Update for Destination Home

As presented by the Corporation for Supportive Housing
to the community of Evansville, Indiana

May 21, 2012

Contact Person:
Lori Phillips-Steele
Director, Indiana Program
Corporation for Supportive Housing
320 North Meridian St., Suite 1027
Indianapolis, IN 46204
Lori.Phillips-Steele@csh.org
317-632-5864

About the Corporation for Supportive Housing

The Corporation for Supportive Housing (CSH) is a national non-profit organization and Community Development Financial Institution that helps communities create permanent housing with services to prevent and end homelessness.

Founded in 1991, CSH advances its mission by providing advocacy, expertise, leadership, and financial resources to make it easier to create and operate supportive housing. CSH seeks to help create an expanded supply of supportive housing for people, including single adults, families with children, and young adults, who have extremely low-incomes, who have disabling conditions, and/or face other significant challenges that place them at on-going risk of homelessness. For information regarding CSH's current office locations, including Indiana, please see www.csh.org/contactus. For more information about CSH's consulting and training services, please contact the CSH Consulting Group at consulting@csh.org.

Acknowledgements

CSH wishes to acknowledge all those who participated in conversations and discussions that helped to shape this document and the Charrette process. Most especially, CSH thanks the Charrette Core Group for all their time and energy before and during Charrette week.

Inquiries

If you are interested in learning more about Destination Home, please contact Luzada Hayes at luzhayes@auroraevansville.org. For information on CSH, please visit www.csh.org for additional on-line resources and materials. If you have questions or comments regarding this document, please contact Lori Philips-Steele at Lori.Phillips-Steele@csh.org.

Update for Destination Home

Table of Contents

Introduction

The Corporation for Supportive Housing (CSH) is pleased to present this report to Destination Home partners and stakeholders. Committing to conduct a thorough, thoughtful and intentional review of implementation of strategies to end homelessness is risky. To do it in an open and authentic manner is laudable. CSH witnessed this throughout the process and hopes that the same authenticity comes through in this document.

CSH also appreciates the willingness of the Commission on Homelessness to undertake the Charrette process as a method of analyzing, discerning, and ultimately making difficult decisions about moving forward on complicated issues.

This report is intended to inform the next body of work under the six issue areas identified and examined through this process; to lay a framework for the next level of work under Destination Home; and to increase the success of the work of Evansville, Indiana for its citizens – homeless and housed.

Success of Destination Home to Date

In December of 2004, Destination: Home was launched and implementation began in 2005, including the formation of the city-county Commission on Homelessness. Many strategies are underway. Below are some highlights of success, a full report is available *(see Appendix A).*

2011 PIT count for Vanderburgh County went down 10.6% (482 compared to 539 in 2010)

- Through the Homelessness Prevention and Rapid Rehousing Program (HPRP), 164 households (480 individuals including 285 children) were prevented from homelessness, and 251 households (604 individuals including 298 children) ended their homelessness

- Lucas Place II opened in 2011 and currently houses 27 formerly homeless Veterans. This increases units of permanent supportive housing to 67.

- The Universal Service Program (USP) was approved to assist customers with a discount of 15%, 26%, or 32% on the gas utility portion of their bill during the months of December through May. This program assisted 5,773 customers for a total benefit amount of $695,154 from 12/1/10- 5/31/11 in the Southern service area.

- The Re-entry Network in partnership with IHCDA and CSH launched the Welcome Home 82 Initiative, a Re-entry project aimed at 20 individuals involved in the criminal justice system and connecting them to housing and support. Partnerships were expanded to include Indiana Department of Corrections, and the Vera Institute of Justice. The first offender was housed in September 2011. The program has already successfully exited one participant who purchased his own home.

- Seven sites for PlaySpaces have been equipped; with funding support from Welborn Foundation, 4C of Southern Indiana assumed the recruiting and training of volunteers for the program and to equip parents with learning-through-play skills
    - There are currently 40 active volunteers
    - Approximately 500 PlaySpace sessions are held per year

- Bridges project has trained and/or exposed over 2,600 persons in the area to Bridges Out of Poverty principles. The Bridges business user group has expanded outreach to Employers of lower wage workers.

The Charrette Process

To condense planning time while involving a broad range of stakeholders, Destination Home engaged the Corporation for Supportive Housing (CSH) to facilitate this work using the CSH Charrette process. The CSH Charrette is specifically designed to help communities address key issues in ending homelessness at the local level. Similar to a traditional architectural Charrette, the CSH Charrette provides a fast-paced but thorough exploration of the critical aspects of developing plans and action steps. CSH Charrettes capitalize on local and external expertise as well as the community organizing principle of engaging stakeholders in a dynamic process.

The goal of this Charrette was to produce a feasible plan, benefitting from the support of stakeholders throughout its implementation. After the Charrette process, the project enters its implementation phase and depends on the commitment and approval of the community to move forward.

Steering Committee: Destination Home established an 8 person core group that supported community meetings; chose six key themes to address; invited participants; recommended local experts; and provided ongoing guidance and participation in the process. The group met regularly from March 20th through May 11th, 2012 before convening more than 100 stakeholders for the Charrette itself (*See Appendix B for list of Core Group members and Charrette participants).*

Charrette Week kicked off on May 14, 2012 with two full days of intense dialogue at the University of Evansville, Ridgeway Center. The conversation focused on six issue areas:

- Access to Permanent Housing
- Coordinated Entry and Prevention
- Healthcare
- Re-entry
- Performance Measures
- Homeless Children and Youth

Each conversation occurred in a "fishbowl" setting with a group of experts sitting in a circle surrounded by outer circles of community stakeholders. For the first hour, the local and external experts engaged in a dialogue that encouraged thinking of new systemic and programmatic responses in the issue areas. Experts from diverse communities and organizations drew from their experiences and expertise to exchange views and craft suggestions for moving forward. *(A full list of experts with their biographies is in Appendix C.)*

While the expert dialogue occurred, the rest of the Charrette participants observed the discussion without comment. Half way through, the conversation among the experts ended and CSH facilitated audience observations and feedback. During this time, the experts were not allowed to respond, and community members were given ample opportunity to agree with or challenge the experts and to offer other suggestions on the issue areas. The purpose of this part of each session was to engage the community members in the discussion and benefit from their expertise and experiences

Following the intensive public process, CSH distilled the information into draft recommendations for each issue area as well as specific recommendations for both local communities and the state itself. This was presented at an open community meeting on May 17th from 6-8 p.m. at the Ridgeway Center on the University of Evansville campus. At this session CSH heard input on how well the recommendations did or did not reflect the learning from the Charrette. The feedback session also tested the recommendations to gauge their likelihood for implementation. CSH then incorporated the feedback in their final report presented at another public meeting on Monday, May 21st from 11-12, also at the Ridgeway Center.

Recommendations

These recommendations represent ideas presented in the Fishbowl sessions that will have the most impact on meeting the ambitious goals of Destination Home. Each issue area has a short introduction, followed by suggested action items. The report concludes with recommendations on three additional topics, including Implementation.

Issue Area Action Items

1. Access to Permanent Housing

Housing is a fundamental need every resident of Evansville and Vanderburgh County has – a safe, decent, affordable place to call home from where all other functions of life develop. As a community, households experiencing homelessness and/or at-risk of homelessness have had difficulty finding housing that is affordable, safe, and meets Housing Quality Standards (HQS). Households that are vulnerable and have high barriers – such as little to no income, living with disabilities, substance abuse disorders, chronic health issues, large families, criminal histories, numerous hospitalizations, poor credit and/or rental histories – will be in need of housing that is affordable and supportive services that assist in maintaining housing.

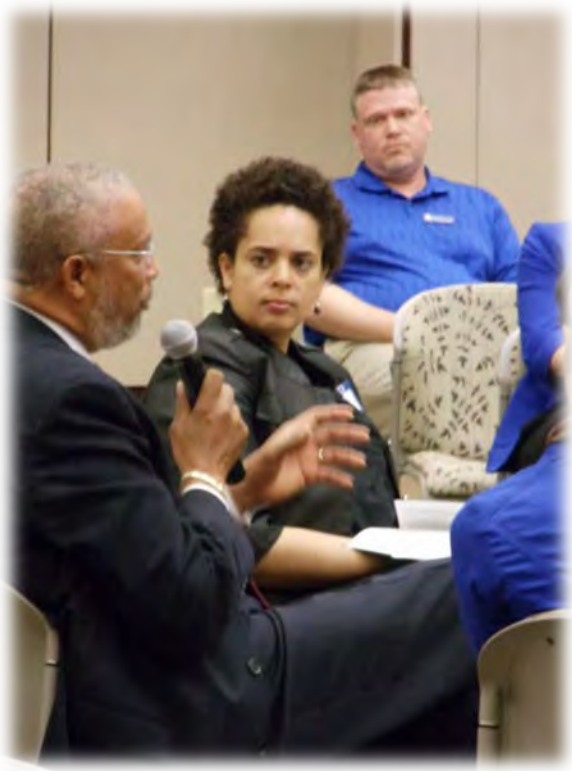
Many efforts are underway to increase access to permanent housing for households experiencing homelessness. The recommendations outlined below are designed to build on activities that are currently underway in the community, align with the direction of the federal and state changes to homelessness resources, and identify new local opportunities to increase access to permanent housing through rapid re-housing efforts and through creation of permanent supportive housing (PSH).

BEST PRACTICE

Working with Public Housing Authorities

PHA's administer a powerful resource for creating supportive housing for homeless and extremely vulnerable populations –through Section 8 vouchers and their public housing stock. Particularly in today's difficult funding environment, public housing authorities' resources, capacity, and experience serving extremely low-income individuals and families, make them critical partners in our efforts to create supportive housing and end homelessness.

- http://www.csh.org/news/focusing-on-public-housing-authorities-role-in-ending-homelessness



These recommendations challenge homeless system staff and key stakeholders to think outside the box to develop innovative strategies to overcome local barriers that restrict access to existing housing units, improve the quality of current housing stock, while also increasing the production of new permanent supportive housing units. Lastly, increasing access and stock of permanent housing available to households experiencing homelessness is becoming increasingly more important. Providing services to households that are homeless is no longer enough. Within the service and housing system providers must be able to demonstrate that households are moving into permanent housing in a quicker, more efficient and streamlined fashion, reducing the length of time households remain homeless and reducing trauma associated with homelessness.

1. 1 Identify PSH unit goal for implementation – based on HMIS data, PIT counts, household characteristics, and current housing inventory determine the need for additional PSH units, broken down by singles and families and timeline for creation.

BEST PRACTICE

Short-Term Rent Assistance (STRA)

As part of the Portland/Multnomah County 10 Year Plan to End Homelessness, the City, County and Housing Authority underwent an extensive systems change effort to consolidate short term rental assistance. There were 3-4 different systems and several boutique programs. Now the Housing Authority administers over six different resources (from FEMA, to HOME TBRA, to SHP, HPRP and others) to more than 40 diverse non-profits throughout the county with consistent outcomes, simplified reporting (all into HMIS), funding priorities across populations, and an advisory body made up of funders and providers. Because of this, Portland and Multnomah County can use outcome measurements to drive systems change. Outcome measurements included: 70% retention after 12 months of placement, 80% retention after 12 months of prevention assistance, Average cost per household - $953

1. 2 **Conduct analysis of current emergency shelter and transitional housing stock to identify opportunities to best target resources and to re-purpose programs to create more permanent housing options** such as conversion of transitional housing to rapid re-housing leasing and supportive service funding or PSH or respite care. Additionally within analysis identify target populations that will best benefit from transitional housing and time limited services and housing, such as youth in transition and survivors of domestic violence.

1. 3 **Build capacity of local providers to create partnerships to develop PSH units** and ability to provide scattered site PSH.

1. 4 **Ensure the implementation of the landlord registry** that is user friendly and easily accessible for case managers, housing locator staff, and clients in identifying available housing units, bedroom size, rent levels, geographic location, ability to pass Housing Quality Standards (HQS) inspections and accept short-term and long-term housing subsidies, etc.

1. 5 **Conduct a rental housing vacancy analysis** to identify the number of vacant units by bedroom size, geographic location, ability to pass HQS inspections, and rent level to identify availability of existing housing stock for at-risk and homeless households. Additionally, the analysis should identify the need for housing subsidies to make units affordable and amount and extent of rehabilitation needed to bring existing housing stock to HQS.

1. 6 **Increase awareness of landlords and property managers** of housing and service needs of at-risk and homeless households and build opportunities for partnership between homeless service and housing providers and landlords and property managers to provide quality housing and ongoing stability, while ensuring households are good tenants and neighbors in the community.

1. 7 **Work with Evansville Housing Authority (EHA) to educate landlords/property managers about Housing Choice Voucher Program** (Section 8) and other homeless housing subsidy programs (such as Shelter Plus Care, Supportive Housing Program, Tenant Based Rental Assistance, etc) and availability of supportive services to assist with housing stability, being good tenants and neighbors and work collectively to address problems as they arise.

1. 8 **Develop marketing materials and messaging to effectively communicate and sell rapid re-housing short-term assistance and prevention resources** (rapid re-housing short-term leasing assistance and

prevention resources) to landlords and property managers.

1. 9 Create a resource, such as a virtual eviction prevention hotline for landlords, to ensure that landlords have a resource to turn to when their tenants are having difficulty in their housing or are at risk of eviction. This support will enable supportive service staff to step in and assist the tenant to help them meet the requirements of their lease to prevent eviction and ensure their housing stability.

1. 10 Explore, identify, and advocate for funding opportunities at the local, state, and federal level to increase the quality of the existing rental housing stock to target units for PSH and/or rapid re-housing
    a. Weatherization resources (grants or low-interest loans) available to landlords and rental housing owners to weatherize housing units to meet HQS and reduce ongoing utility costs
    b. Rehabilitation resources (grants or low-interest loans) available to landlords and rental housing owners (such as local HOME, or CDBG resources)

1. 11 Create a flexible pool of funding that can be accessed by homeless service providers and landlords/property managers to fill gaps in moving and sustaining households into permanent housing, creating a pool of funds to mitigate the landlord's risk.
    a. Damages to rental housing units that landlords/property managers can apply for if formerly homeless tenants damage units
    b. Paying for deposits and fees, such as applications fees, pet and security deposits, 1st and last month rent, etc

BEST PRACTICE

BeRemedy – Deschutes Co. Oregon

Residents in Deschutes Co. can join BeRemedy and receive a weekly text highlighting needs of individuals and families who are either homeless or moving into housing. Anything from socks to beds are requested and there is almost always someone in the community who can meet the need. This reduces the cost of warehousing furniture and furnishings as well as provides an ongoing process to engage people in the community to provide assistance. A text line is one way to implement this, but other social media such as Twitter and Facebook an also provide the platform. More information is available here. Icon City - BeRemedy

1. 12 Coordinate a system-wide commitment of faith based communities, business partners, local civic clubs and groups, and other community partners to streamline housing related donations to prepare households moving into permanent housing. Collectively identify needs, collect donations, and prepare move-in packages for households moving into permanent housing to include things such as dishes, linens, cleaning supplies, etc

1. 13 Explore funding opportunities available to EHA to access housing resources to create and increase PSH housing opportunities. (such as Section 811, Family Unification Vouchers, VASH, Rental Assistance for Non-Elderly Person with Disabilities Program, etc.).

1. 14 Review the Administrative Plan of EHA to identify and advocate for opportunities to expand access to homeless households including eliminating barriers to accessing HCV and public

housing units such as criminal history, credit history, rental history screening criteria, etc.

1. 15 **Work with EHA to explore opportunities to create PSH units** including partnering with communities based providers.

1. 16 **Implement new Rental Rehab Program** The Housing Committee of the Commission on Homelessness is working to create a rental rehab program for families who are homeless that would be a sweat equity, lease to own program where you could rent for up to 5 years with option of purchasing after. The Evansville Housing Authority owns the property and will renovate it and be the property manager.

1. 17 **Effectively and efficiently implement the new Rapid Re-housing ESG resources** Work with IHCDA to identify how HPRP rapid re-housing resources were utilized locally, the successes and challenges of implementation, and how to effectively and efficiently implement the new Rapid Re-housing ESG resources locally.

1. 18 **Integrate cultural competency and language access components into program development and implementation** Require that all housing programs funded with community resources integrate cultural competency and language access components into program development and implementation, (for example, do management and service delivery methods and structure support people served?).

1. 19 **Utilize outreach resources and ESG funds** to assist households in transitioning from homelessness to housing.

BEST PRACTICE

Dayton-Montgomery County coordinated intake

Dayton-Montgomery County just recently went through a local decision making process and have been implementing a coordinated Front Door Assessment system for over a year. They serve as a good example of how to develop a system within a short period of time and using data to guide the process. Lastly, they have shared the lessons they've learned in moving toward a coordinated system that can inform the process locally.
Dayton-Montgomery County Front Door Assessment Presentation - http://www.slideshare.net/naehomelessness/210-joyce-probst-alpine-8637499

1. 20 **Build capacity of providers to serve the most vulnerable** and high housing barrier households in permanent housing including implementing best practices on housing first, harm reduction, trauma informed services, etc.

2. Coordinated Entry and Prevention

Coordinated access provides the community with a uniform, consistent method of assessing household's needs and connecting them with housing resources across the entire system. Coordinated or centralized intake and assessment has been a major component of communities that have successfully reduced the length of time households have remained homeless and reduced the overall number of people experiencing homelessness. Additionally coordinated or centralized intake is a new component outlined within the newly released HUD McKinney Vento Emergency Solutions Grant Program and will be required for communities to effectively connect and target households with the most appropriate housing resources. This could be accomplished in a number of different ways for Evansville and Vanderburgh County, including utilizing a single entry point (a location, phone number, web-based system, etc.) that uses a common, system-wide set of

intake, assessment and application forms. The overall goal is to ensure that households experiencing homelessness, or are at-risk of homelessness, have a consistent experience as they seek housing services and are connected to the best resources to meet their needs. A system like this one would ensure that they do not have to call or visit numerous providers to access services and would remove the 'luck' of visiting the right provider on the right day and time. The following recommendations are provided to best meet the goal of creating a coordinated system and connect households to prevention resources.

2.1. Creation and implementation of a community-wide, coordinated intake and assessment process to assess, triage and target homeless interventions for Prevention (P), Rapid Re-housing (RR), Emergency Shelter (ES), Transitional Housing (TH), and Permanent Supportive Housing (PSH).
   a. Utilization of 211 and IHOPE to best create and implement a system that works. These two great resources are already underway in the community and can assist in moving to a more coordinated system.
   b. Creation of one, community wide application, screening criteria, and standard program acceptance and rejection criteria to be used by all providers to ensure consistent implementation across program types is implemented to remove 'luck' from the equation. This includes targeting appropriate interventions for those who are situationally homeless as well as those experiencing long-term, chronic homelessness.
   c. Utilize HMIS to share client specific information across providers and program types to eliminate duplication of data requests and data entry, and to house documentation materials such as identification, evidence of a disability, homelessness documentation, etc..
   d. Educate and build awareness on coordinated intake and assessment process for front line staff and community partners (i.e. law enforcement, hospitals, etc.)

2.2. Work to identify gaps within the system and target new resources and reprogram existing resources to address these gaps. Analyze current ES, TH, and PSH screening criteria to identify where housing resources are currently focused. After looking at data on needs of individuals who are homeless, determine where gaps in system are. Use this informaiton to adapt existing resources in system and to determine targeting of new resources. Ensure that the systems focus is on screening tenants in, rather than screening them out, to better serve households that are homeless.

BEST PRACTICE

Centralized Intake – Grand Rapids, MI

Grand Rapids, MI has had a centralized intake process for persons in a housing crisis since the 1980s, for single adults, and recently has expanded to include homelessness, through the Housing Assessment Program (HAP). HAP assesses households that are at-risk or literally homelessness and partners with local providers to connect households to appropriate housing intervention. HAP is profiled, along with other communities, in the HUD report 'Centralized Intake for Helping People Experiencing Homelessness.' http://www.hudhre.info/documents/HPRP_CentralizedIntake.pdf

2.3. Promote and increase awareness of 211 and IHOPE in the community and encourage routine update of information and resources.

2.4. Expand the work of the current Homeless Prevention Coalition to explore opportunities to pool prevention resources and distribute resources using one entity in the community (including faith based, local, state and federal prevention resources). These resources should be integrated into the coordinated intake and assessment system.

2.5. Identify and implement an assessment tool for Prevention resources targeting those at most risk for homelessness, including those with multiple housing barriers and characteristics associated with homelessness such as single parent households with young children, history of homelessness, involvement with child welfare system, etc.

2.6. Educate and build awareness of prevention resources and eligibility requirements to private landlords to prevent evictions. Additionally, work closely with EHA to identify households most at risk of eviction and homelessness and target prevention resources (financial assistance and case management).

2.7. Use available data to identify geographic 'hot spots' of evictions and target prevention resources and education. This information can be used to partner with neighborhood associations and specific landlords.

2.8. Work closely with Re-entry Network to create discharge planning protocols for jails and prisons to link individuals to housing resources in the community.

BEST PRACTICES

Coordinated Entry

There are many resources and toolkits to assist think through the creation and implementation of a centralized/coordinated intake and assessment system. The NAEH has a Coordinated Assessment Toolkit with community examples that is very helpful in beginning local conversations and help guide a local decision making process.

NAEH Coordinated Assessment Toolkit http://www.endhomelessness.org/content/article/detail/4514
NAEH Coordinated Assessment Toolkit - Community Examples - http://www.endhomelessness.org/content/article/detail/4532

3. Healthcare

Individuals and families experiencing homelessness in Evansville and Vanderburgh County have the benefit of Destination Home's Homeless Healthcare Network (HHN). This network is focused on providing high quality, integrated healthcare and support services and the strategies encompass both physical and mental health. The HHN creates strategies for serving individuals who have chronic health conditions and linking individuals and families with primary health and behavioral healthcare, stopping the revolving cycle of costly emergency care. HHN coordinates with the Re-entry Network to ensure those discharged from hospitals, jails, and prison who are homeless or at high risk receive appropriate access to care and treatment to prevent recidivism. It also coordinates efforts across the outreach teams including the Veterans Administration Center outreach team. HHN coordinates with the Re-entry Network to ensure that those who are discharged from hospitals, jails, and prisons who are homeless or at high risk receive the appropriate access to care and treatment to prevent recidivism.

BEST PRACTICE

Chicago Housing for Health Partnership

Chronically medically ill individuals who are experiencing homelessness face enormous barriers to obtaining and maintaining housing as they cycle through utilizing emergency services including hospital emergency rooms, inpatient hospital services, and nursing homes. The Chicago Housing for Health Partnership (CHHP) responded to this issue by identifying this population in hospital emergency rooms and linking individuals to permanent supportive housing. This form of housing includes intensive case management services to ensure improved health outcomes and housing stability. Research demonstrates that for every 100 individuals experiencing chronic homelessness housed, nearly $1 million in public funds can be saved making this "hospital to housing" approach both humane and cost effective. For more information, see www.aidschicago.org/housing-home/chhp.

Many people experiencing homelessness have chronic health conditions exacerbated by life on the streets and cycling in and out of shelters. These conditions often result in making frequent trips to the emergency room and/or not seeking care until the symptoms are acute. In addition, those with serious health conditions who are experiencing homelessness leave the hospital or clinic without an appropriate setting to heal or follow medication regimens. People need access to integrated primary and behavioral healthcare linked with social services and permanent housing options to improve their health outcomes. Those experiencing long-term and chronic homelessness require a comprehensive approach that focuses on movement toward

permanent supportive housing as a long-term approach to recovery with improved health outcomes and reduced use of emergency care.

3.1 **Prioritize and invest in supportive housing for those who are medically vulnerable.** Create healthcare strategies with a focus on housing as a foundation for recovery.

3.2 **Build on and strengthen linkages to the Veterans Administration** to ensure access and delivery of high quality services for Veterans and their families experiencing homelessness. Assess system for gaps in coordinating healthcare and support services to Veterans and their families experiencing homelessness. Integrate health delivery with outreach to Veterans.

3.3 **Identify a physician "champion"** to help convey the importance of a coordinated system of care for those experiencing homelessness and assist in the effort to create a medical respite program.

3.4 **Develop a respite care program** for those experiencing homelessness who are living on the streets or in shelters and need a place to recover from an illness or for those leaving the hospital who need a place to recover. Use hospital and outreach data to determine the number of beds needed in a respite care facility. Identify partners and funding sources for respite program. Consider repurposing existing space for respite care program

3.5 **Develop an intentional strategy to help individuals move directly from respite care into supportive housing**, avoiding release back to shelter or streets.

3.6 **Create a jail diversion program in partnership with the Evansville Police Department**, the local jail and the court system. For those individuals experiencing homelessness, create rapid linkages to appropriate housing and service options in the community (supportive housing). Develop a range of addiction recovery, mental health and healthcare treatment options for those diverted from jail to prevent costly recidivism.

3.7 **Create cross-system service and funding strategies for services in supportive housing by working** with partners to identify mechanisms for reimbursing primary and behavioral health care services through Medicaid and other sources 1) Services in housing 2) Outreach and engagement services 3) Primary and behavioral health clinic care

3.8 **Explore how healthcare reform** could impact care and coverage and actively engage in and advocate with State partners on healthcare coverage for those experiencing homelessness.

3.9 **Identify and reduce barriers to accessing healthcare by examining** the current primary care system for barriers and developing strategies for increased linkages among primary healthcare providers and the homeless service delivery system providers. Dedicate a part-time person to work with pharmaceutical programs to access free

samples and Coordinate outreach and linkage to healthcare. Adopt a triage nurse program for use by homeless program staff to determine if participants need to go to the emergency room (ER). Identify the appropriate provider of care for each individual and Create healthcare allies to help individuals get to and from appointments and build relationships between individuals experiencing homelessness and their healthcare provider

3.10 Develop an integrated approach to behavioral and physical healthcare including the integration of treatment for addictions and Provide training on best practice approaches for integrated care and expand access to behavioral health care

3.11 Provide assertive community treatment (or similar level of services) staff willing to work with people with severe mental illness including medical management, benefits restoration, and ongoing long-term assertive support services delivered in the home and on the streets and in shelters. Create recommendations for how this level of service can be provided both to Medicaid and non-Medicaid eligible individuals or households.

3.12 Create strategies for obtaining benefits and regaining benefits when leaving institutions by Continuing systems work to ensure continuity of services and funding and avoid gaps in services for people transitioning from institutional settings or for those who have lost their benefits for other reasons and Obtaining Community SOAR training through collaborative effort with the Division of Mental Health and Addiction.

3.13 Develop strategy for restorative dental care for individuals experiencing homelessness. Research programs providing free or much reduced cost restorative dental care which may involve identifying dentists willing to provide their services at a free or much reduced cost.

BEST PRACTICE

Jail InReach – Cook County

Trilogy, a behavioral healthcare agency, created an effective jail inreach model as part of the Frequent Users of Cook County Jail and Mental Health Services Project. As part of this project Trilogy placed a case manager in the jail who worked with targeted inmates with histories of cycling between homelessness, incarceration and the mental health system. The case manager engaged with inmates to develop a plan for post release services and linkages between inmates and participating mental health providers to support and guide their successful transition from jail to supportive housing. The case manager assessed targeted inmate's personal, medical, social, emotional, and environmental status in order to plan for linkage and treatment course and provided individually-based motivational treatment to assist in their recovery from mental illness. Trilogy also offered a toll free linkage number as well as emergency phone triage to inmates to assist them in coordinating and linking with their identified follow-up provider. Housing is an essential part of the follow-up services.

4. Re-entry

In 2011, 875 offenders were released and returned to Vanderburgh County. Hundreds more were released back to the community from the local county jail. A significant number of these individuals struggle to find housing due to their convictions, lack of resources, and estranged family relationships. They struggle through the transition of returning to the community without structure, support and supervision, causing a majority of them to exhibit symptoms of PTSD. Many lack marketable skills, transportation, and connections to employment opportunities.

The Re-entry Network is the planning body that coordinates Re-entry activities and includes service providers, parole, probation, mental health, drug court, healthcare and others. One of their projects is the Welcome Home 82 Initiative which is a pilot project using 20 housing vouchers from IHCDA to create permanent supportive housing for ex-offenders. The University of Southern Indiana is the evaluator for this pilot project. The Re-entry Network has begun to see system change based on their efforts (an example of this is a Judge reaching out to the outreach team that lead to the individual going into treatment rather than into prison).

4.1. Conduct Social Support Assessment and Planning through Inreach when possible and post incarceration when not, work with people exiting

BEST PRACTICE

Hennepin County FUSE Program

The Frequent User Service Enhancement (FUSE) program is a Housing First initiative in Hennepin County MN created as a partnership between St. Stephen's Human Services, Hennepin County Community Corrections, Hennepin County Human Services and Public Health Department, the Minnesota Department of Human Services, and the Heading Home Hennepin Initiative. FUSE was targeted to 50 individuals who were high users of the county correctional and shelter systems who had a history of crimes that were directly related to their status as homeless. This project was designed to use housing as an intervention to transition individuals quickly into housing to both improve the quality of life of the person and reduce costs to the county.

The participants in FUSE had an average length of homelessness of 8.1 years and more than 50% struggled with mental illness or chemical dependency. The 22 month program evaluation demonstrated the following outcomes:

- 85% of FUSE participants reduced their shelter use
- 60 % of FUSE participants decreased their arrests
- There was a total reduction of 1,704 less shelter nights (a 43% reduction)
- 700 less nights spent in county jails (39% reduction).

corrections to assess and plan their social supports to assist them in identifying who they can turn to when they return to the community. Include their families and other supports in these meetings when possible.

4.2. Outreach to Faith Communities to increase number of congregations connected to the Re-entry Network to support needs of ex-offenders (move in kits, transportation to visit incarcerated family members, act as allies/mentors, etc.) and to assist with exploring ways to increase faith based resources.

4.3. Work with prisons and jails to start application process for benefits (SSI, Medicaid, etc.) before exit from facility. Provide SOAR training.

4.4. Increase collaboration between Evansville Police Department and the Homeless System Cross training between systems. Someone with authority from Evansville Police Department sits on the Homeless Services Council. Create peer to peer exchange to support best practices. Crisis Intervention Training for police officers.

4.5. Coordinate work of agencies addressing juvenile justice to ensure effective impact and address gaps in services.

4.6. Increase Access to Public Housing for Ex-offenders work with the Evansville Housing Authority to explore reducing barriers to access for ex-offenders and create opportunity for ex-offenders to return home to their families living in public housing when they exit corrections.

4.7. Improve Housing Access and Choice for Ex-offenders Develop strategy for locating housing that meets Housing Quality Standards and is located in areas of the city that support reintegration. Develop relationships with landlords to address barriers faced by ex-offenders seeking housing.

4.8. Develop Re-entry Network Policy Plan that fosters outreach and advocacy to increase resources for ex-offenders in the community.

4.9. Work with corrections to develop plan to provide mental health assessments before exit to support matching ex-offenders with housing that best matches their needs, and follow up post release to ensure supports continue for appropriate needs.

4.10. Explore creating a website that notes resources available for ex-offenders.

4.11. Explore expanding resources for ex-offenders to support increasing employability and income level. Ensure system has sufficient resources for ex-offenders to increase skills and improve employability. Work with businesses to reduce barriers to employment for ex-offenders, including both eligibility and flexibility (attending to parole or probation responsibilities, participating in supports, etc.).

4.12. Support Families Staying Connected to Incarcerated Family Member both through case management support and through connection to community resources that support family member's ability to connect by providing transportation and other resources.

5. Performance Measures

Fewer resources mean fewer opportunities to make the case for housing and services for people experiencing homelessness. It's no longer enough to just talk about the need. A more effective argument can be made by showing how well a community is doing to end homelessness, including using data to make effective arguments about reducing costs in expensive emergency systems. Also, these measures define how well a community is doing by its people that are experiencing homelessness, which is the ultimate goal of these plans. Additionally, performance measures are primarily a tool to measure program effectiveness, not just to show success. Honestly and transparently understanding that no program is perfect, and a willingness to be open to evaluation and improvements will only increase the opportunities to end and prevent people's homelessness. These action items can help move forward on performance measures while also increasing political and community support for the issue.

5.1 Designate a convener/implementer to oversee the process of developing community wide outcomes and managing the implementation. The convener/implementer should be a single entity, and either a) not be a provider or b) be a provider that does not present a real or perceived conflict in the process. This could be another committee under the commission.

5.2 Consider a cross staffing of this work with Coordinated Entry. Many of the systems change issues that will arise as a result of implementing performance measures will also come up in the planning for Coordinated Entry. Cross staffing, or occasional joint meetings will help facilitate communication and easier methods for planning for change.

5.3 Determine what success looks like for the community. Work through differences of opinion to ensure that measures are inclusive, and also adequately measure performance across a broad range of programs.

5.4 Use IHCDA Planning Council measures (derived from HEARTH Act metrics) as system-wide measurements to help define program outcomes and funding. Those are:

a. HEARTH ACT Metrics
   - Decrease Point-in-Time count
   - Increase emergency shelter diversions
   - Reduce length of time people are homeless
   - Increase income of assisted households
   - Increase permanent housing exits
   - Reduce recidivism

b. IHCDA measures
   - Reduce recidivism of households experiencing homelessness.
   - Decrease the number of Veterans experiencing homelessness.
   - Decrease shelter stays by increasing rapid re-housing to stable housing
   - Decrease the number of persons experiencing Chronic Homelessness.
   - Decrease the number of homeless households with children.
   - Increase the percentage of participants in Continuum of Care funded projects that are employed.
   - Increase persons experiencing homelessness access to mainstream resources.

- Collaborate with local education agencies to assist in the identification of homeless families and inform them of their eligibility for McKinney-Vento education services.
- Improve homeless outreach and triage to housing and services.
- Improve HMIS data quality and coverage, and use data to develop strategies and policies to end.
- Develop effective discharge plans and programs for individuals leaving State Operated Facilities at risk of homelessness.

5.5 Involve Funders in the process to develop performance measures for the homeless system. The more they are involved in defining success, the more likely measurements will be streamlined. Liaison at city and county with IHCDA to review all funding that touches homelessness.

5.6 Use measures to show the effectiveness of relationship building in helping to end and prevent people's homelessness. Identify natural family and community supports to help people maintain health and housing beyond provider services. Keep the focus on the outcome of the relationship versus counting contacts or other reports that show outputs, but not outcomes.

5.7 Define consistent outcomes and keep them as simple as possible. For example, if the system is going to track retention after housing placement, does it track after financial assistance ends, after service ends, after leaving a program, etc? Does it track at 6 months, 12 months, longer?

5.8 Look at cost effectiveness of programs within emergency shelter, transitional housing, supportive services, and permanent supportive housing categories. Consider their outcomes, population served, program design (as well as other variables) and understand the variation by programs.

5.9 Analyze the existing reporting requirements to determine what has to be reported versus what would be nice to know. Streamline reporting requirements to ask only necessary information needed to track key performance measures.

5.10 Provide resources for data analysis, including training, time and staffing. Data without the capacity to analyze for local and statewide use will prove inefficient and inadequate.

5.11 Develop a process to share outcomes across and among providers in the system through regular meetings (monthly, quarterly) to promote transparency and accountability among providers and funders. Use that process to promote a system of support for success for helping to end people's homelessness. Sharing information helps promote shared accountability, creating an environment where all providers are responsible for reduced lengths of stay in shelter (for example), not just shelter providers.

5.12 Share information with political and community leaders to make the case for greater investment in ending and preventing homelessness.

5.13 Combine data with people's stories and experiences. Reports only provide part of the picture, narrative describing the knowledge of homeless and formerly homeless people as well as staff is integral to getting a fuller understanding of programs and systems outcomes.

5.14 Continue to report out to the community on progress toward implementation on a regular basis. It helps hold the plan accountable, it keeps stakeholders informed, and providers see that all that data entry means something, in the end.

5.15 Allow for mistakes. Programs and systems undertaking changes to better serve and house homeless people will be taking risks that may result in some failures. Allowing for that will permit agencies to continue to try new approaches and learn from those mistakes.

5.16 Consider using new tools (technology, like air cards and iPads) to reduce the steps and therefore the amount of time that front line staff spends collecting and reporting information. Portable case management

5.17 Ensure data system (HMIS) is user friendly by allowing agencies to generate reports and make changes to the database that do not alter the full system, but allow for additional custom reports.

6. Homeless Children and Youth

It is estimated that over 500 children in the Evansville School Corporation are currently experiencing homelessness. It is incredibly difficult to identify families who are doubled up and young adults who bounce from one couch to another, so it is likely that the actual number of youth without permanent housing is higher than can be documented. Households lacking stability often include children who do not have all of their basic needs met, are at risk of falling behind in school, and may struggle to maintain healthy relationships if they move frequently. As well, youth aging out of the foster care system and those exiting the corrections systems are in great danger of facing homelessness. Both young children and young adults need advocates, age appropriate interventions, and a community response that involves caring for the developmental needs of the youth in addition to ensuring stable and safe housing.

6.1 **Formalize the body that works together on behalf of families with children facing homelessness.** Include all agencies that work with this population and develop strategies to improve the coordination of services to families with children who are experiencing homelessness or at risk of homelessness. Members of this specialized group should include: School Corporation, Agencies providing services to this population, Department of Child Services, Juvenile Justice System

6.2 **Approach funders in a coordinated fashion.** As a coordinated entity, this group should work together to approach funders regarding support for identified community strategies to end and prevent child homelessness.

6.3 **Incorporate a question related to permanent housing into the school corporation enrollment process** so that families who qualify can be made aware of transportation funds to keep the child in his or her current school.

6.4 **Add questions about housing stability to the childcare referral hotline** to identify those who may also require other services in addition to child care. Those who require rapid rehousing or homelessness prevention assistance should be directed to the single point of entry for their need.

6.5 **Send information regarding resources for families with children and young adults facing homelessness to 211.** This valuable resource offers information and referrals, so it is imperative that they have updated information regarding opportunities for families with children and young adults.

6.6 **Expand the PlaySpaces program** since it is effective. In addition to reaching families in shelters, also include other families who meet the school corporation definition of homeless and those in permanent supportive housing. Consider utilizing schools as places where this program can take place.

6.7 **Set aside spaces for children facing homelessness in programs such as Head Start, Big Brother Big Sister, and other programs designed for youth** to prioritize this vulnerable population.

BEST PRACTICE

Lighthouse Youth Services – Ohio

Lighthouse Youth Services, serving Southwestern Ohio, provides support to families and youth who are in crisis. Programs offered include a juvenile corrections facility, youth crisis center, transitional living for 18 – 24 year olds, permanent supportive housing for homeless young adults suffering from a mental illness, and a youth employment program. With a strong understanding of the impact of childhood trauma, clinical workers in a variety of programs wrap services around youth who require support, and work with the family unit in all possible cases. Services related to mental wellness and substance abuse compliment stability supports such as identifying employment and housing opportunities.

The Lighthouse Civic Justice Corps program is funded by the U.S. Department of Labor, and serves 18 – 22 year olds who have been adjudicated through the Juvenile Justice System. This voluntary offering aims to reduce recidivism, reunite youth with the community in positive ways, and promotes education and career level employment. Based on the Restorative Justice Model and using service learning projects, youth are engaged in landscaping and/or light construction to agency partners who wish to partner with this program to promote the success of the participants. After completing 32 hours of service learning, participants move into paid apprenticeship positions with Lawn Life. They receive case management, mentoring, leadership training, and may participate in therapy if needed.

http://www.lys.org/index.html

6.8 **Target and accept the most vulnerable families into permanent supportive housing** so that those with the most barriers to obtaining and maintaining housing can utilize this resource.

6.9 New Child Enrichment Center should target homeless families and those at risk of homelessness so that this resource can be utilized by those who have the greatest needs.

6.10 Map out services from birth to age 23 and then share this information with community partners, including giving it to 211 and the national runaway switchboard to include in their database for referrals. Also share with the community at large through agencies.

6.11 Conduct outreach to families residing in motels to ensure that those who may be on the brink of homelessness are aware of support services in place in the community that can help prevent homelessness.

6.12 Assess the effectiveness of the National Runaway Switchboard Let's Talk Curriculum with youth providers. If appropriate, offer this training for providers and work to promote awareness of the offerings of NRS in the community by partnering with the Evansville School Corporation to spread the message.

6.13 Establish a contingency fund for young people with an income and no co-signer and engage landlords in the mission of housing this population.

6.14 Identify resources and gaps for pregnant and parenting teens in order to set goals for addressing their needs. For example, pregnant and parenting teens may require day-care, flexible educational opportunities, vocational training, parenting skills, and daily living skill building.

6.15 Increase involvement in Fostering Connections, a Department of Child Services program that involves community members mentoring youth aging out of foster care to grow the youth's support network.

6.16 Link older youth and young adults to education and employment opportunities. In this process, identify partners who will play a role in identifying opportunities and connecting this population to necessary resources.

6.17 Collaborate with the Reentry Network to ensure that youth involved in the Juvenile Justice System are offered necessary support. This will involve working to build a positive support network in the community for the young person, educational and employment opportunities, and supports needed to obtain and maintain housing.

Other Action Items

7. Implementation

7.1 Create the infrastructure to implement the Plan. Aurora staff and many others have been instrumental in the implementation of Destination Home to date, however, this has been done with Aurora staff spending working on this project while also doing their regular jobs.

7.2 In communities across the country, plans that are implemented well often are as a result of paid full time staff whose job it is to "work" the plan. Consider seeding one position in an organization that is either a) not a provider or b) a provider that does not present a real or perceived conflict in the process, with supporting coordinators for other subcommittees. Foundations that support systemic change and bigger impact work would be appropriate places to approach for seed funding resources.

7.3 Consider how you phase out each of the action areas and strategies. Assign timelines and remember that not all of the work will happen immediately. Create a table for each action area and strategy that you develop with attainable timelines, how you know you are successful, and person(s) responsible. Prioritize what you need to do and can do. *(See Appendix D)*

7.4 Repurpose existing committees instead of creating new committees. There will be meetings to work out the details of implementing the plan, if there are existing committees doing work, attach those committees to Destination Home rather than creating parallel processes. For example, the homeless prevention coalition could become the group that manages the coordinated entry process. Also, once a committee has done its work, do not be averse to ending that committee.

7.5 Continue to use the local Continuum of Care body as the coordinating committee. There should be one place where each of the committees can report in and talk about cross cutting issues. The existing Continuum of Care process via the Homeless Services Council of Southwestern Indiana can support or should be set up to play that role. Coordinate with IHCDA's Homeless Planning Council to share implementation ideas, struggles and successes across the state. A paid position that is seeded to "work" the plan can do this.

7.6 Create early wins and projects. This will keep people engaged and interested. Ideas include:

a. Identifying the longest shelter stayers in all the shelters, and prioritize them for housing placement and assistance to get out of the shelter with a "whatever it takes" approach.
b. A frequent user project with jails, hospitals or both.

7.7 Engage elected officials. Do a ribbon cutting ceremony with elected officials with the heads of key local government agency decision makers announcing the Update to Destination Home. Ask each agency to commit to 2 or 3 action steps and then ask for political support. Fill the room with community members that are interested in ending and preventing homelessness.

BEST PRACTICE

Worcester, MA

Worcester, MA successfully tackled their goal of ending chronic homelessness within three years by moving the needle from 109 people to occasionally one or two. The Community Health Network and South Middlesex Opportunity Council worked collaboratively with the Home Again Planning Process of Worcester Task Force and the State Commission to End Homelessness. An additional partner included the Health Foundation of Central Massachusetts that funded the assessment center where the centralized intake process was conducted. This collaborative concluded that a paradigm shift to a Housing First/Rapid-Rehousing model was needed.

The Home Again model included key strategies of (1) targeting individuals experiencing chronic homelessness through a centralized intake and assessment or triage system; (2) providing a 1:10 staff ratio in the early stages of individuals being housed and then increasing that number as clients began to stabilize; (3) fostering client choice in housing selection; (4) adapting the housing to the client's changing needs, and (5) ensuring timely access to treatment programs. The providers used a client-centered approach both in engagement and housing. As part of this process, the community repurposed existing resources for new needs and cost efficiencies. For example, a local organization transitioned from providing emergency shelter providing permanent housing solutions along with client centered services and linkages to resources.

http://rootcause.org/documents/Homelessness-Issue.pdf

7.8 Continue with the Commission. Consider its role in providing oversight and accountability to the plan. Consider adding members from law enforcement and corrections as well as faith community leaders and individuals who have experienced homelessness. Create a committee of the Commission that will identify funding streams for implementation. The committee can help pool grant writers and other resource development coordination, to go after community based resources as well as be ready when federal resources arise.

7.9 Create a Consumer Advisory Council. Homeless and formerly homeless people should have a say in the plan's implementation. A council that is led and directed by people who understand the causes and solutions to homelessness is a tremendous enhancement to any plan implementation effort. Circles might be a good place to host such a group.

7.10 Continue good work on issues not covered in the Charrette, such as raising incomes and Veterans. Evaluate and update those committee charges if necessary. Additionally, stay flexible and open to other opportunities and issues.

8. Community Awareness

Evansville and Vanderburgh County are caring communities with individuals, agencies and congregations that are committed to preventing and ending homelessness. There are a wealth of community resources that bring together different entities to work on these efforts, but there is still a lack of understanding among the general public about homelessness, the homeless system and its impact on Vanderburgh County and Evansville. Broader community understanding and participation has the potential to lead to increased resources and support to reach the ambitious goals of Destination Home.

Currently there are several approaches to raising community awareness of Destination Home which include a website and an annual celebration event where the community is invited to hear about success of plan. Periodically press releases and press conferences are used to share progress and updates with the community and a video is currently being produced. The Commission on Homelessness reports annually to the City Council, the County Council and the County Commissioners on progress on the plan.

8.1 Create Speakers Bureau Train program staff, volunteers and homeless individuals to talk about the importance of the homeless system to the community. Program staff can share knowledge of their organizations and how they fit into the system, volunteers bring experience serving people who are homeless, and homeless individuals bring the story of their life, which has the most potential to educate the community about homelessness and its impact. Members of the Speakers Bureau would meet with community groups, civic organizations, faith communities and others about the importance of homeless programs, services and housing to the community. Former Re-entry housing participant, who just became a homeowner, if interested, is an example of who could be a very effective and powerful speaker.

8.2 Use Speakers Bureau to do outreach to neighborhood associations to spread word in the community about the need and work of the homeless system in their community.

8.3 Explore adding a committee or roundtable of funders to the Commission on Homelessness to increase their participation in the conversation on how we address homelessness in the community.

8.4 Create communication strategy with network of churches, synagogues and mosques that have a ministry connected to homelessness, ex-offenders, and other vulnerable populations about why serving homeless people is an important part of the community and how congregations can become involved in supporting this work. Focus on relationships building with Church leaders (Pastors, Rabbis, Imams, etc.)

8.5 Develop strategy to raise awareness about 211 so members of the general public know they can use this resource if there is a social service need of a friend, family member or neighbor. Also create strategy to promote 211 to programs that aren't part of the homeless system but offer aid such as food stamps, schools, motels and neighborhood associations.

8.6 Develop approach and message to civic organizations and business trade associations to support them as potential employers and potential funders. Provide opportunities for their employees to volunteer.

9. State Policy and Advocacy

Destination Home leaders find that some barriers to ending homelessness require strong collaboration with State government partners. With representatives from Destination Home and the Regional Planning Council on the State's Planning Council on Homelessness (SPCH), the community has been well represented in planning activities at a State level. Through the process of updating Destination Home, the community has recognized the need to expand its role in statewide public policy planning and advocacy. There are a number of committees and partnerships underway through SPCH and representatives from Vanderburgh County can assist the State in its work to develop public policy that leads to ending homelessness through prevention, rapid rehousing and permanent supportive housing efforts. Support for these types of programs with resources targeted to the right intervention will reduce public system costs and improve outcomes for a variety of populations with multiple needs.

9.1 Create a cross system public policy committee to track and understand local, national and statewide policy efforts that have an implication on local efforts impacting the implementation of Destination Home.

9.2 Create recommendations for best practices in discharge policies in collaboration with the Indiana Department of Corrections (IDOC), the Division of Mental Health and Addiction (DMHA), the Indiana Housing and Community Development Authority (IHCDA) and SPCH to:

a. Identify and resolve barriers to in-reach into jails and prisons
b. Review discharge policy implementation from hospitals, State Operated Facilities (SOF), jails and prisons for individuals at high risk of homelessness with a mental illness, history of substance use and/or chronic health condition.
c. Review internal discharge policies to ensure they do not prohibit individuals with a mental illness or those with behavioral health conditions from participating in early release or step-down programs.
d. Encourage the State to include assessments for risk of homelessness in their discharge planning process and to link individuals with appropriate local partners.
e. Use data elements to identify individuals most at risk of homelessness and create strategies to prevent release into shelters, streets or precarious housing situations.

9.3 Advocate for an on-going plan for filling funding service gaps by working with DMHA, IHCDA, IDOC, Indiana State Department of Health (ISDH) and SPCH– both for non-Medicaid eligible services and for services provided to those not eligible for Medicaid. This work will build on the SPCH efforts to create a support service delivery model for services in supportive housing.

9.4 Support efforts to apply for new and potential funding streams to provide support in housing for those who are at highest risk of homelessness or already living in supportive housing. This effort would include resources available through or in partnership with DMHA, IHCDA and the Office of Medicaid Policy and Planning (OMPP) to

9.5 Partner with the Indiana Chapter of the National Alliance on Mental Illness (NAMI Indiana) in planning for supportive housing for those experiencing homelessness who have a serious mental illness or co-occurring substance issue.

9.6 Advocate for prioritizing funding and support for FUSE (frequent users service engagement) projects with the goal of reducing high costs of inpatient medical and mental health treatment and emergency room, jail and prison costs. A reduction in these costs will have a positive impact on the programs administered through the State agencies.

9.7 **Strengthen policies and support for youth aging out of foster care to prevent and end homelessness** by working with the Department of Child Services (DCS) and SPCH to review existing policies and funding.

9.8 **Develop policies and funding targeting homeless families** and assist with better coordination of services to children and families experiencing homelessness in partnership with DCS and SPCH.

9.9 **Prioritize childcare vouchers for families experiencing homelessness** to assist families in job searching and stability once they start with a new employer.

9.10 **Increase opportunities for employment by partnering** with the Department of Workforce Development (DWD), Department of Labor (DOL), SPCH and local programs.

9.11 **Encourage the State to participate in national SOAR (SSI/SSDI Outreach, Access and Recovery) initiative** and provide training to local providers.

9.12 **Educate legislators on the work accomplished through Destination Home** and the partnerships with local and statewide policy makers.

9.13 **Encourage involvement of State legislators and other public leaders** to create sound policy that promotes preventing and ending homelessness.

Appendix A – Destination Home, A Ten-Year Journey to End Homelessness in Evansville and Vanderburgh County – Report – Year 7

In December of 2004, Destination: Home was launched and implementation began in 2005, including the formation of the city-county Commission on Homelessness. Many strategies are underway.

A. PLAN FOR OUTCOMES -- WORKING TOGETHER TO END HOMELESSNESS
   1. All area homeless service providers are using the Homeless Management Information System (HMIS) for collecting data on our local homeless population with the exception of 2 sites, an emergency men's shelter and a family emergency shelter
   2. The Homeless Services Council of Southwest Indiana (HSCSI) assists with data monitoring and collection
   3. Increased data quality is being promoted to ensure date is reliable.
   4. 2011 PIT count for Vanderburgh County – 482 compared to 539 in 2010.

B. CLOSE THE FRONT DOOR TO HOMELESSNESS – PREVENTION
   1. Develop a homeless prevention system to identify & assist people most likely to face homelessness
      a. Through the Homelessness Prevention and Rapid Rehousing Program (HPRP), 164 households (480 individuals including 285 children) have been assisted to prevent homelessness
      b. A Coalition of approximately 60 individuals has been working to educate the community:
         i. Radio and television interviews aired
         ii. The Mainstream Resources committee hosted an open forum with the Division of Family Resources; hosted a presentation and open forum with the Social Security Administration focused on SSI and SSDI; partnered with Circles Big View to host METS general manager for a presentation and question and answer session.
         iii. The Neighborhood Development presented on risk factors related to loosing housing and prevention resources at a United Neighborhoods of Evansville General Membership meeting.
      c. Issues of Child-Care and coordinated Financial Assistance are being addressed in committees.
   2. Develop a year-round utility subsidy program for the 30% Area Median Income (AMI) population
      a. The Universal Service Program (USP) has been approved to assist customers with a discount of 15%, 26% or 32% discount on the gas utility portion of their bill during the months of December through May. USP has been approved to continue through October 2012. This program assisted 5,773 customers for a total benefit amount of $695,154 from 12/1/10- 5/31/11 in the Southern service area. Program continuance beyond 2012 must receive approval from the Indiana Regulatory Commission.
      b. The Crisis/Hardship Program, a segment of the USP, provided 715 customers with $140,070 in benefits to either help customers restore their service or to help them keep their service on.
   3. Create a community discharge plan to prevent release from a publicly funded institution (Hospitals, Corrections, Foster Care System) resulting in immediate homelessness
      1. The Re-entry Network launched The Welcome Home 82 Initiative, a re-entry project aimed at 20 individuals involved in the criminal justice system involving housing and support. Partnerships were expanded to include Indiana Department of Corrections, and the Vera Institute. The first offender was housed in September 2011. The program has already successfully exited one participant who purchased his own home.
      2. The Homeless Healthcare Network created a shared data collection document that allows identification of individuals using multiple services ineffectively so that a plan to better intervene and prevent individuals from becoming homeless due to medical, mental health or substance abuse issues can be created. A steering committee also toured a medical respite program in Nashville, Tennessee.
      3. Case studies of unaccompanied youth are being developed to provide a broader prospective of the needs and barriers of homeless youth in our community.

Appendix A – Destination Home, A Ten-Year Journey to End Homelessness in Evansville and Vanderburgh County – Report – Year 7

C. OPEN THE BACK DOOR TO LEAVE HOMELESSNESS
   1. Develop a "Housing First" program for those in emergency shelter that includes subsidy & case management for up to 250 households
      a. The HPRP Rapid Re-housing program assisted 251 households (604 individuals including 298 children) move from homelessness into housing.
      b. Lucas Place II opened in 2011 and currently houses 27 formerly homeless Veterans. This increases our units of permanent supportive housing to 67.
      c. New Start, a permanent supportive housing program, has provided housing to 32 households since 2009.
      d. Shelter Plus Care, a permanent supportive housing program, has provided housing assistance to 35 individuals since 2008.

D. BUILD THE INFRASTRUCTURE
   1. Housing
      a. Develop 500 units of supportive Single Room Occupancy (SRO) Housing
      b. Develop a program to move 1000 currently low-income renters into homeownership through assessment, training & down-payment assistance
      c. Since 2005, 147 low-income households have moved into homeownership through Habitat for Humanity of Evansville
      d. Current inventory of affordable units to households earning up to $20,000 = 3,891 units
      e. 110 units added since 2005 with another 55 units in development
      f. Vision 1505 began renovations to provide 32 units of permanent supportive housing
      g. The Housing Committee has developed a plan for creating a Parking Meter Awareness Project and assisted in the development of a Rental-Rehab program including a care plan for participants
   2. *Raising Incomes and Increasing Assets*
      a. Improve coordination of employment services
         i. Coordinated case manager training in WorkOne's online tools led by Kay Johnson of Grow SW Indiana Workforce
      b. Establish training & employment options
         i. Facilitated career mentoring partnership of the YWCA Transitional Housing program and the Evansville-Area Human Resource Association that will pair HR professionals with residents to equip them to get a better job and plan to build a career.
      c. Increasing Family wealth and assets
         i. Four VITA Sites operated during 2011, sponsored by United Way.
            1. Number of clients who qualify for EITC above state VITA Site Average
            2. Over 75% of clients surveyed reported plans to use refunds to pay bills that might prevent them from stable housing or to build savings to apply toward larger big-ticket purchases that promote social mobility, such as down payments on homes, automobiles, school tuition, or health-care services.
         ii. Bank on Evansville – 3,194 accounts opened to date

Appendix A – Destination Home, A Ten-Year Journey to End Homelessness in Evansville and Vanderburgh County – Report – Year 7

3. Services
    a. Improve/develop transportation options for low-income individuals
        i. METS has increased service to the North 41 corridor
        ii. Some public transportation has been created in Warrick county
        iii. The Bike To Work program has given out 497 bikes to adults experiencing homelessness since 2006
    b. Develop improved access to information about sources of assistance
        i. Indiana 2-1-1, operated by United Way, continues to expand in Southwestern Indiana
    c. Improve access & coordination of services for specialized populations--youth, Veterans
        i. Seven sites for PlaySpaces have been equipped; with funding support from Welborn Foundation, 4 C of Southern Indiana assumed the recruiting and training of volunteers for the program and to equip parents with learning-through-play skills
            1. There are currently 40 active volunteers
            2. Approximately 500 PlaySpace sessions are held per year
    d. Homeless Youth Coalition partnered with Hillcrest Washington Youth Home to launch a Safe Place program. Results as of Nov. 15, 2011:
        i. Youth accessing Emergency shelter: 4
        ii. Active Safe Place Sites: 35
        iii. Youth Presenting at Safe Place Sites: 9
        iv. Community Presentations: 1,031
        v. Average Age of Safe Place Youth: 16
        vi. Student Outreach, School Presentations: 4,074
    e. VA hired a Case Manager for homeless veterans working through the VA Outpatient Clinic
    f. Provide training for community service providers and community at large
    g. Bridges project has trained and/or exposed over 2,600 persons in the area to Bridges Out of Poverty principles. The Bridges business user group has expanded outreach to Employers of lower wage workers.
        i. 305 individuals experienced Poverty Simulations provided by United Way Getting Ahead and Circles, an expansion of the Bridges project and is being coordinated by Evansville Christian Life Center. Individuals in poverty who complete the Getting Ahead process can become Circles Leaders. Allys from the community become part of leader's circle offering support for the completion of the leader's goals
            1. Currently, more than 30 active Circles Network Members
            2. Since joining Circles, Circle Leaders collectively have increased their income by 22%.
            3. Since joining Circles, Circle Leaders have collectively decreased public assistance benefits by 25%
            4. Since joining Circles, Circle Leaders have indicated that the number of people they feel they can count on has increase by 32%
    h. Homeless Services Council Education Committee provides regular trainings to front line staff of programs serving a variety of homeless populations
    i. Community Standards of Care for homeless services have been developed and 7 programs within the Homeless Services Council have received certification.
    j. Develop new services as needed
        i. White Flag, hosted by United Caring Shelters, was developed in Dec. 2010, provided 63 nights of relief from the frigid weather serving 2,015 individuals (duplicated)
        ii. United Caring Shelter's Women's Night Shelter opened with 15 beds to accommodate the increased need for emergency beds

Appendix A – Destination Home, A Ten-Year Journey to End Homelessness in Evansville and Vanderburgh County – Report – Year 7

E. PUBLIC AWARENESS

1. Dispel the misconceptions
2. Promote Destination: Home--a Ten-Year Journey to End Homelessness
    i. Web site identifies strategies and progress: www.destination-home.info
    ii. Community Survey conducted in 2010 and compared to 2004 survey results: Those surveyed have a greater awareness of the issue of homelessness and the local prevalence
    iii. 295 Endorsements have been submitted to date
3. Commission on Homelessness--the oversight body charged to keep the Destination: Home strategies moving forward
    i. Has restructured its working groups: Discharge Planning Coalition included the Re-Entry Network and Homeless Healthcare Network, Housing Committee, Homeless Youth Coalition, Homeless Prevention Coalition, and Raising Incomes Committee
    ii. Hosted the third Vanderburgh Homeless Connect on March 16, 2011, serving over five hundred guests with the assistance of 61 booths and 120 volunteers
    iii. Increased advocacy efforts to further federal legislation to support Destination: Home

Appendix B – Evansville Charrette Participants

Kathy	Adams	Guillermo	Guevara	Kimron	Reising
Cindy	Allega	Christine	Hagan	Jan	Reutter
Donna	Bailey	Birdie	Harrison	Jackie	Richards
Deborah	Barnett	Dan	Haviza	Gail	Riecker
Carol	Barnett	Sage	Hawkins	Charles	Ringham
Emily	Baxter	Donna	Jones	Gwen	Rode
Gordon	Bennet	Erin	Jones	Ashley	Rodgers
Mary Jo	Bennet	Mike	Kough	Ryan	Romines
Tracy	Bertram	Sean	Kuykendall	Danette	Romines
Ty	Bohls	Heather	Landy	Ryan	Romines
Abby	Bohnenkampf	Terri	Lauther-Uebelhor	Michelle	Schaefer
David	Bothast	Jamie	Madigan	Sherry	Schapker
Jill	Buck	Melissa	McClanahan	Soogi	Scheller
Shannon	Burden	Paul	Medcalf	Jen	Scheller
Sharon	Burns	June	Miller	Erica	Schmidt
Joshua	Calhoun	James	Morgan	Lee Anne	Shafer
Amy	Carlisle	Stephen	Mulcant	Grace	Shymanski
Laura	Chandley	Anna	Mulcant	Barbara	Smiley
Robert	Collins	Sarah	Murray	Jennifer	Smith
Kent	Conway	Kimron	Myers	Julie	St. Clair
Jared	Council	Taylor	Nellis	Sr. Mary Jo	Swift
Bambi	Deig	Nicole	Niziolek	Rachel	Taratino
Patti	Deshields	Beth	Pace	Blake	Tisserano
Michael	Erwin	Jessica	Pajda	Jill	Walters
Sally	Finley	David	Parker	Mignon	Ware
Robin	Forney	Pam	Payne	Stacy	West
Sr. Brenda	Fritz	Tiffany	Piazza	Nina	Wing
Shannon	Gasque	Bettye	Poole	Sarah	Wolf
Tabitha	Givens	Aaron	Pryor	Cherrie	Wood
Natasha	Goodge	Patty	Pyle	Sr. Mary Anne	Woodward
Cathy	Gray	Stephen	Ralph	Jerry	Yezbick
Rhonda	Greene	Connie	Ralph	Rosey	Young

Appendix B – Evansville Charrette Participants

Participating Agencies

4C of Southern Indiana
Adult Probation
AFBC
Anthem
Aurora Inc.
Brothers Keepers
Catholic Charities
Circles of Evansville
City Building Commission
City of Evansville
Daughters of Charity
Deaconess
Department of Metropolitan Development
Evansville Christian Life Center
Evansville Day School
Evansville Police Department
Goodwill
Green Peace
Habitat
Hillcrest Youth Home
HOPE
House of Bread & Peace
Lampion Center
Pigeon Township Trustee
Probation
Salvation Army
Southwestern Behavioral Healthcare
St Mary's Church
St. Mary's
St. Vincent Center for Children and Family
Sustainable Business Ventures
The Potter's Wheel
United Caring Shelters
United Way of Southwestern Indiana
University of Souther Indiana
Vectren
Vocational Rehabilitation
Welborn Baptist Foundation
YMCA
Youth Resources
YWCA

Core Group

Member	Affiliation	E-mail
Carol Braden-Clarke	United Way of Southwestern IN	cbraden@unitedwayswi.org
Naila Carnagua	Aurora – Homelessness Prevention	naila@auroraevansville.org
Luzada Hayes	Aurora/Destination Home	luzhayes@auroraevansville.org
Wyeth Hatfield	ECHO Community Health Care	whatfield@echochc.org
Gayl Killough	City of Evansville	gkillough@evansvillegov.org
Mindy Neihaus	Destination Home – Discharge Planning	homelink@destination-home.info
Sharon Taylor	Evansville Christian Life Center	staylor@restoringpeople.com
Laura Walker	City of Evansville	
Angela Williams	University of Evansville	Aw162@evansville.edu

Appendix C – Expert and Staff Biographies

Issue Area	Experts	Affiliation
Increasing Access to Permanent Housing	Lindsey Bishop-Gilmore	Corporation for Supportive Housing (CSH) Facilitator
	Luzada Hayes	Aurora, Inc. & Destination Home Coordinator
	Christine Haley	CSH
	Rick Moore	Evansville Housing Authority Director
	Rodney Stockment	Indiana Housing & Community Development Authority (IHCDA)
	Kim Walker	National Alliance to End Homelessness (NAEH)
Coordinated Access & Prevention	Naila Carnagua	Aurora, Inc.
	Heather Lyons	CSH Facilitator
	Stephanie Norrick	211
	Stephen Ralph	Evansville Christian Life Center
	Rodney Stockment	IHCDA
	Kim Walker	NAEH
Healthcare	Sherry Aliotta	St Mary's Medical Center
	Sally Finley	Deaconess Health
	Wyeth Hatfield	ECHO Health Care
	Dan Haviza	Southwestern Community Mental Health Center
	Christine Haley	CSH Facilitator
	Rachel Hester	Room In the Inn
	Julie St. Claire	University of Southern Indiana
	Charles Strobel	Room In the Inn
Reentry	Cindy Brush	Evansville Police Department
	Shayla Clark	Youth Expert
	Pam Craycraft	Franklin County Jail Project
	Margaret diZerega	Vera Institute
	Sharon Hess	Southern IL Coalition to End Homelessness
	Mindy Niehaus	Destination Home
	Lori Phillips-Steele	CSH Facilitator
Performance Standards	Lindsey Bishop-Gilmore	CSH
	Gayl Killough	Evansville Department of Metropolitan Development
	Heather Lyons	CSH Facilitator
	Barbara Ritter	Consultant
	Ken Scheller	Aurora
Homeless Children and Young Adults	Dennis Avery	University of Southern IN
	Christine Haley	CSH Facilitator
	Betty Poole	Evansville Vanderburgh School Corporation
	Jennifer Walker	Indiana Department of Child Services
	Stacey West	Hillcrest Washington Youth Home
	Angela Williams	University of Evansville

Appendix C – Expert and Staff Biographies

Naila Carnagua is the coordinator for the Homeless Prevention Coalition in Evansville, IN. Before coming to Evansville she worked at the Indiana Association for Community and Economic Development as Program Manager, consulting with communities across the state and coordinating state-wide trainings. She graduated from Ball State University with a BS in Urban Planning and Development with a focus on community development and poverty issues.

Margaret diZerega, the Family Justice Program Director at the Vera Institute of Justice, works with corrections departments, juvenile justice agencies, and faith- and community-based organizations to support them in adopting family-focused and strength-based approaches. Before starting the Family Justice Program at Vera in 2009, Margaret was the director of training and technical assistance at Family Justice where she worked for three years. Prior to Family Justice, Margaret provided technical assistance to affordable housing developers and police as a program officer at LISC's Community Safety Initiative. Margaret holds a Bachelor of Arts in American Studies from Williams College and a Master of Public Administration from New York University's Robert F. Wagner Graduate School of Public Service.

Wyeth Hatfield, Director of Social Work/Outreach, ECHO Community Health Care

Wyeth Hatfield is a Masters Level Licensed Clinical Social Worker (LCSW) who has worked with both children and adults in circumstances ranging from residential, medical, to ongoing outpatient counseling. His work over the last 20+ years has allowed him to work with people in a variety of situations including:

- Adults, children, and infants with developmental disabilities
- Emergency room crisis assessment and intervention
- Severe and persistent mental illness
- Families and individuals in homelessness
- Pediatric inpatient and intensive care hospital social work
- Abuse and neglect prevention, assessment, and intervention
- Severe trauma, grief, PTSD, and end of life issues

He currently serves as the Director of Social Work/Outreach at ECHO Community Health Care which is a group of healthcare clinics for the uninsured, underinsured, and the homeless in Evansville. He oversees clinic social workers, a community outreach team, and LCSW counselors working in the clinical setting in a Behavioral Integration medical program. In addition to these roles, he is an adjunct college Instructor, church Pastor, and also has a private counseling practice. His current community service includes being President Elect on the Board of Directors for the United Caring Shelters. He is also a board member for Mental Health America. And he is Director of Autism Services for a National Volunteer agency serving children.

Dan Haviza has worked in community-based behavioral health services for 25 years. His experience includes working with adults with severe and persistent mental illness and also those challenged by substance abuse disorders. Dan has experience in providing services, and guiding others in providing treatment, in a variety of settings including outpatient, residential, sub-acute, and acute hospital treatment.

Currently, Dan is a Coordinator at Southwestern Behavioral Healthcare where he manages the activities of staff providing outpatient and outreach services to adults with mental illness and substance abuse disorders and also works very closely with Southwestern's Homeless Outreach Team. In addition, he is a member of the Homeless Healthcare Coalition, the Southwestern Indiana Suicide Prevention Coalition, and a member of Board of Director's of Guardianship Services of Southwestern Indiana, a non-profit providing volunteer guardianship services to those in need.

Luzada Hayes is the Executive Director of Aurora in Evansville and also serves as staff support to the Commission on Homelessness and the Resource Coordinator for Destination: Home, the ten-year plan to end homelessness in Evansville and Vanderburgh County. Luzada is a native of Evansville and has over 21 years of experience working with persons experiencing homelessness including previous employment with Salvation Army and Southwestern Behavioral Healthcare before coming to

Aurora in 1999. Luzada has a Master degree in Social Work from the University of Southern Indiana and is licensed by the State of Indiana as a Clinical Social Worker.

Sharron Hess has been working for social service agencies for the past 30 years. She worked for a community action agency in direct client services as County Manager for 15 years. She then became the Executive Director for the Southern Illinois Coalition for the Homeless in 1996. She is a past Co-Chair of the Southern Illinois Continuum of Care, a member of the Governor's Housing Task Force, a past member of the FHLB Housing Advisory Board, and is current President of SHPA. Since becoming Director of the Coalition, she has managed a Homeless to Homebuyer Program, two HUD Transitional programs, a HUD Permanent Supportive Housing Program. All populations have been housed in these programs during the past 21 years of service. Sharon and staff are currently developing the Phoenix Re-entry Housing, which is an apartment complex in Herrin, Illinois, to house returning citizens who are in recovery for substance abuse.

Rachel Hester, Executive Director of Room In The Inn's Campus for Human Development, grew up in Henderson, KY before moving to Nashville to attend Trevecca Nazarene University in 1988. In 1989 she began volunteering with the Room In The Inn program as a college student and within a short time, she began working for the organization full time. Over the years, she has held several leadership positions, including program coordinator and volunteer coordinator, as well as overseeing many administrative aspects of the organization.

In 2010, under Rachel's leadership, Room In The Inn's Campus opened its $13 million state of the art facility designed to serve the homeless. This comprehensive center includes thirteen classrooms with state of the art technology, a commercial grade kitchen that can support 600 meals daily, areas for case management and emergency services, expanded transitional housing, a recuperative care wing, and 38 units of permanent, affordable housing.

Gayl Killough currently works for the City of Evansville Department of Metropolitan Development. Gayl believes that she was born a data geek and is excited to talk about performance standards. Gayl grew up with grandparents that were passionate about helping the homeless, and now she is following in their footsteps. Gayl has a Bachelor of Science in Biology from the University of Southern Indiana and a Masters of Public Affairs with a concentration in policy analysis from Indiana University. Gayl previously worked for Indiana University and Indiana Department of Environmental Management.

Rick Moore has more than 28 years of experience in housing authority management, including Deputy Executive Director positions with the Baltimore Housing Authority (Maryland) and Bridgeport Housing Authority (Connecticut). Prior to Bridgeport, Moore served in director level positions in Huntsville (Alabama) and Dayton (Ohio) housing authorities. His responsibilities have included public housing, voucher, security, and resident services programs in addition to significant interaction with neighborhood groups, civic associations, and local, state and federal agencies.

Rick has received several awards for his outstanding service and improving the quality of life for residents of public housing. He achieved public recognition for his innovative programs that partnered neighborhood and civic organizations for the shared goal of promoting self-sufficiency for individuals depending on public assistance.

Rick holds a Bachelor of Science degree in Organizational Management from Wilberforce University and is a Certified Public Housing Manager. His professional and community affiliations include Rotary International (Bridgeport), First Tee National Golf Organization, Martin Luther King Development Center, Buckeye Trail Girl Scout Council, Big Brothers Big Sisters, National Association of Housing and Redevelopment Officials and Evansville-Vanderburgh County Commission on Homelessness.

Rick and his wife Stephanie have four adult children.

Stephanie Norrick is the Director of Community Resources for United Way of Southwestern Indiana. As Director, she was responsible for implementing 2-1-1 coverage in a five county region- Vanderburgh, Warrick, Spencer, Posey and Gibson Counties. The 2-1-1 Information and Referral Center answer over 20,000 calls annually ranging from the simple- what are the hours of Outreach Ministries- to the complex regarding hunger, domestic violence, crisis and homelessness. Stephanie has

been in the non-profit field for 14 years and has been with United Way for 9 years. She has a Master's degree in Public Administration. Stephanie is a member of Junior League of Evansville and serves on the Board of Wesselman Nature Society. Currently, She lives in Evansville with her husband Chris along with two cats, Charlie and Leo.

Bettye Poole serves as the Homeless Liaison and Outreach Coordinator for the Evansville Vanderburgh School Corporation. She provides various services for homeless students, coordinates parenting education, and builds skills sets for pregnant and parenting students. Betty manages a daycare facility for parenting students located on the Bosse High School Campus.

Ken Scheller, a licensed clinical social worker and Program Director for Auorora, is a native of Evansville and graduated from the University of Evansville in 1988. After college he joined Peace Corps and upon returning to the United States he felt called to live among the homeless on the streets of New York City. For the next 1 ½ years his "home" was a sidewalk across from the United Nations and, later, a park bench on the East River. He developed many friends among the homeless and was impressed by the importance of community. In 1994 Ken returned to Evansville and in 2006 earned a Masters in Social Work from the University of Southern Indiana. He served as a therapist for the next five years. One year ago he was given the opportunity to return to a primary focus serving the homeless as Program Director for Aurora and as Chair of the Homeless Services Council's Data Committee.

Julie St. Clair, RN, MSN, has been a member of the University of Southern Indiana Nursing Faculty since 1990. Her experience prior to that was as a Public Health Nurse and then as Director of Nursing for the Vanderburgh County Health Department over a 10 year period from 1980-1990. Julie teaches Community Health Nursing course as part of the Bachelor of Science in Nursing program to both RN completion students and "traditional" BSN students in their senior year. The course focuses on population health and deals with issues including social determinants of health, community assessment, epidemiology, incarcerated populations, and homelessness.

Julie has experience in working with the homeless and near homeless population in clinical settings such as the Potter's Wheel, Homeless Connect, and with incarcerated populations in the Vanderburgh County Correctional Facilities, Hope Hall and Youth Care Center.

She serves on a variety of boards and teams including the Southwestern Indiana Regional Perinatal Advisory Board (Chair); the Fetal and Infant Mortality Review Team, the Vanderburgh County Child Protection Team, the Headstart Health Advisory Board, and the EVSC School Community Asthma Team.

Julie is a registered nurse and holds a BSN from Western Kentucky University and an MSN from the University of Evansville.

Rodney Stockment is the Community Services Director at the Indiana Housing and Community Development Authority. In this capacity, he maintains oversight of a variety of federal and state housing programs. The Community Services Department has also designed a tenant-based rental assistance program for the Tippecanoe County Reentry Court. Rodney is the lead for the State's Balance of State McKinney Vento Homeless Assistance application to HUD for Supportive Housing Program funds and has oversight of the state Homeless Management Information System. In addition to these programs, Rodney serves on the state's Indiana Planning Council on the Homeless and the Division of Mental Health and Addiction's Transformation Work Group. These inter agency efforts work to improve the delivery of housing and services to homeless individuals and families. Recently, Rodney is the architect of the Indiana Permanent Supportive Housing Initiative, which aims to reduce long-term homelessness through the development of permanent supportive housing over the next six years. Working with the Corporation for Supportive Housing and Technical Assistance Collaborative, Rodney is the project lead to develop a service delivery and finance model for permanent supportive housing and develop a state policy on supportive housing as a means to end long-term homelessness and prevent homelessness for individuals discharged from state operated facilities.

Prior to coming to IHCDA, Rodney was the Executive Director of ECHO Housing Corporation in Evansville and earned his master's degree in Public Service Administration from the University of Evansville.

Appendix C – Expert and Staff Biographies

Charles Strobel, Founding Director of Room In The Inn's Campus for Human Development is a native Nashvillian. He graduated from St. Mary's College in Kentucky with a BA in Philosophy, Xavier University in Cincinnati with a Masters in Education, and Catholic University in Washington, D.C. with a Masters in Theology. He received an Honorary Doctor of Divinity from MacMurray College in Jacksonville, Illinois.

After his ordination to the Catholic priesthood in 1970, he served five years in Knoxville as the Associate Pastor of Immaculate Conception parish, an instructor at the University of Tennessee's Department of Human Services, and opened the office of the National Conference of Christians and Jews as its first Executive Director. He returned to Nashville (1975) as Associate Pastor of Holy Rosary Parish in Donelson and later as Pastor of Holy Name Catholic Church in East Nashville where he began working with the homeless in 1977. While there, he organized Loaves and Fishes Community Meal (1983) and helped to organize St. Patrick's Family Shelter that has now become Safe Havens Family Shelter. In 1986, he founded Room In The Inn, a congregational based shelter program now involving 170+ congregations. He helped spin off from Room In The Inn a homeless shelter for working men, Matthew 25, in 1987.

Presently, he is the Founding Director of Room In The Inn's Campus for Human Development (1995), a comprehensive single site of services for the homeless. In addition, he founded The Guest House (1991), as an alternative to jail for the publicly intoxicated that is now part of the Room In The Inn's Campus as well as other programs that evolved there, such as the Respite Center for the medically fragile homeless, a Day Services Center that offers emergency care of food, clothing and personal hygiene services and long-term services such as education, job counseling, and alcohol and drug counseling. RITI's Campus serves more than 300 persons daily at its 705 Drexel Avenue location, in partnership with the United Neighborhood's Clinic for the Homeless next door.

Jennifer Walker earned a Master of Arts degree in Leadership Development through Saint Mary-of-the-Woods College in 2010. She has worked with youth and children to overcome potential barriers in leading a productive adult life since graduating from Indiana University in 2002. Jennifer began her career working within the Navajo Nation school system assisting elementary, middle and high school students improve their reading and comprehension skills. After returning to Indiana, Jennifer worked as a Family Preservationist through a contractor with the Indiana Department of Child Services (DCS). Jennifer then served four years as a Family Case Manager for DCS in Washington County, moving into a position within the Independent Living team for two years. Currently, Jennifer is the Special Projects Coordinator for the Services and Outcomes division of DCS. Her job duties include: coordinating and maintaining partnerships with agencies outside of DCS, assisting with the development new child welfare programs and services and implementing federal mandates within the state child welfare system.

Lindsey Bishop is a Senior Program Manager at the Corporation for Supportive Housing - Illinois Program. Lindsey has been with CSH since 2008, starting in the CSH Michigan Program. At CSH, Lindsey is responsible for systems-level policy work with government partners to increase the creation of permanent supportive housing. Prior to joining CSH, Lindsey worked for the Washtenaw Housing Alliance in Ann Arbor, MI providing oversight to the 10 Year Plan to End Homelessness implementation, coordinating the local Continuum of Care, and building and maintaining key partnerships between the city, county, state, and local service providers. Additionally, Lindsey worked in the Supportive Housing and Homeless Initiatives Division at the Michigan State Housing Development Authority providing technical assistance and financial underwriting for supportive housing developments; developing and overseeing special projects targeted for homeless families with children, chronically homeless, homeless youth, homeless veterans, and individuals with special needs; and coordinated and facilitated state workgroups on 10 Year Plan to End Homelessness implementation. Lindsey has a Master in Social Work degree from the University of Michigan and Bachelor in Social Work from the University of Kentucky.

Christine Haley is the Associate Director of the Corporation for Supportive Housing Illinois Program. Previously, Ms. Haley led the Massachusetts Department of Public Health's Culturally and Linguistically Appropriate Services (CLAS) Initiative. The Initiative supports direct service providers in integrating language access and cultural competency standards into service delivery systems. Before joining CSH, Ms. Haley served as the Associate Director of Supportive Housing Programs for

Appendix C – Expert and Staff Biographies

Heartland Alliance in Chicago. She worked to ensure culturally competent care for persons of color, immigrants and refugees in various supportive housing models, including Permanent Supportive Housing and Homeless Prevention Rapid Rehousing (HPRP). Ms. Haley earned a Bachelor of Arts from the University of Notre Dame and a Master of Science in Social Administration from Case Western Reserve University.

Heather Lyons, Senior Program Manager, CSH Consulting Group joined CSH in 2008. Based out of Portland, OR, she works with other CSH staff to promote systems and policy change to end homelessness. She has worked in communities as distinct as Wasilla, AK and Los Angeles, CA, as well as many other locations throughout the United States. Her areas of expertise include analysis of community needs across the full continuum of housing types, frequent users of public systems, re-entry related supportive housing and planning, and the intersection of public health and homelessness. Prior to this position, Heather led the City of Portland, Oregon's efforts to end homelessness, working with numerous partners under the policy framework of Home Again: A 10 Year Plan to End Homelessness. She is expert in meeting and group facilitation, using a relational approach that draws people into conversation while moving a process along meaningfully. In addition to working for the City of Portland for 8 years, she's worked for a non-profit supportive housing agency in Portland, and began her career with the City of San Antonio, Texas as a VISTA volunteer in 1992.

Lori Phillips-Steele, the CSH Indiana Program Director, provides a range of training, technical support, and policy advisement services to the local supportive housing industry and partners with local funders to better coordinate resources for supportive housing in the state. She has over twenty years of experience working for Indiana government and non-profit programs that serve underserved populations including people experiencing homelessness and people with HIV/AIDS, with an emphasis on supportive and affordable housing programs and model development. Prior to joining CSH in 2007, Ms. Phillips-Steele served as Program Manager at the Coalition for Homelessness Intervention and Prevention (CHIP); and as Director of the Indiana State Department of Health Division of HIV/ Sexually Transmitted Diseases.

Stephanie Sideman is a Program Manager for the Corporation for Supportive Housing in Indiana. Prior to coming on board in July of 2010, Stephanie was a direct service provider for nine years in Chicago. She provided supportive services for people experiencing homelessness or at risk at the Franciscan Outreach Association emergency shelter, Inspiration Corporation Café, and EZRA Multi-Service Center. Stephanie earned her Bachelor of Arts from the University of Illinois and a master's degree in Social Service Administration from the University of Chicago, where her focus was on policy and systems change work. Having worked as a case manager as part of the Chicago Housing for Health Partnership, a research study examining the effects of housing people who have chronic health conditions, Stephanie is particularly interested in promoting housing as a preventative health care measure for vulnerable populations.

Katrina Van Valkenburgh is a Managing Director at the Corporation for Supportive Housing. She oversees our Illinois, Indiana, Minnesota, Michigan and Ohio offices as well as our work in the in the center of the United States. She was the first Director of the Supportive Housing Providers Association, a trade association of not-for-profit supportive housing providers in Illinois from 1995 through 2000. Katrina worked at Deborah's Place as their Director of Project Development and was responsible for the development and rehabilitation of three permanent supportive housing projects. One of these projects was selected for inclusion on the website for Design Matters: Best Practices in Affordable Housing and another was the 2007 2nd place recipient of the MetLife Award for Excellence in Affordable Housing. Prior to this position, she was the Associate Director of Development, responsible for all public grants, and the Program Administrator of Marah's, the Transitional Housing Program of Deborah's Place. Katrina was the Program Manager of the Permanent Supportive Living Program and Transitional Housing Program of Housing Opportunities for Women from 1990 to 1991. Her direct service experience includes managing group homes for teenage wards of the state, for adults discharged from state mental hospitals in Massachusetts, and working with people who were homeless at the Women's Lunch Place in Boston. Katrina has a BA in Sociology from Kalamazoo College and a certificate in Urban Development from the University of Illinois at Chicago, the College of Urban Planning and Public Affairs. She currently serves on the Community Investment Advisory Council of the Federal Home Loan Bank of Chicago, the Advisory Board of the Law Project and as Secretary of the Deborah's Place II and Deborah's Place III boards. Katrina received the Gem of the Community Award from archi-treasures in 2009.

Appendix D - Action Plan Template

The Action Plan, at a minimum, should identify action steps associated with each goal and strategy. The action steps should directly correspond to outcome statements that define when the action is successful. The plan should include details such as the entity with lead responsibility, names of participants, and the timeframe for accomplishments. As your community develops its Action Plan, remember that repurposing existing committees can be a good way of utilizing existing efforts without creating redundancies.

The examples below are for the purposes of demonstrating the organization of an Action Plan only. Communities are encouraged to develop a plan for each goal in their 10 Year Plans. The Action Plan may include a higher level of detail or a greater number of action steps than the examples provided, but keep in mind that this is a summary document to be shared with multiple stakeholders. Detailed "to do lists" that evolve from the Action Plan can be maintained as separate documents. The Action Plan should be as clear and concise as possible in identifying the key actions and outcomes.

EXAMPLES

Goal 1: Improve Healthcare for Homeless Individuals and Families

Strategy	Lead	Key Participants	Timeframe	Action Steps	Desired Outcome
Prioritize and invest in supportive housing for those who are medically vulnerable	HHN	HHN members (list out names)	First meeting on vulnerability in July 2012 - Vulnerable people housed (and no longer vulnerable) by October 2013	Research available examples of vulnerability indexes	HHN selects the most appropriate index
				Identify highest vulnerability among people who are homeless and/or cycle through institutions via review	HHN members determine the top 25 most vulnerable people
				Identify appropriate supports to engage individuals	Agencies build relationships with institutions and people to encourage them to move to SH
				Identify housing and services (supportive housing) for those who are considered most vulnerable	25 units of SH exist to house the most vulnerable people

Goal 2: Improve Performance Across the Community

Strategy	Lead	Key Participants	Timeframe	Action Steps	Desired Outcome
Define consistent outcomes	Destination Home Staff Person	New Committee (partnered with Coordinated Entry group) (list out names of key members)	First meeting September 2012 Measures defined by January 2013	Review existing outcomes that agencies in the homeless system report on	Existing outcomes inform new, community wide outcomes
				Adopt IHCDA Planning Council outcomes	Each agency is measuring outcomes focused on ending and preventing homelessness
				Define additional outcomes (i.e., retention in housing after placement or prevention)	Agencies agree on what is most important to measure to properly evaluate system
				Set up regular meetings to review outcomes data as a group	Transparent and mutually accountable process promotes community wide success