DRAFT Indianapolis Blueprint Program Models Matrix

This matrix describes all of the homeless program types that are envisioned as part of the future homeless assistance system needed to achieve the goals of the Indianapolis Blueprint to End Homelessness. A number of these program types and qualities already exist within the community; the degree to which is, in many cases, directly related to the resources available. The program models matrix provides a framework for making changes when necessary and enhancing support for those modeling Blueprint qualities. All programs do not need to be structured identically nor will they all be expected to achieve the same outcome targets; however, for the Blueprint to be successfully implemented the homeless assistance system as a whole should reflect all of these qualities and achieve the proposed outcomes. Indianapolis will also need underlying infrastructure and system resource components that are not captured in this matrix, such as system-level planning and administration, training and technical assistance, advocacy, information and resource management systems, and evaluation. The homeless assistance program will also rely on strong access to and availability of mainstream services, such as health care, behavioral health treatment, employment services, and other benefits.

Program Type	Description	Essential Program Elements	Time Limits	Population	Program Outcomes
Prevention A set of strategies to assist people in maintaining their housing. Strategies are readily available to all consumers and are integrated with other mainstream services.					
24/7 Referral & Information Access (e.g. 2-1-1 Helpline)	Access to information about housing availability and information on homeless services through 2-1-1 number.	Consolidated information on more than 87 programs serving homeless persons in Indianapolis. Brief assessment and referral from 211 operator to appropriate program. Database of current housing available to homeless and near-homeless persons and use of ClientTrack to produce real-time information on shelter bed availability. Linkage to Youth Helpline, as appropriate	NA	All homeless individuals and families at imminent risk of homelessness	% of callers with a housing crisis will be linked with programs/services to divert them from shelter % of callers for whom shelter is the only option that will be placed in/referred to available shelter within x hours.
Prevention Resource Coordination and Advocacy	Resource Coordination and advocacy to mitigate factors leading to imminent homelessness.	Resource coordination and provision and/or linkage to: housing and risk assessment; landlord mediation; access to financial prevention assistance; and negotiation and advocacy on behalf of client to avoid homelessness. To mitigate factors that created risk of homelessness and to address longer-term needs, Resource Coordinator should also conduct an initial assessment and help develop a person-centered case management plan that is embraced by all systems working with the household, identify necessary resources to achieve the plan, and track and maximize client's access to resources (e.g., Flexfunds). *[The latter role could be provided directly by the Prevention Resource Coordinator or through linkage with Coordinated Case Management (CCM) or System of Care Resource Coordination (SOC/RC) services, as described below in Supportive Services.]*	Variable	Individuals and families at imminent risk of homelessness	% of people referred who are diverted from shelter (i.e., they would have become homeless otherwise) due to prevention assistance.
Financial Prevention Assistance	Emergency financial assistance to assist families in avoiding imminent homelessness and maintaining housing stability.	Financial assistance to pay for rent, back rent, security deposits, mortgage payments, utility payments, back utility payments, emergency home repair that will result in housing stability, or other emergency financial assistance to help people remain in their housing or avoid homelessness. Referrals to Prevention Resource Coordination or CCM services to address other issues that may have contributed to housing instability and barriers to self-sufficiency.	Variable, based on client need (one-time, short-term, TBRA up to 2 yr)	Individuals and families who are at imminent risk of homelessness	% of people referred who are diverted from shelter (i.e., they would have become homeless otherwise) due to financial assistance.
Legal Services to prevent Homelessness	Legal rights education, legal representation, and education for shelter staff and other service providers.	Response to full range of civil legal issues that may put someone at risk of homelessness (e.g., pending eviction, employment termination, benefits appeals). *[Related services: Outreach and collaborative efforts to provide free legal services to homeless persons with legal issues. In-service training to service providers.]*	As needed	Individuals and families who are at imminent risk of homelessness	% of people referred whose eviction is prevented or are otherwise diverted from shelter (i.e., they would have become homeless otherwise) due to legal assistance.

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Program Type	Description	Essential Program Elements	Time Limits	Population	Program Outcomes
Outreach & Engagement Services Services that connect persons who are homeless to needed shelter, housing, and support services.					
Clinical Outreach & Engagement	Street-based, mobile outreach teams that address basic needs and seek to move people off the streets	Low-demand, street-based services that address basic needs (e.g., food, clothing, blankets), seek to build relationships over time with goal of moving people into housing and engaging them in services over time. Using CCM or SOC/RC approach, clinical staff provide or link persons with: resource coordination, assistance to develop a person-centered case management plan, housing placement, on-site psychiatric and addictions assessment, medication, other immediate and short-term treatment, and access to other programs and services. If outreach provider does not serve as person's PCM or RC, outreach team should maintain communication with PCM or RC about client progress and need for additional services.	None, frequently long-term	Homeless persons on the streets, frequently targeting those with mental illness, severe addictions, or dual-diagnosis	% of persons encountered who are homeless and staying on the streets who … are placed in shelter … placed in permanent housing … become engaged in services
Day Centers/ Engagement Centers	Site-based centers that provide or assist consumers to access services.	Day-time refuge for people sleeping on the streets or overnight shelters; front-door access point to other services and housing; low-demand comprehensive services, assessment, referrals offered on-site. Similar to low demand outreach, but site-based.	None	Homeless persons on the streets and in overnight shelter; street youth	% of persons drop into the center who are homeless and staying on the streets who … are placed in shelter … placed in permanent housing … become engaged in services
** Note that other programs that are described in other sections of this matrix (Emergency Shelters, Wet Shelters, Safe Havens Permanent Housing, and Assertive Community Treatment) are also envisioned as tools to assist with engagement process.					

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Program Type	Description	Essential Program Elements	Time Limits	Population	Program Outcomes
Emergency Shelter Program of stabilization and assessment, focusing on re-housing all persons, regardless of disability or background.					
Emergency Shelters	Shelter that provides a safe, clean place to stay with focus on immediate housing placement and linkage to other services	Shelter with showers, laundry, meals, other basic services, and linkage to PCM or RC and Housing Specialist (co-located on-site) with the goal of helping families and individuals move into stable housing as quickly as possible. Linkages to homelessness prevention are made whenever possible. All shelters have a service approach that engages people through relationship building and adherence to basic behavioral rules. Each facility's rules and demands for participation are appropriate to the population being served and with appropriate consideration for children. The system should include an array of shelter and stabilization options that allow for varying degrees of program participation and levels of support based on client needs and engagement at the time they enter the system (i.e., for those with chronic addictions, mental illness, and co-occurring disorders). Across all shelters, staff should be trained in de-escalation techniques. Private/shared sleeping rooms are preferred to offer more privacy and accommodate couples (single shelters) and families with an older or adult male (family shelters). Family shelters should also offer or provide linkage to short-term planned childcare to help support parents seeking housing and employment. All of the existing shelters in Indianapolis include faith-based programs that offer a range of shelter services from overnight to longer-term stays with varying degrees of participant commitment, motivation, and program expectations. Programs are directed toward helping individuals and families achieve self-sufficiency with a spiritual formation component. Some faith-based programs are recognized for working with clients that are struggling with addictions and seek a structured, peer and spiritual support program to assist in their recovery.	Goal of placement within 60 days	Homeless Singles, Homeless Families	% of clients, who stay longer than 3 days, will be connected with a PCM or RC. % of clients, who stay longer than 3 days, will be connected with a Housing Specialist. % of clients will be placed in permanent housing within x days. *(Shared outcome with PCM or RC*)
Wet Shelters	Temporary shelter for inebriated homeless persons that provides prompt access to substance abuse treatment.	Temporary refuge for inebriated homeless persons who cannot be housed in emergency shelters; shelter is expected to be a forum for engagement to move clients off of the streets into housing and to assist with the "stages of change" process. Clients should have immediate access to SA treatment, integrated mental health treatment for individuals who are dually diagnosed with substance abuse and mental illness, and medication management services, as well as linkage to PCM or RC and Housing Specialist.	Not specific	Publicly inebriated homeless persons	Fewer than x% of people who are homeless will be denied shelter on the basis of intoxication % of people who are homeless and chronically addicted to alcohol will be ...housed in shelter ...placed in permanent housing ...engaged in treatment services *(Shared outcome with PCM or RC.)* Reduce the number of persons who are homeless who are arrested for vagrancy or public intoxication by x% per year.

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Program Type	Description	Essential Program Elements	Time Limits	Population	Program Outcomes
Respite Center	Temporary housing with specialized medical respite care	Residential program where clients have private rooms, access to 24h on-site care to address medical needs, comprehensive services tailored to the individuals' needs, along with showers, meals, laundry and other basic services. Linkage to PCM or RC and Housing Specialist (which could be co-located on-site).	As needed for medical recovery or stabilization; Goal of placement into housing once admitting condition has been stabilized.	Individuals with temporary intensive medical needs	Same outcomes as Emergency Shelter and Faith-based Emergency Shelters Additional medical health outcomes: - Stabilization of admitting medical condition - Access to ongoing primary health care services - Ability of patient to take responsibility for ongoing medical conditions without adverse health consequences
DV Shelters	Temporary specialized housing	Temporary, safe housing with showers, laundry, meals, other basic services, and linkage to PCM or RC and Housing Specialist (co-located on-site). Additional specialized services for survivors (e.g., counseling, safety planning services, legal assistance, and specialized children's services) are provided to clients to achieve crisis stabilization and appropriate planning for next steps.	As needed; Goal of placement within 120 days	Survivors of Domestic Violence	Same outcomes as Low Demand and Faith-based Emergency Shelters Additional outcomes based on special client needs
Youth Shelters	Temporary specialized housing	Temporary housing with showers, laundry, meals, other basic services, and linkage to PCM or RC and Housing Specialist (co-located on-site). Additional specialized youth services are provided to clients to resolve immediate service needs and assess appropriate long-term housing options.	As needed; Goal of placement within 180 days	Youth aging out of foster care, Runaway homeless youth (18 - 24)	Same outcomes as Low Demand and Faith-based Emergency Shelters Additional outcomes based on special client needs

Across all Emergency Shelter programs, the PCM or RC will provide assessment, coordinate appropriate resources, and broker access to other services. The Housing Specialist will use info from PCM/RC to identify appropriate housing placement options, provide linkage to appropriate housing resources, and help identify and secure housing.

Transitional Housing

Temporary housing associated with preparing people for independent living.

There are several facility-based transitional housing providers serving our homeless community. Transitional housing has successfully served many groups of homeless individuals and families. Specific to the issues that caused homelessness, transitional housing was developed to offer a supportive living environment tailored at addressing the explicit causes of the individual or family's homelessness. For instance, some persons with chronic addictions may benefit from and desire staged housing options, some survivors of domestic violence may need a physically-secure complex for a transitional period, and certain persons may desire group living for a longer transitional period than can be offered in emergency shelter models.

Because housing needs far outweigh resources and the present system does not have a full range of housing options, it has been difficult to gauge the extent to which different housing models (e.g., transition in place, permanent supportive housing, or facility-based transitional housing) can be effective with different types of individuals and families. For the same reason, it is difficult to fully identify need. There is research that firmly supports that those who have a serious mental illness and co-occuring disorder of mental illness and addiction do benefit from a Housing First, permanent supportive housing approach that includes appropriate supportive services. The same level of research has not been conducted for other populations.

We do know that families are entering the system with increasingly complex needs and recognize the need for additional permanent supportive housing and transition in place options for those families that will benefit from moving directly from shelter into more permanent housing with the appropriate support. We also recognize the need for a broad array of options based on need.

The Blueprint does not project an increase in project-based transitional housing units, but at this stage, the projections do not recommend decreasing the current number of transitional units. There is a need to develop new units representing alternative housing models and to systematically assess which programs are appropriate for each subpopulation. This coupled with national research currently being completed in this area will better inform the system needs. After that type of evaluation and review of new literature, community decisions about the role of facility based transitional housing and transition in place models and the number of units needed will be made over time. We will work together with providers in the community to assess the need.

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Program Type	Description	Essential Program Elements	Time Limits	Population	Program Outcomes
Permanent Housing Housing where people may stay indefinitly with temporary or long-term rental assistance and/or supportive services.					
Transition in Place	Clustered and scattered site permanant housing with short-term system of care targeted to homeless persons with temporary barriers to self-sufficiency and youth aging out of foster care.	Clients are placed in clustered or scattered site permanent housing that they can retain at the end of program involvement. TIP programs generally provide up to two years of rental assistance and housing stabilization services, such as landlord mediation/support, housing inspections, and other property management and tenant support activities. Clients are also expected to receive additional supportive services, such as vocational assistance, coordinated through their PCM or RC.	Up to two years	Homeless individuals or families with temporary barriers to self-sufficiency; youth aging out of foster care and other runaway homeless youth (18 - 25 yrs)	- % remain housed for at least 6 months - % remain housed for at least 12 months - % remain housed for at least 24 months *Shared outcomes with PCM or RC*
Safe Havens	Open stay, no demand, service-enriched housing programs for persons with serious mental illness or dual disorders who are hard to engage in services.	Designated to be safe, non-intrusive, living environments in which skilled staff work gradually over time to engage persons in housing and needed services. No requirement for clients to participate in services. Provision of/access to: permanent rent subsidies; engagement/relationship building; crisis intervention; basic needs services; 24-hour care availability; client assessment of housing and service needs; benefits screening and acquisition; maintenance and management of income and benefits; linkage to mental health and substance abuse treatment and other services desired by client; housing placement (if desired by client); and housing relocation resources/supports (security deposits, utilities, furnishings, etc). Safe Haven providers should maintain communication with PCM or RC about client progress and need for additional services. External services should be coordinated through or in conjunction with PCM or RC.	No limit	Hard to engage persons with serious mental illness or dual disorders who are not currently engaged in housing or systems of care.	- % of clients who stabilize their mental health - % of clients who engage in treatment and/or other services - % of clients who are placed in permanent housing
Permanent Supportive Housing	Project-based, clustered and scattered site permanent housing linked with supportive services that help residents maintain housing. Targeted to persons with significant barriers to self-sufficiency.	Permanent housing with supports that help clients maintain housing and address barriers to self-sufficiency. PSH programs generally provide subsidized housing or rental assistance; 24/7 tenant support services; and property management. Clients are also expected to receive intensive supportive services accessed through their PCM or RC, or directly from the PSH provider, if appropriate.	No limit	Persons with significant barriers to self-sufficiency, including chronic disabilities that impede ability to live independently, street homeless adults and homeless families with chronic supportive service needs.	- % remain housed for at least 6 months - % remain housed for at least 12 months - % remain housed for at least 24 months *Shared outcomes with PCM or RC*

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Last Revised 8/28/06

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Program Type	Description	Essential Program Elements	Time Limits	Population	Program Outcomes
Permanent Housing	Permanent housing opportunities for persons that can live independently	Independent permanent housing with tenant-held leases or single homeownership with appropriate use of community supports.	No limit	Persons and families who were formerly homeless.	- % remain housed for at least 6 months - % remain housed for at least 12 months - % remain housed for at least 24 months *Shared outcomes with PCM or RC*
Supportive Service Systems System of services focusing on community integration, housing retention, and housing stability. Services are individualized and consumer-driven.					
Housing Placement Services	Use of housing specialists to facilitate placement into appropriate permanent housing	Assess housing needs; identify available housing (e.g., www.IndianaHousingNow.org); provide transportation or assistance to view and select best housing option; assist with leasing process; provide downpayment and security deposit assistance; and educate clients on skills/expectations to be a good tenant. Housing specialist should be integrally related to PCM or RC for purposes of assessment, identifying appropriate placement, and ensuring follow-up supportive services. (Childcare should be coordinated through PCM or RC or provided on site at shelters to facilitate efficient and unbiased housing inspections.)	Until housed	All homeless consumers seeking housing	% placed within appropriate housing within x days
Coordinated Case Management (CCM)	Transitional case management coordinated across service providers to help clients maintain their housing, achieve self-identified goals in shared case management plan, and address barriers to self-sufficiency	Coordinated case management services can be provided directly by the Primary Case Manager (PCM) or through its partners, including: strengths-based case management, benefits screening and acquisition, transportation assistance, and brokerage of vocational, social, and recreational activities that will help the client retain housing, achieve self-sufficiency, and support and build on clients' skills and interests. The client's PCM is expected to provide ongoing assessments, work with the client to develop a person-centered Shared Case Management Plan (SCMP), identify other services and programs that would benefit the client to achieve the goals in the SCMP, coordinate access for the client to these services and programs, work to get the other agencies to adopt the SCMP. Coordinated case management services are expected to be needed more often initially, and may scale down over time, as clients need less support. The maximum recommended caseload per PCM is 25-30 clients at any one time, depending on the subpopulation(s) being served by that program or PCM.	Up to two years with interim milestones	Homeless persons diverted from or moving out of shelter with temporary barriers to self-sufficiency	- % remain housed for at least 6 months - % remain housed for at least 12 months - % remain housed for at least 24 months - other vocational, social, emotional, treatment outcomes *Shared outcomes with PH programs*

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Program Type	Description	Essential Program Elements	Time Limits	Population	Program Outcomes
System of Care Resource Coordination (SOC/RC) and Services	Resource coordination, case management and supportive services that help clients maintain housing and achieve self-identified goals in case management plan	The primary concept of SOC/RC is that all resources a client needs to achieve self-identified goals are managed centrally through a Resource Coordinator or Resource Coordination agency. The RC would provide many of the same services offered under the CCM model with the critical, additional role of managing access to all resources that the client may need by purchasing services for the client using a blended pool of resources funded from different systems or through formal interagency agreements that guarantee access to needed services. An important part of the blended pool of resources is flexible funding (e.g., FlexFunds), usually private funding, which can be obtained and accessed quickly and is directly related to the outcomes identified in the client's plan of care. Services can be provided directly by the RC or through SOC partners, including: strengths-based case management (e.g., providing ongoing assessments, helping to develop a person-centered case management plan that is shared by all systems working with that person at any time, and identifying necessary resources to achieve the plan), benefits screening and acquisition, transportation assistance, treatment, vocational services, and social and recreational activities. Employment specialists that understand homelessness will be an integral part of the SOC to work with providers to develop special programs for this population and to step in as needed to help clients maintain employment despite workplace challengess. RC services are expected to be needed frequently at first, but may scale down and up over time depending on client need. For persons who are chronically disabled/ill: The RC will also help develop a crisis response plan and support networks for individuals, who will also have 24/7 access to the SOC team. These SOC/RC services will be long-term, if not permanent, to help the person maintain housing, achieve self-identified case management goals, and address barriers to self-sufficiency. The blended pool of resources coordinated by the RC might include private, housing trust, county funds now spent on emergency medical services, state health and human services funds, HHS, VA, HUD, DOC and DOJ funds, as well as appropriate use of Medicaid services. The maximum recommended caseload per RC for long-term SOC/RC is 10-15 clients. For persons with intensive, but temporary bariers to self-sufficiency: The RC is focused on managing access to resources to help the client obtain and retain permanent housing, achieve self-identified case management goals, and address barriers to self-sufficiency. The blended pool of resources for this population might include: private charity, housing trust, prevention assistance, county and state health and human service funds, TANF, other HHS, HUD, child welfare, and vocational funding streams. The maximum recommended caseload per RC for short-term SOC/RC is 15-20 clients.	No limit; scaleable to clients' needs	All homeless consumers that have intensive barriers to self-sufficiency Long-term SOC/RC for persons who are chronically ill, chronically disabled, dually diagnosed or have significant barriers to self-sufficiency Short-term SOC/RC for persons diverted from or moving out of shelter with intensive, but temporary barriers to self-sufficiency	- % remain housed for at least 6 months - % remain housed for at least 12 months - % remain housed for at least 24 months - other vocational, social, emotional, treatment outcomes - performance measures associated with timely access to and efficient use of resources to support the program outcomes *Shared outcomes with PH programs*

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DRAFT Indianapolis Blueprint Program Models Matrix

Program Type	Description	Essential Program Elements	Time Limits	Population	Program Outcomes
Assertive Community Treatment (ACT) Services	Use of community-based, clinical teams to engage homeless consumers with chronic mental illness in order to achieve housing stability and other client-defined goals	Community-based mental health service team that operates 24 hours/day, 365 days/year to meet basic needs (e.g., food, clothing, blankets), provide thorough assessments (to get to know consumer and his needs), and seek to build relationships over time with goal of engaging them in treatment and services and moving people into housing over time. The ACT model emphasizes consumer choice and active consumer participation in developing and achieving the plan of care. The ACT model primarily uses a self-contained treatment team, managed by a Community Mental Health Center, that can serve all the consumer's identified needs, e.g. psychiatric care, substance abuse treatment and vocational support. An ACT team should operate with a maximum ratio of 10 consumers per team member. The ACT model uses medically-based funding sources, primarily MRO, to finance most services delivered by the team and attempts to facilitate the consumer's access to other sources of funds, e.g. SSDI. This model is more thoroughly defined by the state regulations for MRO funding.	No limit	Homeless consumers with severe and persistent mental illness or co-occurring disorders	- % remain housed for at least 6 months - % remain housed for at least 12 months - % remain housed for at least 24 months - other vocational, social, emotional, treatment outcomes *Shared outcomes with PH programs*

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