased implementation which brings services online as dictated by market demand. The economic feasibility is intrinsically connected to the municipality’s support of adequate and sustainable financial support to holistically address community demands and public health. Lack of stable, long term support creates a paradigm of uncertainty for the providers which create a paradigm of uncertainty for program participants. This exacerbates the cycle of unknowing and creates additional stressors which continue a cycle of poverty and oppression.

There must be funding streams that support long-term service programs. Such supports need to be baselined so they will not vanish with an election or a change in political tide. The community-based public health system must let people do their work and allow for individuals to receive consistent long term care. If government identifies a problem and expects providers to fix it – it must be funded and sustained. Unfunded mandates in the area of public health create a schizophrenic environment and they are a death knell to individuals and providers alike.

A 24/7 Continuous Access Care Center at the HUB presents an opportunity for holistic economic development and impact. A July 2020 report released by HR & A Advisors, a leading policy organization, combined with real estate reports issued by the Real Estate Board of New York and the Northern Manhattan Association of Realtors indicates the devastating impact COVID-19 has and will continue to have on bustling commercial districts. This is
more so true in the South Bronx’s HUB, where the COVID-19 case rate is higher than the citywide average, and its unemployment rate increased from 4.9% to 16.5% between January and April 2020. These devastating impacts may limit both the neighborhood and other Bronx consumers' ability to support Hub businesses.

The Third Avenue Business Improvement District estimates that ground floor vacancy rates which were at 11% pre-COVID-19, will increase to 22%, and office uses for upper floors will also start to decrease as more companies move to a long-term remote work model. While this information paints a dire picture it presents an opportunity for SACHR to implement a ground floor retail activation with the CADI model and present program participants as an untapped consumer base for area merchants. These actions not only assist in mitigating ground floor vacancies, but also work to reduce stigma by presenting a new customer, and possibly employment base, to area businesses.

SACHR’s economic impact by virtue of employing over 50 employees significantly impacts the local South Bronx economy. This impact is increased 30-fold when accounting for program participant spending. Smart use of ground floor and upper floor office space by public health programs can stabilize local economies and provide life saving resources to community residents.

The COVID-19 pandemic has ravaged the Bronx and left a community bearing New York City’s highest rates of COVID-19 deaths and hospitalizations. According to the city’s Department of Health, black and Latino residents make up a vast majority of COVID-19 cases at a rate of 2,768 cases per 100,000 people. Residents in the Bronx, who are majority Latino and black, are more than twice as likely to die from COVID-19 than anywhere else in the city.

The deadly pathogen has exposed the stark divides of race and class — the haves and have nots. The long term economic consequences will be dire unless creative solutions like a community-based Care Center are implemented. These centers address dire public health challenges and enhance local economies which will need to be stabilized post-pandemic.

"The virus, which doesn’t care what race you are or what class you are, it’s looking only for a human body that it can infect and replicate in... all of that is filtered through the realities of race and poverty in our society, and that’s why we see these very disparate patterns of infection where you can see much higher rates among people who are essential workers, among people working in meat packing plants, among people who live on Native American reservations," said Dr. Mary T. Bassett, the director of the FXB Center for Health and Human Rights at Harvard University, "Neighborhoods like the South Bronx, which for generations now have had high, high rates of social deprivation that was there before this novel coronavirus reached us, ... we are seeing ... these inequalities and they’re playing out in terms of the risk of death."

**The 24/7 Continuous Care Center,** if implemented appropriately and properly funded as outlined in the Phase 1 Feasibility Study would save lives, reduce stigma, and stabilize community economies.

**Community Engagement**

Stakeholder engagement was of principle importance to Phase 2. Early on we understood that community residents may succumb to engagement fatigue; however, the need and urgency for the project to be firmly rooted in community decision-making provided energy to ensure stakeholders remained engaged. During this process we not only worked with multi-sector stakeholders, but we also integrated CADI program presentations into existing coalition work throughout the South Bronx. This tactic broadened the network of stakeholders, increased project awareness, and build community buy-in while investing in the community decision making model.
The engagement consulted with individuals, organizations, and companies, across sectors to bring a deep, systemic lens to the challenges impacting the community and their relation to creating a 24/7 CADI Center, and was firmly rooted with co-create innovative approaches that lead to powerful social impacts. By working with communities through robust engagement and collaboration, the phase one feasibility study produced ecosystems of shared value and interconnected community led CADI programs and relationship-centered economic development strategies.

By using design-led capacities we redefined how big picture systemic challenges within the context of community public health are approached, identified opportunities for action, and co-designed more holistic and resilient strategies centered on positive social change.

During Phase 2 the project team

- 4 large scale stakeholder meetings as report backs based on quarterly activities
- 16 small scale stakeholder meetings
  - Small business, LGBTQ+ community, faith based organizations, law enforcement, provider community, parent groups and students, senior citizens, underground economy sector.
- 4 Large Scale conference presentations on CADI to the NYS Senate, NYS Assembly, SOMOS El Futuro, and the NYS Governor’s Office
- Interface with elected officials, community board, and city and state agencies
- 343 business community / commuter surveys
- 3 Kitchen Table Talks (this was projected to be 6; however due to COVID-19 the remaining three were cancelled)
- 8 Zoom Forums centered on the new face of continuous access care and our community
- Participation and leadership in the Community Public Health Certification Program
- Participant training as part of the Good Neighbor Leadership Program
  - The Good Neighbor Leadership Program dovetails with a professional skill building and workforce development program to be launched in Fall 2020.

As a result of COVID-19, the engagement model was altered drastically. In-person sessions were replaced by Facebook and Instagram live or Zoom sessions. This modification opened the door to increased participation; however, it underscored the digital divide in the community and the need to invest in vital technical infrastructure.

As a result of this need, the project team worked closely with the Bronx Community Relief Effort, DreamYard, Here to Here, and the Judy and Jaime Dimon Foundation to secure technology and also worked on a plan with Nos Quedamos and The Point CDC to enhance access to internet. SACHR also purchased and deployed “burner...
phones” to program participants so they might not only engage in CADI services, but also be integral in the evaluation and community engagement programs.

CADI Engagement Participation

Business Sector Response - What are your concerns Post COVID-19 RE: 24/7 Care Center

Bronx Elected Official Feedback - Challenges
The Good Neighbor Leadership Program and the Community Public Health Certification Program have provided opportunities for program participants, peers, business owners, and organizations to work hand-in-hand on community beautification projects and in the virtual classroom to increase community capacity in the area of public health. At the conclusion of the July public health seminar, 43 stakeholders will have completed the 6-seminar public health certification program. 24 participants and stakeholders have enrolled in the Good Neighbor Leadership Program, and four street activations / beautification projects have resulted from this collaboration; one of which was a community clean-up effort post-civil unrest / looting.

A central component of the Phase 2 community engagement was building sustainable relationships with anchor organizational partners and funders. While COVID-19 slowed in-person partner cultivation, it also provided an opportunity for SACHR to showcase its adaptability and innovation to prospective partners and future collaborators. The COVID-19 pandemic provided the space to work with new and often unlikely partners in both providing tangible resources like our Urban Harm Reduction Survival Kits, to meals, to counseling, to access to new technology and a variety of mobile kits for safe sex, family planning, harm reduction, PPE, and feminine kits. Relationships were fostered with area businesses, the Bronx Community Relief Effort, donors and philanthropy, and elected officials / NYC agencies. This level of engagement brought the SACHR mission alive with donors, participants, business leaders, residents working side by side, being trained together – all while developing a new found sense of community.

Above: NYS Senate Hearing on Opioid Use and Overdose Prevention
Continuous Access Program Presentation

Right: Grab and Go meals distributed to participants during the COVID-19 pandemic in partnership with World Central Kitchen and the Bronx Community Relief Effort
DATA // EVALUATION

The COVID pandemic has challenged New Yorkers to adapt to life in a radically altered social environment, but the wide array of problems that have been associated with the virus have disproportionately affected poor communities of color, and none more so than in the Bronx where infection and death rates are among the highest in the city. As a provider that has historically worked with highly vulnerable populations, many with compromised immune systems, SACHR has been on the front lines of combating the pandemic that many “experts” predicted would decimate poor people and communities of color. It is still too early to assess what impact the pandemic will wreak on places like the Bronx, but the response to the pandemic has begun to lay bare the competence and capability of community-based organizations who deliver critical social and medical services to our most vulnerable residents. To better understand how well SACHR had responded to the impact that the pandemic and the lockdown has had on the lives of vulnerable Bronx residents, especially SACHR participants, SACHR staff administered a short survey to more than 70 people (63% male/36%female; 62% Puerto Rican/17% Black/17% White/4% Other).

Because it was widely predicted that the pandemic and the lockdown would decimate and disrupt the lives of the most vulnerable residents, one set of questions in the survey was borrowed from the “Duke–UNC Functional Social Support Questionnaire” which measures “loneliness, social isolation, and social relationships.” These questions were combined with questions that asked respondents to rate, on a scale of 1-10 (with 1 being “easy” and 10 being “hard”), how difficult it had been since the onset of the pandemic to accomplish everyday tasks like getting food, money or health care. Findings from these questions are described and discussed below.

The evidence of SACHR’s success in combatting the effects of the pandemic lies in the resilience and the responses of it’s participants, and their ability to weather the worst of the crisis in relative good health and spirits. SACHR has proved especially nimble in effectively reorganizing and repurposing staff, and in altering the agency’s methods and techniques of service delivery in ways that provide continuity and support for participants who are among the most vulnerable to experiencing the effects of the pandemic.

As a harm reduction agency that serves active drug injectors and sex workers who need constant supplies of harm reduction materials like sterile syringes and condoms, SACHR’s core mission was seemingly threatened by the citywide lockdown that was imposed to combat the COVID virus, but most participants, as seen in the chart below, said that they had no problem getting harm reduction materials that were available for pick-up at the main office or from outreach teams that continued to operate at critical locations across the Bronx.

One worrisome trend that shows up here and in other metrics of how well participants have weathered the lockdown is that women consistently report more difficulty than men in coping with the effects of the pandemic. More research is needed to understand the reasons for this disparity.
One problem that SACHR cannot solve during the lockdown is providing a place for people to spend time, but respondents on the survey show that slightly more than half of them – both men and women – said that it has been relatively easy for them to find a place to spend time. Given that many SACHR participants are homeless and/or tenuously housed, the fact that more than half of them said that it was easy to find a place to spend time during the lockdown is somewhat surprising and requires more research to fully understand where they spend time.
Before the pandemic, many SACHR participants spent considerable amounts of time on the streets and in public places where they mixed and interacted with large numbers of people, and yet, weeks into the lockdown, more than half of them said that they did not have a problem with “social distancing.” Women, however, reported more severe problems than men in maintaining social distancing.
Getting the basic necessities of life – food, shelter and money – are always problems for vulnerable populations like drug injectors and sex workers, and many experts predicted that the pandemic would render the most vulnerable residents of the Bronx homeless and hungry when social support services were suspended or scaled back, but contrary to these expectations, SACHR’s participants showed remarkable resilience in maintaining access to the basic necessities, though women consistently said that they had greater difficulty than men in getting food, shelter and money.
SACHR COVID Impact Survey

How Hard Has It Been To Get Housing

1 = Easy 10 = Hard
n = 72

Men: How Hard Has It Been To Get Housing

1 = Easy 10 = Hard
n = 45

Women: How Hard Has It Been To Get Housing

1 = Easy 10 = Hard
n = 26

How Hard Has It Been To Get Money

1 = Easy 10 = Hard
n = 73
The overall picture that these data provide is that SACHR participants have not experienced the levels of stress, trauma and dislocation as an outcome of the pandemic and its associated hardships that had been predicted by many experts. Support from SACHR is one factor that has allowed their participants to endure the lockdown in better shape than had been anticipated. The degree to which SACHR’s participants defy expectations is also reflected in their assessment of how hard it had been to care for their families during the lockdown. Though it is not surprising that women voiced more problems than men in caring for their families during the pandemic, likely the result of their roles as heads of households and/or primary childcare providers, about half of the women reported that they had very few problems in this regard.
SACHR’s participants include many people who are members of stigmatized and vulnerable populations, and mental health issues are among the constellation of problems that they find help managing with the help of staff at the agency. The pandemic has increased stress levels in every New Yorker’s lives and it was anticipated that this trend would be especially pronounced among SACHR’s participants, especially those with pre-existing mental health issues. The data, however, challenge this assumption. Indeed, more than half of the respondents in the survey said that their mental health had not been problematic during the lockdown.
There are undoubtedly several reasons why mental health issues did not markedly worsen among SACHR participants over the duration of the pandemic, but high levels of social support they receive are among the most important of these factors. Two thirds of the respondents who participated in the survey said that they had “people who care about what happens to me” and that they “get love and affection” “as much as I would like” or “almost as much as I would like.”

Meaningful relationships that sustain participants during difficult times offer more than unconditional love and support, they offer tangible benefits in the form of help and advice about the problems of everyday life. A majority of survey respondents noted that they benefited from “chances to talk with someone about personal or family problems” and that they “get useful advice about important things in life.”
The support that individual participants get extends beyond that which is provided by SACHR staff; the community that has been forged over the years in SACHR’s supportive harm reduction environment ensures that participants support each other in small and big ways, as the charts below suggest:

The success that SACHR has achieved in helping its participants endure the hardships of the pandemic has not been uniformly replicated by other social service and medical providers in the Bronx. A majority of participants said that “getting medical care” had been very difficult during the lockdown.
SACHR has succeeded where others have not because the agency was able to quickly adjust to the changing social landscape in ways that ensured a continuity of services and it managed to extend a critical lifeline to the most vulnerable residents of the Bronx during their time of greatest need. The model that SACHR has pioneered during this transformative period is already demonstrating its effectiveness in preventing and alleviating the worst effects of the pandemic among the most at-risk Bronx residents and it points a way out of morass that threatens all of our lives.
QUALITY ASSURANCE // IMPLEMENTATION

Quality Assurance (QA) activities for this quarter (01/15/20-4/15/2020) include all the following deliverables:

1. A quantitative assessment of all service delivery metrics, including the number of participants served and the number and type of services provided.
2. A survey of participants that asks about their experiences with the CADI program.
3. Qualitative interviews with CADI participants and staff.
4. Ethnographic observation of CADI service delivery and participant interactions.

1) The first two and a half months of 2020 reflected the growing stability of the CADI program and the maturation of the program. The number of attendees had begun to increase since the beginning of the year, topping 650 in the month in February, and included a more diverse group of participants. With new staff that had recently been hired, new groups were offered that appealed to distinct sub-sections of the participants – groups like “Men’s Table Talk” and “Yoga” – groups that reflected the growing diversity of the CADI community. In addition, the implementation of “Self-Care Sunday” was welcomed by participants who enjoyed a hearty breakfast and the music, dancing and games that accompanied the morning’s self-care focus.
2) A survey of participants that asks about their experiences with the CADI program:

A small sample of CADI participants (40) were surveyed in November and December 2019 to find out what they valued in the program and what services they wanted to see more of in the future. Those findings, reported in the last quarterly report, helped staff to create additional services and groups that catered to the interests expressed by participants. In early 2020, a follow-up survey was constructed whose purpose was to find out more about the social networks of CADI participants and people who were not CADI participants, and to better understand how much or how little survey respondents were connected with others, including where they spent their time during the day (when not at SACHR). The survey planned to use “Respondent Driven Sampling” methods and techniques and was scheduled to commence the first week of March 2020 in a vacant office near the 3rd Ave BID, but COVID changed that plan and the office space was quickly rededicated to hosting PPE and other COVID supplies.

Following the lockdown, 2 surveys were constructed and administered by SACHR staff to better understand the impact of COVID on the lives of SACHR participants and others. The first survey was administered in March and April with 53 participants and it asked them to rate, on a scale of 1-10 (with 1 meaning easy and 10 meaning hard), how difficult life has been for them since the lockdown. The initial findings were somewhat surprising in that more than half of the participants indicated that the lockdown had posed little difficulty for them in various areas of their lives (finding money, food, shelter, health care, etc.), except for finding a place to spend time. A follow-up survey with more than 80 participants added an additional bank of questions that gauged social isolation and loneliness. The expectation was that the populations served by SACHR that were already stigmatized and experiencing multiple problems in life would be deeply affected by the lockdown and that their health and mental health would suffer as a consequence. Surprisingly though, the findings showed just the opposite and revealed a hearty resilience among the majority of participants.

3 & 4) Qualitative interviews with CADI participants and staff were begun in January and February and included observations and interviews with participants on “Self-Care Sundays. The interruption of these evaluation activities by the pandemic leaves an incomplete data set to fully describes the impact that the CADI program had begun to play in the lives of participants, but the growing momentum created by CADI program was apparent in these observations. Going forward, the agency has recently installed protective barriers and has an adequate supply of PPE so that observations and interviews can now be scheduled with individual participants, and when SACHR begins to offer in-house services again.

SERVICE PROVISION//COORDINATION//ENGAGEMENT TRACKING

During the Phase 2 Continuous Access program, SACHR created and implemented service tracking forms and subsequent mechanisms to effectively track extended hour specific services, e.g. participant demographics, priority service needs, service coordination, and extended hour services i.e. - meals, groups, programs, referrals to higher threshold services, to produce a quarterly quantitative and qualitative status report.

The summary narrative spans 3- months of services, coordination and engagement during the COVID-19 pandemic including but not limited to:

a) description of services and service coordination methods
b) staff involved and staffing changes
c) summary of participant demographics (race, gender, age, zip code/neighborhood of residence, priority service need)
d) service highlights

e) service challenges

f) service counts (e.g. meals provided, intakes, referrals, etc.)

g) copies of blank service forms, tools, or tracking logs to collect services data, coordinate services or provide referrals

h) if applicable, significant changes made to service provision

Sample forms may be found in the Appendix.

**Description of services and service coordination method:**

Prior to the pandemic that ended in-house services in March 2020, the CADI program featured core services that included syringe exchange, meals and showers. Meals were especially important to the program because it was the one activity that nearly everyone participated in, and they provided the opportunity for socializing and bonding between participants, and between participants and staff. Over the first months of 2020, staff invested more time and energy into the preparation and presentation of meals, aided by the greater availability of items like various types of gourmet bread, and participants responded. The variety and amount of high-quality food, like during Self-Care Sundays, was often a topic of conversation among participants and it set a environment for the ancillary activities, like dancing and games, that piggybacked off the positive tone that a generous and carefully served brunch established for the day. The addition of groups like Yoga and “Men’s Table Talk,” reflected the sensitivity that staff felt toward the specific needs of participants.

**Staff involved and staffing changes:**

Major staffing changes and restructuring at SACHR began in March as the impact of the COVID pandemic began to affect all New Yorkers. The CEO developed a direct line of communication with all staff via daily “narratives” that sought to identify and capitalize on their strengths in order to reimagine and transform the service delivery models used by the agency. The active participation of staff in unfamiliar roles, especially the preparation of Grab & Go Meals/kits/resources, and their reflection on those roles had the effect of identifying and dismantling the silos that once characterized our work and it fostered a reinvigorated spirit of teamwork among the staff in response to the crisis. In collaboration with a professional consultation, SACHR’s programs and lines of authority were restructured to meet the service needs of their participants who now live in a radically altered urban landscape. In this maturation, the organizational restructuring reflects a paring down of programmatic disciplines with more efficient lines of responsibility and authority.

**Participant Demographics:**

<table>
<thead>
<tr>
<th>Ethnicity</th>
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<tbody>
<tr>
<td>Hispanic</td>
<td>77%</td>
</tr>
<tr>
<td>Non-Hispanic</td>
<td>23%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Race</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Black/African-American</td>
<td>19%</td>
</tr>
<tr>
<td>More than 1 Race</td>
<td>4%</td>
</tr>
<tr>
<td>Some Other Race</td>
<td>22%</td>
</tr>
<tr>
<td>White</td>
<td>54%</td>
</tr>
<tr>
<td>Pacific Islander</td>
<td>1%</td>
</tr>
</tbody>
</table>
**Gender**

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Woman/Girl</td>
<td>20%</td>
<td></td>
</tr>
<tr>
<td>Man/Boy</td>
<td>79%</td>
<td></td>
</tr>
<tr>
<td>Transgender</td>
<td>1%</td>
<td></td>
</tr>
</tbody>
</table>

*No participants identified as non-binary*

**Service Highlights:**

Among the service highlights for the quarter are included: 1) an increase in the number of participants, especially on the weekends, 2) greater diversity in the CADI population, especially young men of color, 3) the implementation of new groups that address participant needs, and 4) an upgrade in the quality of meals that have sparked participant comments.

**Service challenges:**

Prior to the pandemic, the primary challenges to the CADI program included: 1) finding and enrolling more eligible participants, 2) finding and retaining staff who have the requisite skills who are willing to work during "off" hours, and 3) ensuring that the growing number and variety of participants were enculturated to a culture at SACHR which champions and promotes respect, tolerance and personal growth.

**Service Counts:**

![Attendance Chart](image1)

![Syringe Access Chart](image2)
Significant changes made to service provision:

As a result of the pandemic, a top-to-bottom restructuring of lines of authority and employee roles at SACHR was implemented. The result of this restructuring has been a paring down of programmatic disciplines at the agency with more efficient lines of responsibility and authority. Services like Telehealth have allowed SACHR to maintain and strengthen relationships with participants during the lockdown, and new initiatives like “The Warehouse,” allow participants to take advantage of a wide range of free resources, including ready-to-eat food for all meal types, personal hygiene materials, PPEs, protein-enhanced one-shot bars/cups, first aid supplies; newborn/baby diapers and associated resources; disposable underwear; and safer drug use and safer sex supplies. Going forward, as the lockdown eases, the installation of appropriate social distancing barriers and protective gear at SACHR will allow for the gradual reopening of the agency and in-house programming.
SACHR AGENCY SUMMARY
Deliverable 1: Centering Vulnerable Populations
MARCH THROUGH JUNE 2020

I. Agency Response to COVID-19

In light of COVID-19, SACHR first adapted and later expanded its services and hours to meet the needs of our vulnerable population while aligning with state, and local health & safety regulations. Once the Governor placed NYS on ‘PAUSE’, SACHR suspended services related to congregate meals, groups, and most in-person services AND it shifted into providing basic life-saving meals and prevention resources related to reducing drug overdose, providing drug user health resources including Buprenorphine, safer sex resources, and 1:1 follow-up/care coordination via tele-communication.

Our meal services became the central point of operations, with ancillary services such as syringe access, mobile syringe outreach, light case management, short intakes, clothing donations, and testing (as-needed). We shifted to ‘grab & go’ for meals and syringe access services. We were able to provide personal protective equipment to not only staff, but to participants as well. The picture below highlights the ongoing grab & go meals on Sundays 9am-2pm (pictured below from L to R – Stav Levy, two participants, Krystal Montalvo, and Wanda Velez):

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1 Exclusive of the following reports: Social Media, Data Quality Management, Fiscal, and CEO.
The following serves as a highlight of operations during COVID-19, from 3/16/2020 to 6/14/2020. Since COVID-19, we have received food donations and were able to ‘double’ and ‘triple’ meals from May and ongoing. Since the beginning of COVID-19 through 6/14/2020, SACHR has distributed approximately 6,324 meals to participants – this is an average of approximately 490 meals per week.

The graph below reflects the amount of meals provided to the South Bronx Community by month:

Through grants and donations, SACHR has been able to continue to alleviate the food insecurity of the South Bronx Community. In April, SACHR expanded hours as a response to the need of basic needs – hours operation extended Monday through Friday 8am – 8pm (including Tuesdays & Thursdays). This allowed for providing participants with ongoing meal service, instead of ‘scheduled’ meals (e.g., breakfast 9am-11am; lunch 1pm-3pm), as well as the productivity required to accept donations, sort and organize items, update inventories, and plan for impactful distribution to the community. The picture below reflects items SACHR put together for ‘urban survival kits’ provided to participants:
It is important to note, the quality of meals served to participants was at the forefront of SACHR’s ongoing meals initiative. The Executive Management Team, and significantly, the Office Manager, spent a lot of thoughtful time on quality end results provided to participants, such as equipment purchases (including food warmer and freezer), organizing and coordinating food donations, and property-management related matters. The picture below is a food warmer purchased via the Robin Hood grant which enables SACHR to keep food warm and fresh for participants:

Personal protective equipment (PPE) including disposable face masks, gloves, and hand sanitizer were difficult to secure during the onset of COVID-19 due to inventory shortages nationwide. SACHR was able to secure some donations, as well as warehouse pricing for the majority of PPE distributed to participants. Having supplies of PPE on-hand has provided a sense of security and safety for staff, as well as participants. The picture below was taken when we received our first donation from PPE4NYC of hand-sewn, reusable face masks and face shields (pictured below from L to R – Stephanie Furgeson, Ruben Rivera, Maria Nogueira, and Brent Latino):
We are projected to increase the distribution of PPE and kits by approximately 25% from May to June 2020, as well as an average 65% month-to-month increase in all services provided to participants during COVID-19.

Through COVID-19, many stores were closed, and participants expressed difficulty securing basic clothing needs. SACHR has been able to provide approximately 300 articles of clothing to participants. The picture below highlights clothing racks placed outdoors for participants to have the space to 'shop' for clothes, while maintaining social distancing (pictured below from L to R – Mariela Traverso & Maria Nogueira):
As we hope COVID-19 subsides, SACHR furnished The New York Forward Agency Safety Plan Template in order to prepare for the possibility of re-opening after Phase II, as well as building transparency to employees with the goal of safety. Please see NY Forward Agency Safety Plan attachment.

II. Agency Updates & Program Deliverables

The Data & Quality Coordinator has been hired and will work closely with Program Managers and Executive Management to monitor the projected targets of program deliverables. Please see attached for YTD targets.

Through COVID-19, SACHR has operated the mobile syringe outreach program twice per week without interruption, and staff have been provided with PPE, including face shields, as protective measures. A monthly average of approximately 267 participants are served through Mobile Syringe Exchange Outreach; the monthly totals of participants served are as follows:

The picture below reflects activities found during Mobile Syringe Exchange Outreach during Tuesdays and Fridays (pictured below from L to R - Francisco Gonzalez and Lourdes Correa):
SACHR has navigated through challenges brought on by COVID-19 by adapting to telemedicine buprenorphine (’Bupe’) services. We have been able to provide bupe services to participants on a steady basis via telemedicine calls facilitated by Case Management, as follows:

It is important to note, there was a gap in Behavioral Health Program Manager from end of February until mid-May. SACHR hired an LCSW/SIFI to assume the role of Behavioral Health Program Manager on 5/18/2020, as well as a Social Worker who started on 6/1/2020. With the new Behavioral Health team, beginning June 2020, we started capturing totals of mental health counseling and psychosocial assessments conducted by the LCSW – weekly averages are approximately 20 counseling sessions and 3 psychosocial assessments provided to participants.

SACHR has also established a Telehealth Sub-committee who worked on framework guidelines in order to navigate around face-to-face behavioral health via telephone. We will be in the process of rolling out the telehealth services with a target of July 2020. The telehealth initiative is grounded on the foundation put forth by the Executive Management Team, and namely the Office Manager, to secure cellular phones to participants paid for by SACHR, as well as the equipment needed for staff to carry out telehealth sessions. The Office Manager and IT Consultant have been instrumental in providing laptops to select staff who provide telehealth counseling services as well.

The Behavioral Health Program Manager and the Compliance Officer will work together to spearhead future Home & Community Based Services, including Medicaid initiatives, in the near future. In order to prepare for this, we began hosting Corporate Compliance training to staff.

Through COVID-19, we have been able to enroll 73 new participants through a ‘short intake’ process. The following reflects new intakes by month:
III. Staff Training

SACHR currently has 39 staff, soon to be 40 (Medical Doctor), including 6 staffers who have been on furlough since the onset COVID-19. Staff training is maintained via an Excel spreadsheet for employee date of hire, performance evaluation due date, as well as annual internal mandatory trainings. A New Employee Orientation curriculum has been established; though, with the onset of COVID-19, has not been held in the anticipated monthly cohort (e.g., first & second Wednesday of each month).

Since the onset of COVID-19, it has been difficult to facilitate group trainings. Therefore, trainings have been split into smaller groups to align with social distancing. The aim has been to have staff trained on a topic every other week or so, in order to reach the ultimate goal of 100% training compliance. The following reflects percentages of staff trained, as of 6/18/2020, accordingly:
IV. Agency Fiscal Year 2019-2020

The Executive Management Team, with the guidance and direction of our Chief Executive Officer, will be working on formalizing key milestones, program performance, and Agency impact via annual reports. Since SACHR is a United Way Agency, we qualify for free consulting services through Catch-A-Fire, a volunteer-based consulting website that matches volunteers to organizations. This will result in cost-savings for SACHR in the tens-of-thousands range.

SACHR has engaged several consultants in support of agency change. One project supports the agency restructuring from contract-based to service-based delivery of services. A second project assists in the preparation of an annual report. A third project assists with the telehealth and the online ordering initiatives. Finally, a fourth project consultant has been engaged in support of SACHR celebrating our 30th anniversary milestone, formerly scheduled for September 11 and now rescheduled for February 26th, 2021.

### END ###
SACHR Social Media Summary: June 2019 – June 2020

Overview

Over the past year, SACHR has seen a steady increase in reach through our social media activity. By maintaining an active presence on Facebook, Instagram, and Twitter we have been able to “cover the spread” as each platform rises and falls in popularity, or as different demographics mass to one or the other.

The content that we post generally falls into one of three categories: announcements about our services, news about public health and harm reduction, and informational public service announcements about harm reduction strategies and other practices designed to improve people’s health and wellbeing. By incorporating these three areas, we are better equipped to attract the interest of Bronxites who may take advantage of our services as well as people with an interest in harm reduction who may live anywhere in the world. Indeed, many other harm reduction agencies and journalists who cover public health use our social media pages to stay up to date with our work. Over the past year, we have had a number of requests for interviews that came directly from a social media post catching the eye of a journalist.

Data

Facebook: We recently crossed the 1,000 “likes” mark on this platform, and have seen several posts surge in popularity far beyond the scope of our normal reach. An internal survey of digital media use among SACHR participants in 2019 showed that Facebook is the most widely used social media platform with 51% of participants reporting that they actively use the service.

Key Statistics from June 2019 – June 2020:

+71% follower growth (from 656 to 1,120)

+88% increase in average monthly reach since 2018 (5,490 to 10,345)

124,135 total reach of our Facebook posts over the past year

Instagram: Despite being designed to attract photographers and fashionistas, Instagram has proven to be a valuable tool for political messaging. It also attracts a younger demographic than Facebook. SACHR has more followers on Instagram than Twitter and Facebook combined: 2,633. It is the second most popular platform among SACHR participants, with 20% using the service. Since we began using the service in early 2018, we have seen our monthly reach grow more than five-fold.

Key Statistics from June 2019 – June 2020:
+54% follower growth (from 1,714 to 2,633) over the past year

+574% increase in average monthly reach since 2018 (1,090 to 7,346)

88,155 = total reach of our Instagram posts over the past year

**Twitter:** Over the past year, Twitter has grown to be our most powerful platform in terms of putting our content in front of the most people. It is interesting to note that this is despite having far fewer Twitter followers than the other platforms. This can be partially explained by the fact that it is easier for tweets to be found and viewed by users who are not following you than it is on other platforms. In 2019, our tweets were seen an average of 10,000 times per month. In 2020, that number had jumped up to more than 15,000 impressions per month.

**Key Statistics from June 2019 – June 2020:**

+23% follower growth (from 558 to 684) over the past year

+150% increase in average monthly reach since 2018 (4,825 to 12,083)

145,000 = total impressions of our Twitter posts over the past year

From June 2019 to June 2020, our social media posts have had a combined reach of 357,290 and our total number of followers on all platforms has increased by 52%.

**Most Popular Posts**

Periodically, a certain post will surge in popularity to a level that far exceeds the norm. Over the past year, we have had two such examples. While these posts were popular on all of our social media platforms, they truly took on viral status on Facebook in particular. It is important to note that these posts succeeded organically, meaning that we did not pay to boost them.

**Example 1:**
The post shown above was shared 300 times and reached nearly 30,000 Facebook users. To put this in context, this post reached more people than all Facebook posts over the previous three months combined.

Example 2:

The report also found that, “Comprehensive syringe services programs play an important role in preventing HIV.”

Time and time again, the data shows that these kind of harm reduction strategies do not encourage drug use as opponents claim. Instead, the opposite is true.

https://www.cdc.gov/mmwr/volumes/68/wr/mm6830a1.htm

Learn about our Syringe Access Program by visiting:
https://sachr.org/syringe-exchange/

CDC #DrugPolicy #HarmReduction #HIV #SyringeAccess #SyringeExchange #Data #EvidenceBasedTreatment #SupportDontPunish #Health

One highly destructive result of the War on Drugs is that many people have been taught to associate substance use with morality.

The post shown above was shared nearly 200 times and reached more than 18,000 people.

An analysis of these two examples along with other posts that performed above average suggests that our most successful posts are those that make clear, declarative statements about harm reduction philosophies and their impact on public health.
Summary

By maintaining active social media accounts that share our efforts and promote our message, we have been able to steadily build a diverse digital following. Having this virtual mouthpiece not only raises visibility about our own work, but also helps educate the public about public health and drug policy, often providing perspectives they may not encounter elsewhere.
Chief Executive Officer Report to the BOD

June 20, 2020

In the last quarter of FY 2020, COVID-19 expressed itself in unprecedented impact upon the health and well-being upon the Bronx, NYC and beyond. Governor Cuomo responded by closing all businesses but those considered “essential”. The services and resources provided by St. Ann’s Corner of Harm Reduction are considered ‘essential’.

Executive Management responded by creating and successfully launching several new initiatives with long-term, beyond COVID-19 impact for the well-being and success of the agency. This restructuring will be discussed below. Funding for the initiatives was made possible through grants written during this period to the New York Community Trust (NYCT), Robin Hood Foundation, Hispanic Federation. The NYCDOH approved a small increase to existing funding.

1. Emotional Wellness Support to Staff
2. Telehealth
3. Grab & Go Meals
4. Grab & Go Drug User Health resources, including MAT and Feminine Kits
5. On-line ordering - The Warehouse
6. Electronic Health Record (TREAT)
7. Funding
8. Evaluation

1. Emotional Wellness Support

Immediately following the COVID-19 announced ‘Pause, all group services were closed including those conducted in the Sanctuary (acupuncture and stress-reduction), the education/support groups, the recreational engagement, personal hygiene, and the congregate meals.

To support staff during this period of fear-of-contagion and misinformation, we, 1a). reduced staff hours and, 1b). Developed an emotional support component with our Retreat Consultant.

1a). All staff received a full payroll as follows: Full-timers had to work 24 hours for 40 hours; Part-timers had to work 12 hours for 20 hours. This benefit limited the number of days they had to report to the office. The exception to this benefit were all members of executive management who worked daily to ensure continuity of services during the restructuring that took place.

1b). Emotional Wellness support was contracted wherein two one-hour sessions were made available to all staff. An extension of the contract will provide emotional support sessions into August 2020. The fear of contracting COVID and the required shift in duties that came with the emerging restructure was
challenging to all, some more than others. The silos that had impeded comprehensive teamwork became open to change.

2. **Telehealth**

The telehealth initiative is currently utilized for case f/u and coordination of care by our Ryan White Counselors; our behavioral health LCSW for case f/u and crisis management; and our Buprenorphine prescribing initiative.

In July we will begin to conduct **intakes via telehealth**. This will enable SACHR to provide continuous access to HIV/HCV/Drug User Health resources and to individuals within and outside our current community. The impact of improving the health via resources provision will be evaluated but it’s important to recognize that the initiative will break down the barriers established by drug use-related Stigma and intra-ethnic/racial classism.

The ability to conduct 1:1 Intakes via telehealth responds to the new social distancing requirements. The Behavioral Health Component has developed protocols for on-call **telehealth consultations** that will provide **24/7 1:1 access to any SACHR participant that needs our assistance**.

SACHR has purchased 50 phones for participants with IBM-app management capacities to safeguard SACHR property; another batch of phones were ordered for all staff conducting telehealth. IBM ThinkPads were secured through donation and distributed to all staff conducting face-based telehealth counseling.

SACHR, a member of the EngageWell IPA, received a funding commitment that will strengthen our growing telehealth initiative and connectivity with other agencies across the IPA.

There are other benefits associated with telehealth and providing participants with the technology they need to participate in a COVID world through e-communication, e.g., connecting with others—family, friends, self-help activities including learning and commerce. Tele-based communication that facilitates intakes also facilitates care coordination, follow-up and access to resources including **online ordering from SACHR**. (see below)

3. **Grab & Go Meals**

Our full-service kitchen made it possible for SACHR to immediately shift to providing Grab & Go meals. This switch from cooking and serving food in our Commons Space to Grab & Go requires additional steps, all untested for this team, from Start-to-Finish. For example, increases in volume meant additional cooking; additional food and storage capacity; new equipment purchases; monitoring and inventory management. The serving of meals throughout the day not merely at designated hours of breakfast, lunch and dinner (our regular schedule) required the placement and rotation of all staff through the kitchen. (Not everyone was happy with the placement even though the working in the kitchen reduced potential exposure to COVID-19).
As volume increased, executive management joined the newly created Bronx Community Relief Effort (BCRE) who has taken leadership in establishing ‘verticals’ that deal with the economy, food, education and (it was expected) public health. Shortly thereafter we began to receive food donations from NosQuedamos (also a member of the BCRE). Additional food support has come from: Off-the-Plate (they work with Ms. Chirlene McCray, Bill deBlasio’s wife), COMPASS, the Veterans Administration, and World Central Kitchens (Chef Andres). Food donations also appear as one-shot events from a range of groups, including FoodbankNYC who recently provided $3K+ in food credits.

New equipment purchased through foundation support allow SACHR to comply with NYCDOHMH food-provider certification requirements and include a Hot Food-gerator (big like a refrigerator but keeps food warm to the requested information) and a combination Freezer/Refrigerator.

4. Grab & Go Drug User Health Resources, including MAT and Feminine Kits

Our original intervention in the community, syringe exchange, has grown into a full-service drug user health hub where a range of prevention and MAT is provided to a varied group of substance users. Keeping the s/e open was vital to all our operations and we immediately set about to create ‘kits’ that could be easily packaged for Grab & Go. Each kit includes drug user supplies including safer sex and a ‘sharps fitpak’ for safe disposal. Aware that our women would require dignity kits, separate feminine supply kits were prepackaged. The chase for donations started with PPE and masks were shortly followed by sanitizer donations. Foundation funding enabled us to provide masks gloves, visors, and sanitizer to all participants (doubling and tripling where requested), at our Westchester site and our outreach sites (139th & St. Ann’s and 148th and Bergen). WSU staff worked diligently and creatively in securing donations for women’s underwear (200 brassieres).

One:One naloxone trainings were conducted on the sidewalk and later in the conference rooms. Our Buprenorphine services (new intakes, f/u and prescription maintenance) conducted through linkage with Project Renewal were continued throughout the quarter, each Thursday.)

Recruitment and hiring of all personnel for the Drug User Health Hub (DUHH) has been completed. With the securing of malpractice insurance, we added a consultant doctor who will begin on 6/25 preceded on 6/22 by an LPN and a medical assistant. The DUHH room is fully equipped with new equipment and medical instruments.

We have kept the street outreach component open and busy throughout COVID-19. Staff were trained on protecting themselves through the wearing of PPEs and social distancing. We have had no pushback from participants regarding social distancing requests.

5. Online Ordering

SACHR gained a head-start on the new way of conducting business through securing AIDS Institute approval for online ordering. Executive management worked with our social media Guru to develop the
architecture for online ordering through our website. Participants who do not want to wait in line can place an order for supplies through our website. Supplies will be viewable to everyone but, through the architecture of the site, only a participant can place the order. The order will be processed at SACHR at our new entrance for the Warehouse (formerly projected as a pharmacy).

The newly renovated space includes three service windows, an intake room, waiting space, and a wheelchair lift.

But the hot button behind our online ordering initiative is The Warehouse. The Warehouse consists of 800+ sf of shelf space where we have built a resource supermarket for our participants and their ‘familial’ unit. Our range of free resources for our participants includes ready-to-eat food for all meal types, personal hygiene, PPEs, protein-enhanced one-shot bars/cups, first aid; newborn/baby diapers and associated resources; disposable underwear; all exclusive of our safer drug use and safer sex supplies.

Our intention is to be ready for the second wave of COVID-19 expected in early Fall. Before going ‘Live’ in late July/August, we will be hiring a Warehouse Coordinator (posting this week) whose duties will include establishing contact with grassroots activists working in identified hot spots for drug harm, as a critical component to strengthening our outreach to persons with substance-use related needs and risks. The Coordinator will play a key role in SACHR efforts to introduce barcoding to staff related to the barcoding of all documented deliverables and resources.

First stage of online ordering will be directed to ordering and pickup of supplies. The second stage will be directed to participants who cannot and/or are not able to come to our offices or outreach sites for resources; namely, shipping. By monitoring the Online Ordering/The Warehouse we will learn a bit about unexpected consequences and develop adaptation remedies; these findings will direct the opening of the second stage of Online Ordering for home delivery.

We are working on designing boxes sized to fit for shipping a range of pre-order DUHH for a range of users. We have reached out to the 3rd Avenue BID and a Catch-A-Fire Consultant to identify community business partners for a joint venture on shipping.


A common problem in documentation of services and associated billing is the multiplicity of data systems that exist due to funder silos. The more contracts you get the likelier you are to be required to document in as many data systems; and by its obvious inefficiency it undermines staff creativity and engagement by amplifying the reduction of complexity into beans to be counted, prioritizing the latter for the former. Another challenge is staff comfort and competence with e-communication.

Prior to COVID-19 we had addressed the challenge associated with re-introducing a central electronic health record through a general training of all relevant staff. During COVID the managers have been working on building out the architecture of specific program commitments with attention to differentiating between shared data and funder-deliverable data needs. A new Data Quality Coordinator has been hired and with our data partners including the Bx RHIO, she is addressing the strengthening of our electronic health system.
7. Funding

You have read/will read from the CFO’s fiscal report we exceeded our funding expectations for this year. In this quarter, we partnered with grant writers funded through our membership in the EngageWell IPA, to successfully invite the New York Community Trust and the Robin Hood Foundation to fund our new initiatives. In our other funding requests, both the Hispanic Federation and the MAC AIDS foundation, provided successful responses; we await a response from the Mother Cabrini Fund. The biggest percentage increase in our funding in the last quarter of the fiscal year came from individual donors. The majority of new donors became familiar with our work directly from visiting our website or through our social media posts across FB, Twitter, Instagram. But drug related harm and the current socio-political environment, have driven repeat donations and ‘in honor’ donations.

In-kind donations – of equipment (29 Think Pads; one refrigerator/freezer) and resources (PPEs, Food, Clothing) reflect a moment of community connection unlike any other.

8. Evaluation

To assure staff they were safe—with their employment, within the space, and in the course of their engagement with participants, CEO developed a direct line of communication with all staff via daily Narratives. The only narrative requirement was that staff describe who they worked alongside and how they worked together along the many steps necessary to hand the needed Grab & Go meals/kits/resources. This collage of stories offers an aperture into the daily challenges and strengths experienced by our staff and that we in executive management hold safely with our collective work.

The teamwork that we have cultivated is tested daily and daily the strength of our efforts offers the best recommendation for building tomorrow. For three months staff have worked through the ego-safety offered by silos through active participation in unfamiliar roles. To sustain the success, we sought professional consultation with the restructuring of SACHR’s programs and lines of authority. The restructuring also responds to the upcoming retirement of the Deputy and Clinical Director and semi-retirement of the Founder/CEO. A new position of Chief Operations Officer has been created to replace the Deputy and Clinical Director. In this maturation, the organizational restructuring reflects a paring down of programmatic disciplines with more efficient lines of responsibility and authority.

To gauge participant perspective on their experience of safety during COVID-19, participants are responding to a survey prepared by our consultant evaluator (see attached). A recent conclusion drawn by the evaluator states, “People might expect that our participants are battered and bruised from the pressures of the last few months, but they seem remarkably resilient. That is testimony to the hard work that SACHR has done with them over the years to establish that lifeline and to the years of social distancing that others have forced on them which makes these social changes less impactful on them as compared with non-stigmatized people.” R. Curtis, Ph.D., 6/16/2020
The COVID pandemic has challenged New Yorkers to adapt to life in a radically altered social environment, but the wide array of problems that have been associated with the virus have disproportionately affected poor communities of color, and none more so than in the Bronx where infection and death rates are among the highest in the city. As a provider that has historically worked with highly vulnerable populations, many with compromised immune systems, SACHR has been on the front lines of combatting the pandemic that many “experts” predicted would decimate poor people and communities of color. It is still too early to assess what impact the pandemic will wreak on places like the Bronx, but the response to the pandemic has begun to lay bare the competence and capability of community-based organizations who deliver critical social and medical services to our most vulnerable residents. To better understand how well SACHR had responded to the impact that the pandemic and the lockdown has had on the lives of vulnerable Bronx residents, especially SACHR participants, SACHR staff administered a short survey to more than 70 people (63% male/36% female; 62% Puerto Rican/17% Black/17% White/4% Other).

Because it was widely predicted that the pandemic and the lockdown would decimate and disrupt the lives of the most vulnerable residents, one set of questions in the survey was borrowed from the “Duke-UNC Functional Social Support Questionnaire” which measures “loneliness, social isolation, and social relationships.” These questions were combined with questions that asked respondents to rate, on a scale of 1-10 (with 1 being “easy” and 10 being “hard”), how difficult it had been since the onset of the pandemic to accomplish everyday tasks like getting food, money or health care. Findings from these questions are described and discussed below.

The evidence of SACHR’s success in combatting the effects of the pandemic lies in the resilience and the responses of it’s participants, and their ability to weather the worst of the crisis in relative good health and spirits. SACHR has proved especially nimble in effectively reorganizing and repurposing staff, and in altering the agency’s methods and techniques of service delivery in ways that provide continuity and support for participants who are among the most vulnerable to experiencing the effects of the pandemic.

As a harm reduction agency that serves active drug injectors and sex workers who need constant supplies of harm reduction materials like sterile syringes and condoms, SACHR’s core mission was seemingly threatened by the citywide lockdown that was imposed to combat the COVID virus, but most participants, as seen in the chart below, said that they had no problem getting harm reduction materials that were available for pick-up at the main office or from outreach teams that continued to operate at critical locations across the Bronx.

One worrisome trend that shows up here and in other metrics of how well participants have weathered the lockdown is that women consistently report more difficulty than men in coping with the effects of the pandemic. More research is needed to understand the reasons for this disparity.
One problem that SACHR cannot solve during the lockdown is providing a place for people to spend time, but respondents on the survey show that slightly more than half of them – both men and women – said that it has been relatively easy for them to find a place to spend time. Given that many SACHR participants are homeless and/or tenuously housed, the fact that more than half of them said that it was easy to find a place to spend time during the lockdown is somewhat surprising and requires more research to fully understand where they spend time.
Before the pandemic, many SACHR participants spent considerable amounts of time on the streets and in public places where they mixed and interacted with large numbers of people, and yet, weeks into the lockdown, more than half of them said that they did not have a problem with “social distancing.” Women, however, reported more severe problems than men in maintaining social distancing.
Getting the basic necessities of life – food, shelter and money – are always problems for vulnerable populations like drug injectors and sex workers, and many experts predicted that the pandemic would render the most vulnerable residents of the Bronx homeless and hungry when social support services were suspended or scaled back, but contrary to these expectations, SACHR’s participants showed remarkable resilience in maintaining access to the basic necessities, though women consistently said that they had greater difficulty than men in getting food, shelter and money.
The overall picture that these data provide is that SACHR participants have not experienced the levels of stress, trauma and dislocation as an outcome of the pandemic and its associated hardships that had been predicted by many experts. Support from SACHR is one factor that has allowed their participants to endure the lockdown in better shape than had been anticipated. The degree to which SACHR’s participants defy expectations is also reflected in their assessment of how hard it had been to care for their families during the lockdown. Though it is not surprising that women voiced more problems than men in caring for their families during the pandemic, likely the result of their roles as heads of households and/or primary childcare providers, about half of the women reported that they had very few problems in this regard.
SACHR’s participants include many people who are members of stigmatized and vulnerable populations, and mental health issues are among the constellation of problems that they find help managing with the help of staff at the agency. The pandemic has increased stress levels in every New Yorker’s lives and it was anticipated that this trend would be especially pronounced among SACHR’s participants, especially those with pre-existing mental health issues. The data, however, challenge this assumption. Indeed, more than half of the respondents in the survey said that their mental health had not been problematic during the lockdown.
There are undoubtedly several reasons why mental health issues did not markedly worsen among SACHR participants over the duration of the pandemic, but high levels of social support they receive are among the most important of these factors. Two thirds of the respondents who participated in the survey said that they had “people who care about what happens to me” and that they “get love and affection” “as much as I would like” or “almost as much as I would like.”

Meaningful relationships that sustain participants during difficult times offer more than unconditional love and support, they offer tangible benefits in the form of help and advice about the problems of everyday life. A majority of survey respondents noted that they benefited from “chances to talk with someone about personal or family problems” and that they “get useful advice about important things in life.”
The support that individual participants get extends beyond that which is provided by SACHR staff; the community that has been forged over the years in SACHR’s supportive harm reduction environment ensures that participants support each other in small and big ways, as the charts below suggest:

The success that SACHR has achieved in helping its participants endure the hardships of the pandemic has not been uniformly replicated by other social service and medical providers in the Bronx. A majority of participants said that “getting medical care” had been very difficult during the lockdown.
SACHR has succeeded where others have not because the agency was able to quickly adjust to the changing social landscape in ways that ensured a continuity of services and it managed to extend a critical lifeline to the most vulnerable residents of the Bronx during their time of greatest need. The model that SACHR has pioneered during this transformative period is already demonstrating its effectiveness in preventing and alleviating the worst effects of the pandemic among the most at-risk Bronx residents and it points a way out of morass that threatens all of our lives.
Number 13: Service Provision, Coordination, and Engagement Tracking

Create and implement service tracking forms and subsequent mechanisms to effectively track extended hour specific services, e.g. participant demographics, priority service needs, service coordination, and extended hour services i.e. - meals, groups, programs, referrals to higher threshold services, to produce a quarterly quantitative and qualitative status report.

Quarterly summary narrative spanning 3- months of services, coordination and engagement including but not limited to:

a) description of services and service coordination methods
b) staff involved and staffing changes
c) summary of participant demographics (race, gender, age, zip code/neighborhood of residence, priority service need)
d) service highlights
e) service challenges
f) service counts ( e.g. meals provided, intakes, referrals, etc.)
g) copies of blank service forms, tools, or tracking logs to collect services data, coordinate services or provide referrals
h) if applicable, significant changes made to service provision

a) Description of services and service coordination method:
Prior to the pandemic that ended in-house services in March 2020, the CADI program featured core services that included syringe exchange, meals and showers. Meals were especially important to the program because it was the one activity that nearly everyone participated in, and they provided the opportunity for socializing and bonding between participants, and between participants and staff. Over the first months 2020, staff invested more time and energy into the preparation and presentation of meals, aided by the greater availability of items like various types of gourmet bread, and participants responded. The variety and amount of high-quality food, like during Self-Care Sundays, was often a topic of conversation among participants and it set a environment for the ancillary activities, like dancing and games, that piggybacked off the positive tone that a generous and carefully served brunch established for the day. The addition of groups like Yoga and “Men’s Table Talk,” reflected the sensitivity that staff felt toward the specific needs of participants.

b) Staff involved and staffing changes:
Major staffing changes and restructuring at SACHR began in March as the impact of the COVID pandemic began to affect all New Yorkers. The CEO developed a direct line of communication with all staff via daily “narratives” that sought to identify and capitalize on their strengths in order to reimagine and transform the service delivery models used by the agency. The active participation of staff in unfamiliar roles, especially the preparation of Grab & Go Meals/kits/resources, and their reflection on those roles had the effect of identifying and dismantling the silos that once characterized our work and it fostered a reinvigorated spirit of teamwork among the staff in response to the crisis. In collaboration with a professional consultation, SACHR’s programs and lines of authority were restructured to meet the service needs of their participants who now live in a radically altered urban landscape. In this maturation, the organizational restructuring reflects a paring down of programmatic disciplines with more efficient lines of responsibility and authority.
c) Summary of participant demographics:

<table>
<thead>
<tr>
<th>Ethnicity</th>
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<tbody>
<tr>
<td>Hispanic</td>
<td>77%</td>
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<tr>
<td>Non-Hispanic</td>
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<th>Race</th>
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<tbody>
<tr>
<td>Black/African-American</td>
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</tr>
<tr>
<td>More than 1 Race</td>
<td>4%</td>
</tr>
<tr>
<td>Some Other Race</td>
<td>22%</td>
</tr>
<tr>
<td>White</td>
<td>54%</td>
</tr>
<tr>
<td>Pacific Islander</td>
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<thead>
<tr>
<th>Gender</th>
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</thead>
<tbody>
<tr>
<td>Woman/Girl</td>
<td>20%</td>
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<tr>
<td>Man/Boy</td>
<td>79%</td>
</tr>
<tr>
<td>Transgender</td>
<td>1%</td>
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d) Service Highlights:
Among the service highlights for the quarter are included: 1) an increase in the number of participants, especially on the weekends, 2) greater diversity in the CADI population, especially young men of color, 3) the implementation of new groups that address participant needs, and 4) an upgrade in the quality of meals that have sparked participant comments.

e) Service challenges:
Prior to the pandemic, the primary challenges to the CADI program included: 1) finding and enrolling more eligible participants, 2) finding and retaining staff who have the requisite skills who are willing to work during “off” hours, and 3) ensuring that the growing number and variety of participants were enculturated to a culture at SACHR which champions and promotes respect, tolerance and personal growth.

f) Service Counts: (see below)
g) Copies of blank service forms: see attached forms

h) Significant changes made to service provision:
As a result of the pandemic, a top-to-bottom restructuring of lines of authority and employee roles at SACHR was implemented. The result of this restructuring has been a paring down of programmatic disciplines at the agency with more efficient lines of responsibility and authority. Services like Telehealth have allowed SACHR to maintain and strengthen relationships with participants during the lockdown, and new initiatives like “The Warehouse,” allow participants to take advantage of a wide range of free resources, including ready-to-eat food for all meal types, personal hygiene materials, PPEs, protein-enhanced one-shot bars/cups, first aid supplies; newborn/baby diapers and associated resources; disposable underwear; and safer drug use and safer sex supplies. Going forward, as the lockdown eases,
the installation of appropriate social distancing barriers and protective gear at SACHR will allow for the gradual reopening of the agency and in-house programming.
#12: Quality Assurance (QA) Implementation

Quality Assurance (QA) activities for this quarter (01/15/20-4/15/2020) include all of the following deliverables:

1. A quantitative assessment of all service delivery metrics, including the number of participants served and the number and type of services provided.
2. A survey of participants that asks about their experiences with the CADI program.
3. Qualitative interviews with CADI participants and staff.
4. Ethnographic observation of CADI service delivery and participant interactions.

1) The first two and a half months of 2020 reflected the growing stability of the CADI program and the maturation of the program. The number of attendees had begun to increase since the beginning of the year, topping 650 in the month in February, and included a more diverse group of participants. With new staff that had recently been hired, new groups were offered that appealed to distinct sub-sections of the participants – groups like “Men’s Table Talk” and “Yoga” – groups that reflected the growing diversity of the CADI community. In addition, the implementation of “Self-Care Sunday” was welcomed by participants who enjoyed a hearty breakfast and the music, dancing and games that accompanied the morning’s self-care focus.
2) A survey of participants that asks about their experiences with the CADI program:
A small sample of CADI participants (40) were surveyed in November and December 2019 to find out what they valued in the program and what services they wanted to see more of in the future. Those findings, reported in the last quarterly report, helped staff to create additional services and groups that catered to the interests expressed by participants. In early 2020, a follow-up survey was constructed whose purpose was to find out more about the social networks of CADI participants and people who were not CADI participants, and to better understand how much or how little survey respondents were connected with others, including where they spent their time during the day (when not at SACHR). The survey planned to use “Respondent Driven Sampling” methods and techniques and was scheduled to commence the first week of March 2020 in a vacant office near the 3rd Ave BID, but COVID changed that plan and the office space was quickly rededicated to hosting PPE and other COVID supplies.

Following the lockdown, 2 surveys were constructed and administered by SACHR staff to better understand the impact of COVID on the lives of SACHR participants and others. The first survey was administered in March and April with 53 participants and it asked them to rate, on a scale of 1-10 (with 1 meaning easy and 10 meaning hard), how difficult life has been for them since the lockdown. The initial findings were somewhat surprising in that more than half of the participants indicated that the lockdown had posed little difficulty for them in various areas of their lives (finding money, food, shelter, health care, etc.), except for finding a place to spend time. A follow-up survey with more than 80 participants added an additional bank of questions that gauged social isolation and loneliness. The expectation was that the populations served by SACHR that were already stigmatized and experiencing multiple problems in life would be deeply affected by the lockdown and that their health and mental health would suffer as a consequence. Surprisingly though, the findings showed just the opposite and revealed a hearty resilience among the majority of participants.

3) Qualitative interviews with CADI participants and staff were begun in January and February and included observations and interviews with participants on “Self-Care Sundays. The interruption of these evaluation activities by the pandemic leaves an incomplete data set to fully describes the impact that the CADI program had begun to play in the lives of participants, but the growing momentum created by CADI program was apparent in these observations. Going forward, the agency has recently installed
protective barriers and has an adequate supply of PPE so that observations and interviews can now be scheduled with individual participants, and when SACHR begins to offer in-house services again.
Third Avenue Business Improvement District successfully completed all deliverables for Phase 1 Feasibility Study development. Third Avenue Business Improvement District submitted contract documents for the second round of CADI implementation in August 2019. The deliverables report includes all work completed from January 1, 2020 through March 31, 2020.

**Deliverable 9 – External Marketing Plan**

- Submitted in Quarter 1

**Deliverable 11 – Marketing Plan Implementation**

**Quarter 3**

<table>
<thead>
<tr>
<th>Task</th>
<th>Summary Narrative</th>
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<tbody>
<tr>
<td><strong>Description of External Marketing Activities</strong></td>
<td>While winter months prohibited large scale street activations there was an increase in small sector-based and large multi-sector meetings with an intentional focus on building momentum while also providing updates RE: real estate and programmatic additions/modifications. Additionally, the launch of the Good Neighbor Leadership Program allowed for broader community based work in the areas of harm reduction 101, customer service, and the importance of language and cultural competency.</td>
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<tr>
<td>• 1/6/2020, Multi-Sector briefing following death of program participant</td>
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<td>• 1/7/2020, Press Conference w/ CM Gibson on CADI Community Resources</td>
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<td>• 1/9/2020 LGBTQ Sector meeting</td>
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<td>• 1/10/2020, Capital Funding Briefing with City Council Delegation</td>
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<td>• 1/15/2020, Business Sector meeting</td>
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<td>• 1/21/2020, NYS Business Council CADI presentation</td>
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<td>• 1/29/2020, Bronx BID CADI Roundtable</td>
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<td>• 2/4/2020, NYS Senate - CADI briefing to the Joint Senate Taskforce on Addiction, Recovery, and Overdose Prevention</td>
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<td>• 2/5/2020, Bronx Chamber of Commerce CADI update for South Bronx Businesses</td>
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<tr>
<td>• 2/7/2020, NYC DOHMH CADI Site Visit and Briefing</td>
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<tr>
<td>• 2/11/2020, YMCA of Greater NY briefing of cross CADI programs</td>
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</table>
24/7 Continuous Access Drop In Center

DELIVERABLES REPORT

- 3/5/2020 - Large Multi Sector CADI Community Report Back
- 3/13/2020 - LGBTQ Sector Meeting
- 3/16/2020 - NYPD and District Attorney CADI Briefing and Feedback
- 3/11/2020, Youth Sector Group, Facebook Live session
- 3/24/2020, CADI Engagement Partner ZOOM Tutorial Capacity Building
- 3/27/2020, Bronx Relief Effort, CADI Briefing for additional resources

Awareness

- 2/14/2020-2/17/2020 - NYS Minority Caucus Weekend, 2 CADI Workshop presentations and 1 roundtable with Sen. Rivera
- 3/6/2020-3/8/2020 - SOMOS Albany Conference, 1 CADI Workshop presentation
- 2/20/2020, Good Neighbor Program Seminar - Language
- 2/26/2020 Good Neighbor Program Seminar - Harm Reduction 101
- 2/26/2020, Good Neighbor Program Seminar - Narcan Training

Prior to the COVID-19 pandemic all sector meetings occurred in person; however, in late winter those sessions were also offered on Facebook like. The use of technology broadcast the messaging and content of the sector meetings to a larger scale audience and proved to be a positive adaptation to standard engagement processes. From that point on all public sector meetings are being offered via social media platforms. This proved to be helpful as engagement pivoted to a purely digital offering during the pandemic.

Prior to the pandemic, many standing conferences and gatherings were leveraged to build community support and garner feedback on project status and planning.

Staff Involved:

Consultants: Third Avenue Business Improvement District – Michael Brady and Selam Yemeru
24/7 Continuous Access Drop In Center

DELIVERABLES REPORT

Highlights

The central elements of the external marketing for CADI remain the same - building coalitions and programs while informing implementation. Prior to the COVID-19 pandemic many of this outreach was done using our traditional model. However, we learned in late winter that fully embracing social media platforms and digitizing our outreach materials reached a broader audience. The digital toolbox significantly expanded how we reach community stakeholders and when combined with traditional street outreach cast a wider net for community feedback. This also prepared the engagement team to pivot to 100% digital offerings in light of the COVID 19 pandemic. Programs like the Good Neighbor Leadership Program are now offered digitally and dovetail with a community based public health certification that builds community capacity while reducing stigma.

Challenges / Barriers

Challenges include engagement fatigue for many sector participants. These individuals are traditionally engaged with many community activities; so ensuring that the sector meetings provide new information and new methods to receive feedback has been fundamental.

While significant progress has been made with elected officials and their staff – from education to one-on-one tours and briefings, there are some hold outs that we must continue to work with.

Lessons Learned / Next Steps

Ensure that digital offerings has a translation service provided and that recorded sessions are easily accessible.

Understand that many participants may have device or connectivity barriers that need to be addressed while offering remote services. We have made head way with Google and the Bronx Relief Effort to minimize this digital divide.

Deliverable 15 – Feasibility Plan Implementation

Quarter 3

<table>
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<tr>
<th>Task</th>
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<tbody>
<tr>
<td>Real Estate Search</td>
<td>Two locations have been identified, vetted and had Letters of Intent issued by the project team. Additionally, funding support has been requested from City and State agencies to assist with long term programming and capital build out. Site 1 - 2825 Third Avenue, 2nd Floor This site was home to the Diabetes Relief Center of America and is pre-fit out for a</td>
</tr>
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</table>
public health facing operation. It is located at 148th and Third Avenue in the HUB and provides 6,000 sf of space inclusive of kitchenette, shower rooms, and restrooms, while also accommodating testing rooms, staff offices, and an enormous open space for programming and rest.

- Elidex Realty is the owner of 2825 Third Avenue. Elidex received a non-binding letter of intent from SACHR. This property is currently in a holding pattern as the 2nd floor space is being used for emergency operations associated with the COVID-19 pandemic. The property owner has assured us that he is willing to move forward after the pandemic subsides.

**Site 2 - 2739 Third Avenue (BronxCare)**

This is the ideal site for the CADI Center as it dovetails the medical model with the SACHR and CADI model of human agency. The site is currently master leased to BronxCare with twenty years negotiated into their new lease (effective May 2020). SACHR would occupy roughly 6,000 sf of ground floor space under the LOI sent to BronxCare in early March.

- While BronxCare is the master lease holder the property owner must sign off on any sub-leases. At the time this report was draft BronxCare indicated that their lease renewal for a 20 year extension was finalized, but awaiting a signature from the property owner. Once that lease is fully executed BronxCare indicated that it would welcome a partnership with SACHR’s CADI program. Simultaneously, BronxCare is exploring a partnership with SACHR at its Westchester Ave location to offer buphernorphine and potentially collaborate on shared mental health services.

**Solutions / strategies related to affordability**

2739 Third Avenue appears to be the most promising and we expected a firm response in early February; however, there has been a delay in the property owner signing the 20-year lease extension which has delayed the process. This challenge combined with the COVID-19 pandemic has delayed further negotiation - however, we remain hopeful that the full terms outlined in our letter of intent can be negotiated and resolved in the near future.

The incremental approach with partnerships has assisted in navigating affordability.
**Stakeholder Findings Incorporation**

Stakeholders are eager to see CADI fully implemented. We have fully briefed all stakeholder groups on the real estate plan and feedback regarding siting has been incorporated into our work.

Stakeholders have noted that the BronxCare site more closely aligns with project goals and the feasibility study; however, both sites present a tangible opportunity. The BronxCare site presents a more sustainable model which incorporates a medically focused model with an innovative relationship centered approach to public health.

Additionally, elected official stakeholders have been helpful in identifying funding sources for the FY2021 budget. They include:

- NYS budget line item
- NYC Discretionary Funding – program expansion
- Bronx Relief Effort Funding
- Bronx Foundation Funding
- REMS grant funding from Purdue Pharma

**Staff Involved:**

- Consultants: Third Avenue Business Improvement District – Michael Brady and Selam Yemeru
- Architect: ACQ Architects
- Real Estate: Hiram Torres, VP of Facilities and Operations - BronxCare
- Doug Riech, Chairman of Family Medicine - BronxCare

**Highlights**

A good deal of headway on site location and implementation has been made with LOIs issued to two locations which align with the feasibility study. The BronxCare site presents the best location for CADI while also creating a sustainable partnership between SACHR and a Bronx Health system. The COVID-19 pandemic has put both opportunities on hold.

**Challenges / Barriers**

COVID19 and property owner delay in lease negotiations have stalled the LOI and future lease process.

**Lessons Learned / Next Steps**

Ensure that stakeholders are fully aware of the real estate process and its impact on moving the project forward.
February 25, 2020

Elidex Realty, LLC
2825 Third Avenue
Bronx, New York 10455

RE: Letter of Intent to Lease
2825 Third Avenue – 2nd Floor South
Bronx, New York 10455

Dear Mr. Saad:

This correspondence shall serve as a Non-binding Letter of Intent to lease the property located at 2825 Third Avenue Bronx, New York 10455.

Proposed Terms and Conditions:

Property: Legal Description: Block 2326 Lot 33 is a 1-story building owned by F & J Realty Co. LLC and has an estimated floor area of 12,000 sf. The building has a R6 zoning with a C2-4 commercial overlay. The building’s current tenant is BronxCare – Third Avenue Medical and Dental Practice.

Municipal Address: 2825 Third Avenue – 2nd Floor
Bronx, New York 10455

Lease Term:
Primary term to be three (3) years effective June 1, 2020 or upon completion of the premises or Tenants occupancy the latter of which shall be the determining date. Tenant to retain two (2) renewal options each for a period of three (3) years.

Property Access:
Tenant to have full and complete access to the Property ninety (90) days prior to the Lease Commencement date in order for the Tenant to initiate and complete Tenant improvements necessary for the intended use of the premises.

Upon completion tenant shall have 24/7 access to the building 365 days a year.

Lease Rate:
The lease rate shall be $29.00 psf for 5,500 sf and shall not exceed $159,500 / annually or $13,291.66 / month. The lease rate shall include all property taxes and M&O expenses.
Rent for the first option and second period shall be increased by 3% per year.

**Deposit:**
A deposit check in the amount equal to the first month’s rent shall accompany the executed Lease Agreement.

**Capital Improvements:**
The tenant shall submit to the landlord a capital improvement plan and budget and shall be responsible for all capital upgrades to the building except for those that are assigned to the property owner.

**Expenses:**
The following details the party responsible for the respective expenses:

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<th>Description</th>
<th>Responsible Party</th>
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<td>E. Janitorial</td>
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<td>F: Trash Removal (Exterior Grounds / Dumpster)</td>
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<td>G: Driveways / Parking Lot / Grass / Yard</td>
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<td>H: Roof / Structural Maintenance</td>
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<td>I: Interior / Exterior non structural</td>
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<td>K: Liability Insurance</td>
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<td>L: Property/Fire &amp; Extended Coverage</td>
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<td>N. Property Taxes</td>
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<td>O. Glass / Windows Maintenance</td>
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<td>P. Security/Locks/Keys</td>
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**H/VAC:**
Landlord to insure that all H/VAC systems are in good working condition prior to occupancy and shall, for a period of one hundred and twenty days (120) days from date of occupancy, be responsible for any repair and/or replacement necessary.

**Electrical / Plumbing:**
Landlord to insure that all existing electrical system(s) and plumbing system(s) are in good operating condition prior to occupancy. Thereafter Tenant shall be solely responsible for all Electrical & Plumbing systems (Tenant responsible only for plumbing above the slab. Landlord to warrant all plumbing for 60 days from lease commencement).

**Permits/Licensing:**
Lease Agreement is contingent upon Tenant obtaining all necessary permits to include occupancy, zoning etc. necessary for operating the intended business.

**Signage:**
Tenant to be responsible for any new signage in front of the leased property; however, the Landlord shall be responsible for the removal of any unwanted existing signage.

**Environmental:**
Tenant cannot be responsible for any existing contamination at the site. Although Tenant does not anticipate environmental problems, Tenant will require copies of whatever environmental information that the Landlord may
have to assist in the environmental evaluation of the Property prior to Lease execution.

**ADA Compliance:**
If required by New York State or Federal law, Landlord shall be responsible for the property to comply with ADA regulations for restrooms and property access.

**Tenant:**
St. Ann’s Corner of Harm Reduction
886 Westchester Avenue
Bronx, New York 10459
Joyce Rivera, CEO
jrivera@sachr.org

**Intended Use:**
The tenant shall use the aforementioned property for a 24/7 Care Center as associated with the mission of the organization.

**Non-Binding:**
This Letter of Intent is completely non-binding and has no effect on either party whatsoever until a Lease Agreement has been fully executed by both Tenant and Landlord.

Each party shall keep confidential each of the provisions of this Letter of Intent and all information each party obtains regarding the other party, and Landlord shall not offer subject property to any other prospective tenant during the term of this Letter of Intent. This Letter of Intent supersedes any and all previous negotiations with Tenant, whether written or verbal.

If the above terms and conditions are acceptable, please indicate in the appropriate space provided and provide a formal lease agreement for the sub-tenants review within ten (10) days of the acceptance date of this Letter of Intent. Please consider this proposal valid until 5:00pm, ______________________________.

**AGREED TO AND ACCEPTED:**

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<th>MASTER LEASE HOLDER</th>
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Print: ____________________________  Print: ____________________________
Date: ____________________________  Date: ____________________________
February 28, 2020

Mr. Hiram Torres
Vice President, Operations
BronxCare Health System
1650 Selwyn Avenue
Bronx, New York 10457

RE:  Letter of Intent to Lease
BronxCare – Third Avenue Medical and Dental Practice
2739 Third Avenue
Bronx, New York 10451

Dear Mr. Torres:

Per our conversation, this correspondence shall serve as a Non-binding Letter of Intent to sublease the property located at 2739 Third Avenue Bronx, New York 10451 within the context of the assignability clause of the Master Lease.

Proposed Terms and Conditions:

**Property:**

*Legal Description:* Block 2326 Lot 33 is a 1-story building owned by F &J Realty Co. LLC and has an estimated floor area of 12,000 sf. The building has a R6 zoning with a C2-4 commercial overlay. The building’s current tenant is BronxCare – Third Avenue Medical and Dental Practice.

*Municipal Address:* 2739 Third Avenue
Bronx, New York 10451

For the purposes of this lease negotiation, the proposed lease would include 6,000 sf of ground floor space with a designated entry way, as well as three parking spaces.

**Lease Term:**

Primary term to be three (3) years effective May 1, 2020 or upon completion of the premises or Tenants occupancy the latter of which shall be the determining date. Tenant to retain two (2) renewal options each for a period of three (3) years.
Property Access: Tenant to have full and complete access to the Property thirty (30) days prior to the Lease Commencement date in order for the Tenant to initiate and complete Tenant improvements necessary for the intended use of the premises.

Lease Rate: The lease rate shall be $25.00 psf for 6,000 sf and shall not exceed $150,000 / annually or $12,500 / month. The lease rate shall include all property taxes and M&O expenses.

Rent for the first option and second period shall be increased by 3% per year.

Deposit: A deposit check in the amount equal to the first month’s rent shall accompany the executed Lease Agreement.

Capital Improvements: The tenant shall submit to the landlord a capital improvement plan and budget and shall be responsible for all capital upgrades to the building except for those that are assigned to the property owner as outlined in the Master Lease.

Expenses: The following details the party responsible for the respective expenses:

A. Electricity (Demised Premises) Sub-Tenant
B. Electricity (Exterior Signage) Sub-Tenant
C. Water / Sewer Master Lease Holder
D. Gas Sub-Tenant
E. Janitorial Sub-Tenant
F: Trash Removal (Exterior Grounds / Dumpster) Sub-Tenant
G: Driveways / Parking Lot / Grass / Yard Sub-Tenant
H: Roof / Structural Maintenance Master Lease Holder
I: Interior / Exterior non structural Sub-Tenant
J: Window Washing Sub-Tenant
K: Liability Insurance Both
L: Property/Fire & Extended Coverage Both
N: Property Taxes Master Lease Holder
O: Glass / Windows Maintenance Sub-Tenant
P: Locks/Keys Sub-Tenant

H/VAC: Landlord to insure that all H/VAC systems are in good working condition prior to occupancy and shall, for a period of one hundred and twenty days (120) days from date of occupancy, be responsible for any repair and/or replacement necessary.

Electrical / Plumbing: Landlord to insure that all existing electrical system(s) and plumbing system(s) are in good operating condition prior to occupancy. Thereafter Tenant shall be solely responsible for all Electrical & Plumbing systems (Tenant responsible only for plumbing above the slab. Landlord to warrant all plumbing for 60 days from lease commencement).
Permits/Licensing: Lease Agreement is contingent upon Tenant obtaining all necessary permits to include occupancy, zoning etc. necessary for operating the intended business.

Signage: Tenant to be responsible for any new signage in front of the leased property; however, the Master Lease Holder shall be responsible for the removal of any unwanted existing signage.

Environmental: Tenant cannot be responsible for any existing contamination at the site. Although Tenant does not anticipate environmental problems, Tenant will require copies of whatever environmental information that the Landlord may have to assist in the environmental evaluation of the Property prior to Lease execution.

ADA Compliance: If required by New York State or Federal law, Landlord shall be responsible for the property to comply with ADA regulations for restrooms and property access.

Tenant: St. Ann’s Corner of Harm Reduction  
886 Westchester Avenue 
Bronx, New York 10459  
Joyce Rivera, CEO  
jrivera@sachr.org

Intended Use: The sub-lease agreement shall be provided by the Master Lease Holder.

Non-Binding: This Letter of Intent is completely non-binding and has no effect on either party whatsoever until a Lease Agreement has been fully executed by both Tenant and Master Lease Holder.

Each party shall keep confidential each of the provisions of this Letter of Intent and all information each party obtains regarding the other party, and Landlord shall not offer subject property to any other prospective tenant during the term of this Letter of Intent. This Letter of Intent supersedes any and all previous negotiations with Tenant, whether written or verbal.

If the above terms and conditions are acceptable, please indicate in the appropriate space provided and provide a formal lease agreement for the sub-tenants review within ten (10) days of the acceptance date of this Letter of Intent. Please consider this proposal valid until 5:00pm, ______________________________.

AGREED TO AND ACCEPTED:

TENANT MASTER LEASE HOLDER

_________________________________  ___________________________________
Print:_____________________________  Print:_______________________________
Date: ____________________________  Date: ______________________________
MINUTES AND ACTION ITEMS

Meeting: BronxCare Facilities Overview and CADI Integration
Location: BronxCare, 1650 Selwyn Avenue
Date: Wednesday, February 26, 2020, 2:00pm
Present: Hiram Torres – Vice President, Operations (BronxCare)
Doug Reich, MD – Chairman, Family Medicine (BronxCare)
Joyce Rivera – CEO (SACHR)
Michael Brady – CEO (Third Avenue Business Improvement District)

The meeting between the aforementioned parties was convened to explore the possibility of program integration and colocation as part SACHR’s 24/7 Continuous Access Drop In Center initiative.

Joyce Rivera provided an overview of SACHR programs, mission, vision, and more specifically the CADI program model. Ms. Rivera noted that the BronxCare location at 2739 Third Avenue was under consideration by SACHR for a possible partnership to full deploy CADI goals. Ms. Rivera noted that this integration would create a paradigmatic shift in community based public health and integrate existing medical models with human agency models of care. The BronxCare site is currently underutilized and an integration of services would maximize utilization, reduce strain on medical staff, reduce visits to emergency rooms, provide a stop gap to address HHC’s reduction of detox units, provide early identification for morbidities, center healthcare in community, and align the healthcare model with intersectional realities and change.

Michael Brady provided a high-level overview of the Feasibility Study SACHR released in August 2019 and spoke to the three scenarios for bringing a 24/7 Care Center online. Brady highlighted the natural synergy with BronxCare and areas where BronxCare could maximize on DSRIP value-based reimbursement as well as SAMSHA deliverables. Brady noted that pending BronxCare’s timeline, lease renewals with the landlord, etc. CADI would be a well-positioned complement to more fully utilize the BronxCare space. Brady then ask BronxCare for feedback on lease renewals, rates, etc.

Hiram Torres indicated that BronxCare expects to finish the lease negotiation with the landlord over the next week and that the final copy of the lease is waiting for the landlord’s signature. Torres stated that the new lease provides BronxCare with 15-20 years of operation at that location, with an annual rent of approximately $500,000. Torres indicated that the sub-lease clause of the Master lease allows BronxCare to sublease 40% of the total useable space. At present BronxCare has 6,000sf of underutilized space. Torres stated that this space is in the lower level, but that he would be willing to think creatively – and potentially move the dental unit to the lower level to accommodate CADI goals.

Torres noted that BronxCare was considering opening a cardiology unit at the Third Avenue location; however, that has been paused during lease negotiations and he is uncertain if the cardiology partner is interested in moving forward. Torres noted that he would know over the next two weeks if the cardiology partner is still interested in partnering. If that does not occur, he would like to move forward with SACHR’s CADI program and behavioral health programs. Torres indicated that the current price per square foot is $36.00; but that he would try to see if there was room to bring that down to $20-$25 psf. Torres also noted that SACHR may want to consider partnerships with for-profit partners, like urgent care centers – he noted ESSEN Medical. NEXT STEP: SACHR will draft and hold a Letter of Intent for 6,000 sf of ground floor space at the Third Avenue location.

Torres went on to state that BronxCare’s model includes working with existing partners in different catchment areas with a focus on connecting those patients to BronxCare Hospital where they can be fully integrated into care (surgical, etc.). In this scenario BronxCare would rent and build out a site at a partner location and provide medical staff and funding to a partner for staff time. The goal would be that patients in partner care centers would then be referred to BronxCare for general care / treatment. Torres referenced the successful BronxCare
expansion to Washington Heights. Torres stated that in addition to exploring the Third Avenue site for CADI we should discuss SACHR’s immediate medical needs and how this model can be integrated.

Joyce Rivera noted that a logical connection would be administering buprenorphine with a secondary need for a psychiatrist. Dr. Riech noted that there was a shortage of psychiatrists and that there were other models that could provide similar care and that there could be a cost sharing to maximize resources. Michael Brady stated that SACHR has a store front which is slated to be activated and could provide the space necessary to begin this program integration. **NEXT STEP: SACHR will develop a draft proposal for BronxCare to activate the storefront location with aforementioned services. Doug Riech will provide a similar proposal from BronxCare.**

Mr. Torres concluded the meeting by stating that the landlord should send an executed lease in the next week. Pending that lease, Mr. Torres will contact the cardiology partner, if that partner if not prepared to move forward he would like to move immediately with SACHR.

Dr. Riech stated that he would provide a follow-up call with Joyce Rivera and also begin the MOU / Agreement necessary to formalize services and move toward more permanent services deployment at the SACHR Center’s Westchester Avenue location.

The meeting ended at 3:30pm.
Date: ________________

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## CADi

**EVENINGS & WEEKEND SHOWERS**

### Monday, Wednesday & Friday

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<th>Participant Name</th>
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St. Ann's Corner of Harm Reduction

Date: ________________________

**CADI EXTENDED HOURS**

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**Meal Sign In Sheet**

DATE: ____________  
TIME: _______ - _________

[ ] Breakfast/Desayuno [ ] Lunch/Almuerzo [ ] Supper/Cena [ ] Saturday/Sábado [ ] Sunday/Domingo

WORKER: ____________________________  
SIGNATURE: _________________________

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**Staff Assessment Codes**

1. Drug Use
2. Lost Syringes/Known Exchanger
3. Police
4. Homeless/Housing

**Race Codes**

- 01. PUERTO RICAN
- 02. BLACK OR AA
- 03. ITALIAN
- 04. IRISH
- 05. POLISH
- 06. JEWISH
- 07. SWEDISH
- 08. ENGLISH
- 09. GERMAN
- 10. CARIBBEAN
- 11. COLUMBIAN
- 12. CUBAN
- 13. ISRAEL
- 14. PORTUGUESE
- 15. FRENCH
- 16. DUAL RACE
- 17. KOREAN
- 18. DOMINICAN
- 19. SOUTH AMERICAN
- 20. MEXICAN / MEXICAN CHICANO (A)
- 21. CENTRAL AMERICAN
- 22. WHITE
- 23. OTHER
- 34. Mexican

**Contingency Contracting (CC) Reasons**

- 01. Homeless – No Place To Store Syringes
- 02. Marginally Housed (Transitional Housing Of Any Type)
- 03. Police – Afraid Of Arrest
- 04. Police – Conducting Neighborhood Sweeps
- 05. Police – Syringes Confiscated
- 06. Leaving For Extended Period (Days / Weeks)
- 07. Long Travel Distance – Coming From Far Away
- 08. Disposed Of Syringes – Hiding Use From Spouse / Family
- 09. Binging – Injecting More Frequently
- 10. Fearful – Drug-Induced Paranoia
- 11. Other: ____________________
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<th>LA</th>
<th>WH</th>
<th>AA</th>
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<th>Native Hawaiian or Pacific Islander</th>
<th>American Indian Native Alaskan</th>
<th>More Than One Race/Ethnicity</th>
<th>OTHER</th>
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### IDUHA/CDC Health Education

- Drug Use Management and Stopping Techniques
- Syringe Exchange, Syringe Cleaning, Effective Medication
- Substance Use Treatment Induction
- Needle Exchange Maintenance
- Overdose Prevention Education
- Overdose Knowledge of User
- Opioid Use Recognition at Site
- Opioid Use Myths about Reversal
- Opioid Use Stead for Response & Reversal
- Harm Reduction Education
- HIV Prevention Education
- STD Prevention Education
- Alcohol Use Education
- tuberculosis Prevention Education
- Hepatitis Prevention Education
- Mental Health Education
A). Overview-Objectives and activities

In Community Partnerships: Community Talent Show, SACHR invited the NYCDOHMH to consider the perspective of community as organic and inclusive of everyone and offering safety for everyone. If this positive standpoint is the goal of civic life, then public health has a social metric and context by which to identify sub-metrics for policy development, investment, and measurement of success and/or failure, or degrees thereof.

The organic community, in practice, is beset by divisions driven by politics that favors some groups over others. Warrens of disadvantage are created over time by policies that are institutionalized across all social sectors with outcomes now called social determinants. Stigma is a systemic instrument that, once embedded into received culture, becomes ‘naturalized’, appears as if G-d-given, and eludes social critique. One of the accomplishments of harm reduction has been its collective work to deconstructing the ‘naturalized’ stigma against Persons Who Use Drugs (PWUDs). Because harm reduction emerged to fight against State-imposed prohibitions against access to syringes, and since State-action was directed at the poor and communities of color, Stigma, herein, is viewed as an instrument of State power against the poor and communities of color.

The driving idea behind the Talent Show was to expose the ‘naturalized’ stigma for what it denies, the intra-subjective experience of humanity. SACHR teamed up with Pregones/PRTT to create an opportunity to amplify the voices of those who voices are silenced; whose bodies are criminalized; whose personhood is marginalized; whose life tethers between passivity and internalized rage. The purpose was also to demonstrate to the audience, who consisted of providers and other local stakeholders how from their various schools of training and experience they too misperceive and blindly/willfully enact stigma.

Following along the timeline of previous quarters, the 4th quarter began with the building of a storyline for the end of quarter show. Pregones Artistic Director (Jorge Merced), his assistant dramaturge (Yanilka R.S.) and two managers were developing a central skit focused on Women-who-use-illicit substances and Stigma. Our Birth Justice Reproductive Health HUB Manager led a discussion on the use of punishment at a major Bronx acute care facility against pregnant Black and Latinx pregnant women. Informed by our participants and colleagues, she described, how poor working-class mothers’ urines are routinely tested for cannabis. Mothers-to-be with positive toxicology are subsequently monitored with the threat of neo-natal infant removal by the Agency for Children’s Services. There was unanimity on the central skit on women supported by others specific to relationships and stigma; a dance revue; solo singers/poets; a salsa improvisation; and the art show.

Then COVID hit us in mid-March.
B). Update

Upon Governor Cuomo placing the state of New York on PAUSE, SACHR – an essential public health provider – shifted all operations to align with the order. The decision to prioritize maintaining our services open to participants led to innovative programming, extended hours, while placing on hold groups and/or congregate services. The Talent Show fell victim to the ‘Pause’ and adjustments had to be made to move to a digital talent show via Zoom/Video. Due to the digital divide among participants the talent show has been postponed until the Fall or Winter so that participants can safely lead the event's production with appropriate digital resources. To facilitate closing the digital divide, SACHR secured funding for the purchase of smart phones for participants.

Additionally, a relationship with El Barrio Art Space and artistic director Emanuel Hernandez also has been cultivated to allow social distance filming of participants for the virtual talent show. This was piloted with the 2020 Bronx LGBT Pride celebration where stakeholders, many of whom are part of our LGBT stakeholder group, created an hour and a half long Bronx Pride presentation with the Third Avenue Business Improvement District.

C). Staff Opportunities & Challenge

Pregones/PRTT, like other local and cultural resources, has shuttered its doors and moved to replays of performances via Zoom/other digital platforms. Resources for staff, including enhanced salaries via a reduction of hours and emotional wellness support, have helped to keep spirits lifted and pronounced teamwork.

D). Highlights and Lessons Learned

Community Partnerships – Talent Show is focused on deconstructing with the goal of eliminating the unexamined use of stigma that so deprives the poor and people of color of their, and our shared, humanity. Stigma diminishes the other by diminishing the humanity of the person who enacts stigma; it is a double-edge sword. In strengthening equitable, fair participation in the community, we are driving transformative community change.

The harm reduction culture that SACHR created, promoted and built over the decades has been one reason for the diversity of the agency’s participants, and it is the reason why we have been able to switch gears from providing congregate to individualized services, like Grab & Go Meals, Drug User Health needs, Birth Justice Health needs, and telehealth (upcoming).

The talent shows have centered the social ostracism that our constituencies have historically, and continually experience. Our participants are socially conditioned to social isolation—it is in those spaces that resources are limited, where government is unprepared to help, where people are vulnerable to diseases for which they cannot locate protection—whether it is a sterile syringe or a protective gear. By remaining open and extending service hours, SACHR has prioritized the humanity and well-being of participants and reduced their social isolation. In all ways, this has been the goal of the Talent Show.