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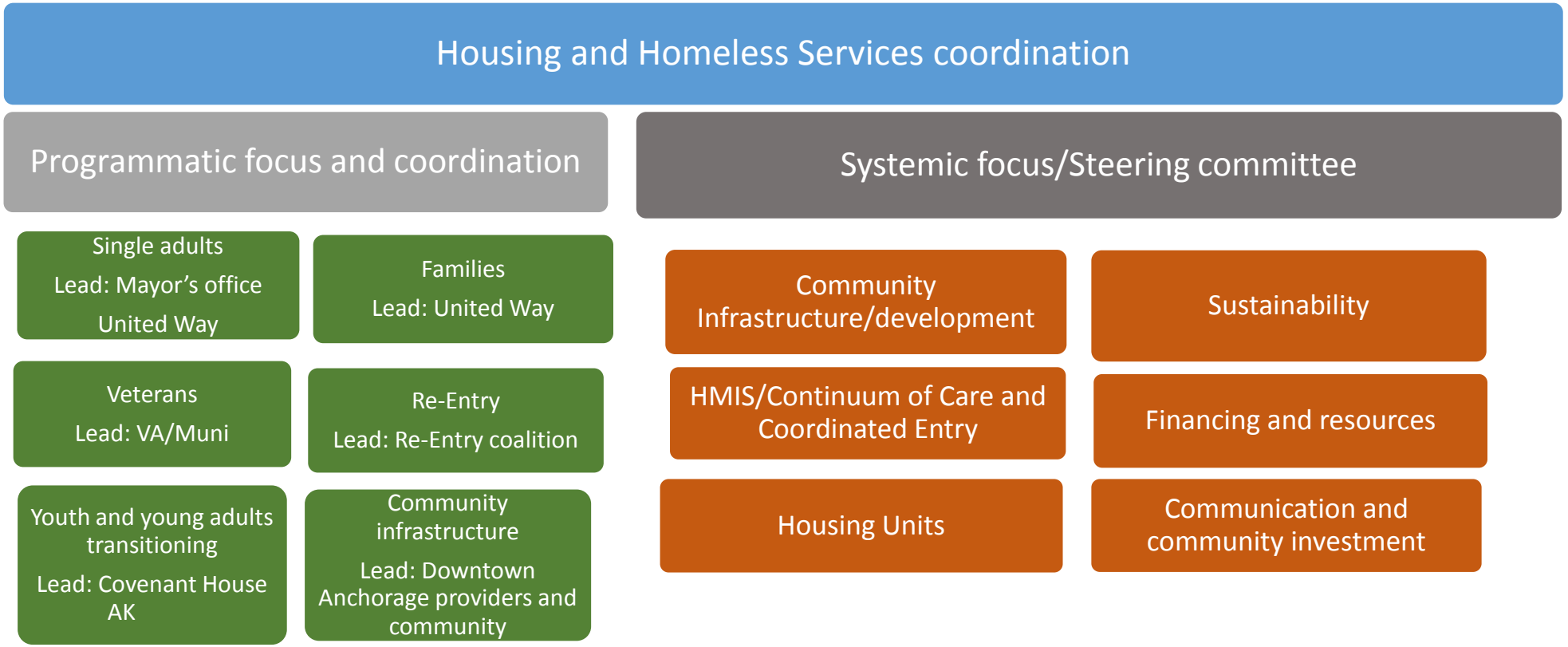
Anchorage's community system overview



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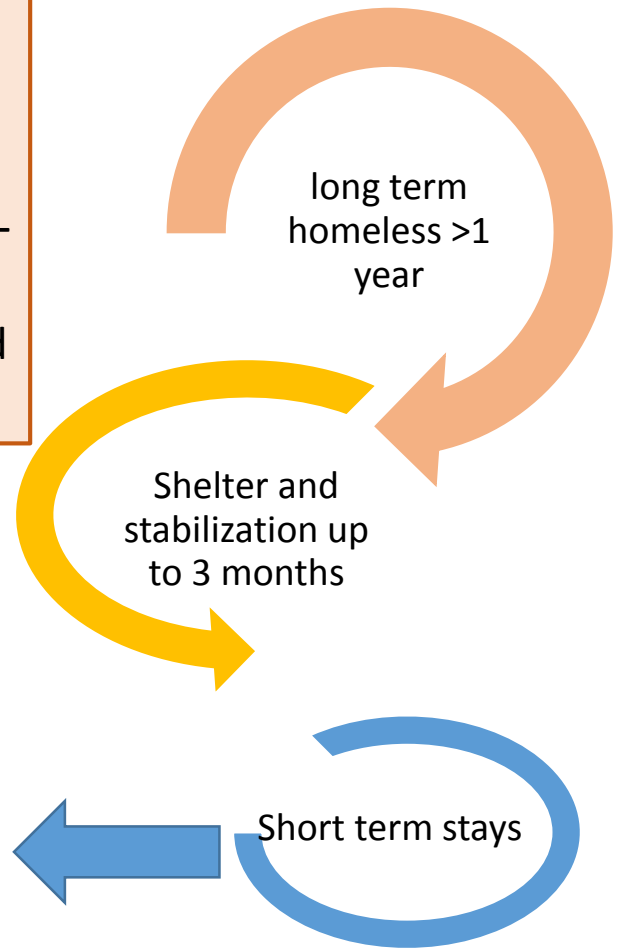
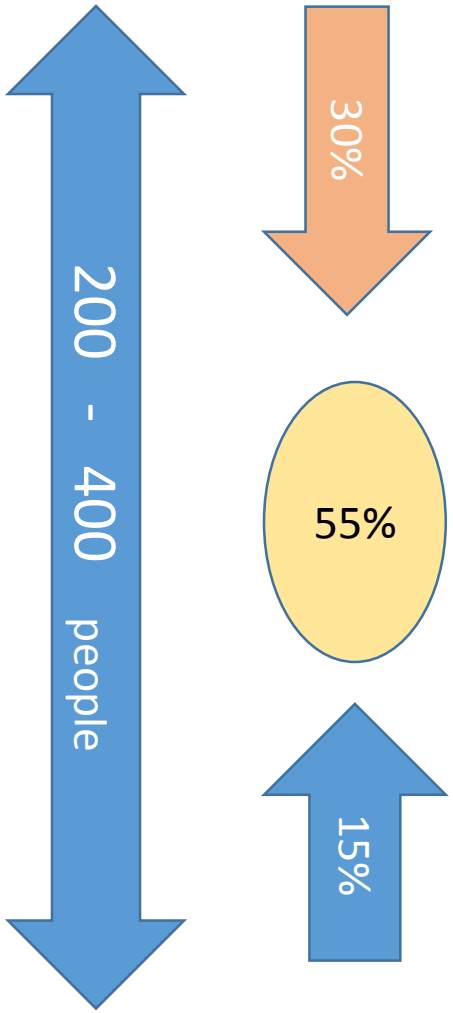
Anchorage's safety net

Housing First – chronically homeless individuals with multiple medical and psychiatric conditions – cycling through camp, shelter, emergency and institutional services

Shelter users with fewer disabling conditions

First homeless episode and potential for quick return to housing





Building a housing continuum

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Housing First – intensive support and treatment needs

- 100 units existing RurAL CAP properties
- 150 – new needed in community

Case management and community support (faith and social orgs), apartments in community, work opportunities

- 50-100 – apartments, rehabilitation and sober support
- family, relocation to home cmty

First homeless episode- quick return to housing

- Short treatment program (mental health or substance), return to community

Step One:
Coordinate Outreach and assessment

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- Community coordination in working off of “By Name” list
- Data collection: January 27-28 camp canvass to determine exact numbers of people and assessment of vulnerability
- Outreach teams weekly meeting-Tuesday afternoon beginning in February 2016
- Team members: CSS, Beans Café, RurAL CAP, ACMHS, Downtown Soup kitchen, APD, CHOICES, Alaska WorkSource, Muni, VA

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Step Two: Housing teams

- Community coordination: working off of one “By Name” list to be matched up with housing options
  - Personal housing choice questionnaire along with community living skill assessment to determine location of housing
  - Rental assistance- identifying resources
- Community housing providers to meet following weekly outreach teams – matching housing to people
- Team members – RurAL CAP, CSS, NeighborWorks, VOA, Veteran’s Admin, Landlord liaison, MOA staff, AHFC, State DHSS/Division of Behavioral Health, community advocates

Step Three:
Employment and vocational team

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Community coordination: working off of one “By Name” list begins to be matched up with employment

- Employment teams prioritizing candidates for various opportunities – training, vocational, volunteer
- Meet following weekly outreach teams – matching economic stability opportunities with people + housing
- Team members – Governor’s Council on Disability and Special Education, Alaska WorkSource, CHOICES, Anchorage Community Mental Health Services, Assets, RurAL CAP, community advocates

Step Four:
Safety Net – shoring up and realign

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- Adaptation of individual agency case management to have “navigators” that can span agencies and population areas – not tied to any one agency or parameters (Coordinated entry component)
- Alignment of shelter services to help assess and channel people into the right resources for needs and housing
  - Daytime services added –
  - reconfigure spaces in downtown areas to provide intensive engagement for shelter stayers

Step Four:
Safety Net reconfiguration

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- Targeted and consistent outreach to campers who won't come into downtown
- Medical coordination to better meet acute care needs
- Shuttle service for better access to resources: Brother Francis/Beans, Alaska Native Medical Center & Anchorage Neighborhood Health Clinic
- Intervention points identified and targeted: Sleep off, corrections discharge, Municipal and state courts, community locations

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Tying it all together - outcomes

Anchorage will set targeted outcomes –

- 300 people housed over 3 years – working off of the By Name coordinated list with most vulnerable people prioritized
- Stability in housing will be primary measure of success – 80% of people stable is the national norm. Anchorage projects have run approx. 78-80% historically
- Hours of employment/work will be counted as outcome for those able to work or volunteer
- Clinical goals will be measured by state programs targeting the population – ACT and Intensive Case Management programs. Community will monitor alongside state for appropriateness of services to level of need

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Tying it all together - outcomes

Anchorage will set targeted outcomes: System change measures will be accounted – realignment and shoring up of shelter

- Ratio of shelter users to staff moving to 50:1 (national best practices)
- Community resources complimenting shelter case management – churches, employment resources assisting in success of shelter guests engaging in Case management
- Mental Health case management levels appropriate for level of care – 35:1 = responsive in times of need
- Engagement time to housing – benchmarks set. Current timeline – 3 months. Target – one to two weeks

End Homelessness in Anchorage:
Adult, veteran, street and camp homelessness

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House 300 people in three years

Stability in Housing: Targets and outcomes
#People housed
Length of stay in housing (tenure)
transition plans or program assessments completed (HAWC, ACT, ICM)

Metrics on volunteering and working	Long term homeless: Metrics on stabilization	Shorter length homeless: Metrics on community integration	Rapid re-housing: Community stabilization -up to 3 months
- Hours volunteering - Hours training and vocational activities - Income earned ($)	- 80% retention in housing - Increases in health and access to medical care - decreases in drinking - increases in daily prosocial activities - decreases in emergency levels of services, sleeps off, API, etc,	- length of time in shelter - Increases in health and access to medical care - Increases in access to treatment services - Decrease in emergency levels of services, sleep off or other	- Length of time in shelter - Transition plans completed - # permanent transitions completed (more than one year)

Sample chart from Los Angeles dashboard

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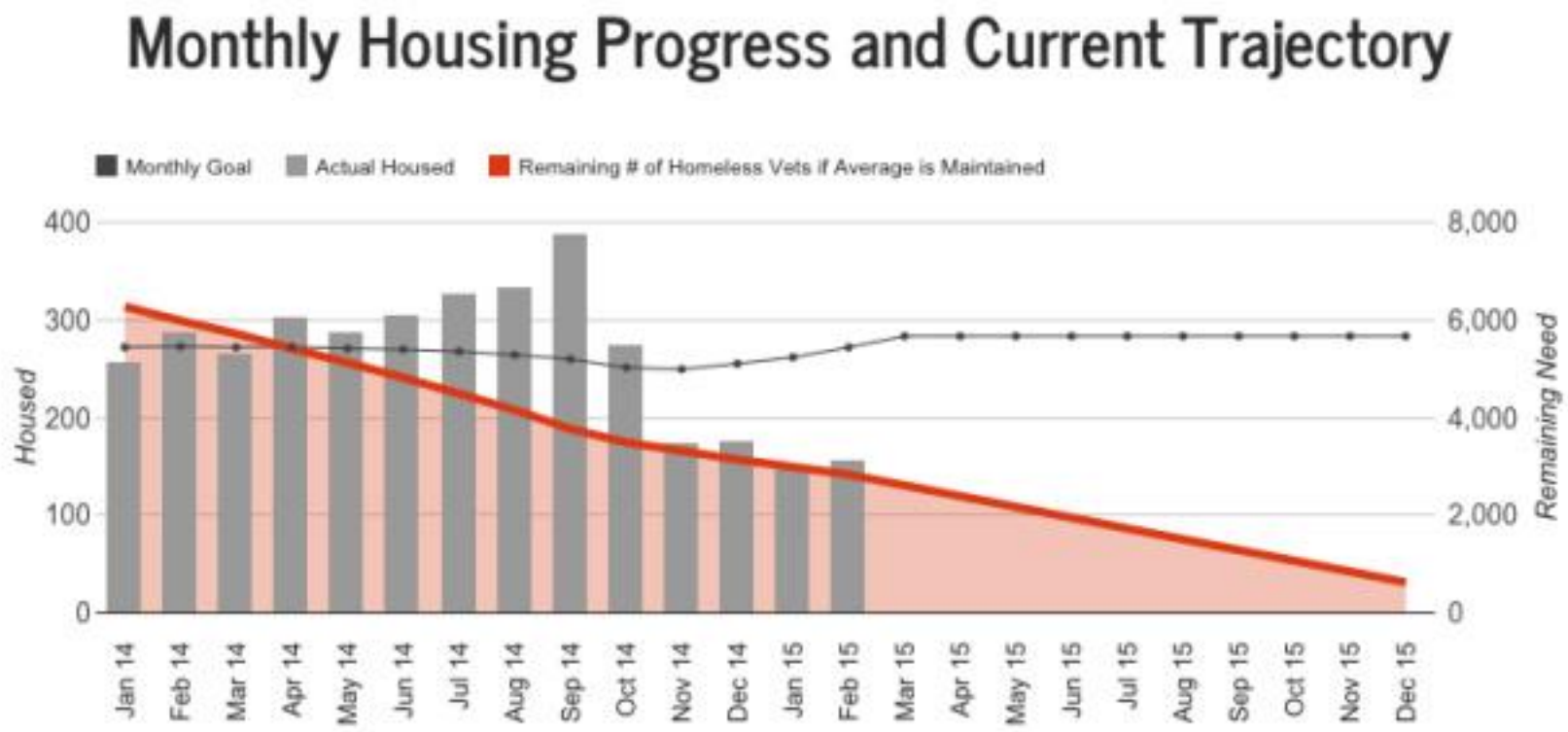

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Community support and connection