WITHIN REACH

ENDING UNSHELTERED HOMELESSNESS
IN THE ASHEVILLE-BUNCOMBE CoC

About the Alliance (NAEH)

The National Alliance to End Homelessness is a nonprofit, non-partisan, organization committed to preventing and ending homelessness in the United States. We do this work by centering equity and justice for marginalized people — including people of color, people with disabilities and LGBTQ people — and adhering to evidence about what works.

As a leading voice on the issue of homelessness, the Alliance analyzes policy and develops pragmatic, cost-effective policy solutions; works collaboratively with the public, private, and nonprofit sectors to build state and local capacity; and provides data and research to policymakers and elected officials in order to inform policy debates and educate the public and opinion leaders nationwide.

Acknowledgements

Within Reach: Ending Unsheltered Homelessness in the Asheville-Buncombe Continuum of Care (CoC) was authored by the National Alliance to End Homelessness (Alliance) but is the result of work conducted throughout the community by many stakeholders. First, this plan would not have been possible without the participation of people experiencing homelessness and front-line staff who work in the City of Asheville/Buncombe County's homeless system. We are incredibly grateful for their assistance in helping us understand how this plan should most effectively reflect their experiences and needs.

Emily Ball and Nikki Reid (City of Asheville), Jennifer Teague and Rachael Nygaard (Buncombe County), and Kaitlynn Lovelace (Dogwood Health Trust) provided essential support to this process through their roles on the project's Steering Committee. Their feedback, thought partnership, and critical thinking were key in the development of the final product.

We also wish to express our appreciation to the many community partners and leaders who worked with the Alliance over six months to provide the information needed to conduct and vet this analysis, including: The Homeless Initiative Advisory Committee (HIAC), Homeward Bound, Asheville Buncombe Community Christian Ministry (ABCCM), Housing Authority of the City of Asheville (HACA), Salvation Army, Helpmate, Haywood Street, Western Carolina Rescue Mission, Community Paramedics, Eliada, Beloved, VA Medical Center (VAMC), Explore Asheville Convention & Visitors Bureau, Asheville Police Department, Vaya Health, Coalition of Asheville Neighborhoods, Asheville Survival Program, and Asheville Area Chamber of Commerce. Many others participated in the community focus groups, stakeholder meetings, and surveys and we appreciate their knowledge and participation.

We received thought partnership and subject matter expertise on this needs/recommendations report from our national partners at **Impact Consulting Group**.

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EXECUTIVE SUMMARY

INTRODUCTION

The National Alliance to End Homelessness (the Alliance) was engaged by the City of Asheville with partnership from Buncombe County, with funding support from Dogwood Health Trust, to identify needs and develop recommendations to guide the county's work on homelessness. Implementing these recommendations will support an equitable, systems-level approach to homelessness that will move the needle toward reducing homelessness within the CoC.

Stakeholders across the CoC contributed to the development of recommendations described in this report through a community-driven engagement process. They articulated a sense of urgency and a deep desire to develop short-, medium- and long-term solutions and strategies that will **significantly decrease the number of people experiencing unsheltered homelessness in the region.**

This report uses the CoC structure as the basis for its recommendations. A CoC is a community planning body that coordinates homelessness and prevention activities in a self-determined geographic area, and submits funding applications to the U.S. Department of Housing and Urban Development (HUD). A CoC has three major responsibilities: operating the CoC, designating and operating a **Homeless Management Information System**, and conducting planning for the area's homelessness response system. The City of Asheville serves as the HUD applicant for the Asheville-Buncombe CoC; the Homeless Initiative Advisory Committee serves as the CoC governance board. Other key partners include Buncombe County, the Housing Authority of the City of Asheville, the Homeless Coalition, service providers, and people with lived experience of homelessness.

NEED

When households pay more than 30 percent of their income towards housing, **they fall into homelessness at a faster pace**. The Asheville-Buncombe CoC reflects these national trends: both the supply and affordability of rental units are an increasing challenge.

Within Buncombe County, more than 17,000 renter households are cost burdened; since the start of the COVID-19 pandemic, rents in Asheville have risen 41.7 percent. Overall vacancy rates in the County are less than 4 percent, and in the City Asheville vacancy rates for tax-credit or government subsidized units are 3 percent. This challenging housing market increases inflow into homelessness as households are priced out of their current units, and decreases outflow as providers cannot find rental units even when a household has a subsidy.

In January 2022, 637 people were counted as experiencing homelessness in the CoC, of whom 232 were unsheltered: a 16 percent increase overall and a 257 percent increase in unsheltered homelessness since 2020. More than 2,400 people interacted with the CoC's homelessness services over the course of 2021. Consistent with national trends, Black residents represent only 6 percent of Buncombe County's population but represent 24 percent of the County's homeless population per the 2021 Point-in-Time (PIT) count.

The majority of homeless resources are located in the City of Asheville. Based on the CoC's Housing Inventory, there are not enough shelter or permanent housing beds to meet the need, and the inventory of homeless resources are disproportionally dedicated to serving veterans.

RECOMMENDATIONS

The Alliance recommends that the CoC pursue a goal of decreasing unsheltered homelessness by 50 percent in two years by taking action in five broad strategies:

1. **Create a Strong Foundation**
2. **Implement Evidence-Based and Inclusive Policy**
3. **Improve System Performance Through Program Design**
4. **Improve Data Quality and Reporting**
5. **Invest in the Future**

Chapter 3 of this report details priorities and action steps that serve as the foundation of a workplan for the CoC's partners. Recommended action steps are categorized as short-, medium-, or long-term in nature. They are designed to quickly address short term needs and drive momentum, while also building provider capacity, creating strong governance, addressing the affordable housing crisis, and creating linkages to needed services.

The following are key recommendations that the Alliance believes the CoC should prioritize:

- **Improve system governance**
- Implement an **encampment resolution policy**
- **Build the capacity of street outreach**
- **Increase crisis response capacity**
- Begin the implementation of **system improvements to the Coordinated Entry System**
- Create a **high-utilizer targeted initiative**
- Promote a **housing surge for unsheltered** people
- **Implement Moving On strategies**

CONCLUSION

To successfully execute this plan, the CoC, City of Asheville, Buncombe County, and key community stakeholders will need to work collaboratively and fully coordinate their resources, as well as communicate across the system and with the public. Though the plan outlines immediate goals, it is important to understand that building an efficient, effective, and equitable system will take time, but is within reach.

INTRODUCTION

The National Alliance to End Homelessness (the Alliance) was engaged by the City of Asheville with partnership from Buncombe County, with funding support from Dogwood Health Trust, to work in partnership with key partners to identify needs and develop recommendations to guide the community's work on homelessness.

The recommendations outlined in this report set forth bold strategies that can be implemented in the homeless service delivery system of the Asheville-Buncombe Continuum of Care (CoC) to make a positive impact for people who experience homelessness in the community. Implementation of these recommendations will support the CoC to create, align, and implement an equitable, systems-level approach that will move the needle toward reducing homelessness within the county.

Stakeholders from across the City and County have contributed to the development of these recommendations through a community-driven engagement process designed to build ownership, increase accountability, develop a common strategic vision, and ensure cross-agency alignment. These stakeholders have articulated a sense of urgency and a deep desire to develop short-, medium- and long-term solutions and strategies to be implemented via a unified, community-based approach.

The most pressing goal identified through the engagement process was **to significantly decrease the number of people experiencing unsheltered homelessness** — and therefore reduce the suffering currently being experienced on the streets of the Asheville-Buncombe community.

The affordable housing crisis has impacted communities across the country and has contributed to significant increases in chronic and unsheltered homelessness nationwide since 2015. In the Asheville-Buncombe CoC, which saw a 21 percent increase in homelessness between 2021 and 2022,[1] the lack of affordable and supportive housing options is adversely affecting the ability of service providers to create paths to successful permanent solutions for persons experiencing homelessness. This stress has been compounded by the economic effects of the COVID-19 pandemic, which include rising housing prices and plummeting vacancy rates, and disproportionally impact communities of color and exacerbate existing racial disparities.

Although the pandemic brought about new federal resources to prevent and help people exit homelessness through both interim and permanent solutions, the funding streams and policies that were implemented during the pandemic are quickly coming to an end, even while the racial disparities in the data remain and the number of unsheltered people in the community climbs. The visibility of homelessness, particularly with the highly vulnerable unsheltered population, has created public concern and increased political pressure to respond with urgency.

Bold action by community leaders and stakeholders is needed.

[1] 2022 Annual Homelessness Assessment Report to Congress, https://www.huduser.gov/portal/sites/default/files/pdf/2022-AHAR-Part-1.pdf

Understanding the Continuum of Care

The **McKinney-Vento Homeless Assistance Act**, which establishes the statutory framework for the U.S. Department of Housing and Urban Development's (HUD) response to homelessness, created the Continuum of Care Program (CoC Program) that provides more than $2.6 billion nationwide to communities each year to combat and end homelessness. To qualify for this funding, a community must establish and operate a Continuum of Care.

In its **Introductory Guide for the CoC Program**, HUD states:

> "The CoC Program is designed … to promote community-wide planning and strategic use of resources to address homelessness; improve coordination and integration with mainstream resources and other programs targeted to people experiencing homelessness; improve data collection and performance measurement; and allow each community to tailor its program to the particular strengths and challenges within that community."

The community planning body referred to above is the CoC: the group that coordinates homeless services and homelessness prevention activities. The CoC serves a self-determined geographic area (i.e., a city, county, or region of multiple counties or state), and has three major overarching responsibilities (as described in the **CoC Program Interim Regulations** at 24 CFR part 578):

- to operate the Continuum of Care;
- to designate and operate a **Homeless Management Information System** (HMIS), which may include identifying an eligible HMIS administrator and funding applicant; and
- to conduct planning for the Continuum of Care.

In an operational sense, these three broad requirements include the following required activities:

- the CoC must establish a Board to act on its behalf and identify an eligible entity to apply for HUD funds (called the **Collaborative Applicant**);
- the CoC must develop a governance charter that outlines the delegation of authority for operating the CoC;
- they must establish and operate the systems that act as the backbone of the local response, including the **Coordinated Entry System (CES)** and HMIS;
- they must create and enforce written standards for operating the CoC;
- they must establish performance targets and gather data through a Point-in-Time Count and gaps analysis process;
- they must consult and coordinate with recipients of Emergency Solutions Grants (ESG) funds;
- they must develop a CoC-wide plan to prevent and end homelessness; and
- they must submit the application for funding through the CoC Program to HUD.

CoCs have the flexibility to meet these requirements in a variety of ways based on their local needs and environment. Therefore, some CoCs have a strong non-profit organization that is designated as the Collaborative Applicant/Lead Agency (for example, **San Diego** and **Houston**), while some choose to center the CoC's activities with a unit of local government (**Spokane, WA**) or with a Housing Authority (State of **Maine**). No matter what type of Collaborative Applicant a CoC may have, the CoC structure must rely on all of its partners – local government, people with lived expertise, non-profits, faith-based communities, affordable housing providers, mainstream service systems, businesses, and others – to work together to solve homelessness locally. HUD requires communities to center equity in their efforts evident by making identifying and addressing racial disparities' and addressing the needs of LGBTQIA+ individuals and families a priority.

CHAPTER 1: HOUSING AND HOMELESSNESS IN THE ASHEVILLE-BUNCOMBE COC

CoC Partners and Roles in Asheville-Buncombe County

While there is currently no formal cross-agency structure for City and County collaboration as is found in other CoCs, several entities make up the community's response to homelessness:

- **The City of Asheville** serves as the Collaborative Applicant/Lead Agency for the Asheville-Buncombe CoC. This role includes managing the Homeless Management Information System (HMIS), facilitating the CoC's Coordinated Entry System (CES), and supporting the Homeless Initiative Advisory Committee (HIAC). The City of Asheville receives annual funding from HUD of $53,227 to support their role as the Collaborative Applicant. The City's Community and Economic Development Department (CEDD) manages federal and City funds that support homeless response programs, and was recently restructured to include two new divisions: the Affordable Housing Division and the Homeless Strategy Division.
    - The Affordable Housing Division is responsible for providing affordable housing within the City and for eliminating the housing affordability gap many residents experience and that contributes to homelessness.
    - The Homeless Strategy Division describes its role as a partner and convener for the organizations that serve people experiencing homelessness in the community. It is responsible for developing a "**collective vision and an effective and streamlined community wide collaboration to maximize resources and efforts to best respond to homelessness as a unified Continuum of Care (CoC)**↗."
- **Buncombe County** ooversees some mainstream systems that serve persons experiencing homelessness or at risk of homelessness. These include public health, child welfare, social services, jail, and law enforcement. Coordinating this mainstream work with the homeless system is a challenge. Buncombe County does not have a dedicated staff position to support homeless service activities. Staffing is shared between various positions with a focus on allocating federal and county funds to support homeless response program components.
- **The Homeless Initiative Advisory Committee (HIAC)** serves as the Governance Board overseeing policy, strategy, and federal resource allocation for the CoC and is responsible for ensuring the federal dollars are procured, reported, and compliant with all requirements mandated by HUD. It creates long-term strategies (e.g., 5-year and 10-year plans to end homelessness) to direct the vision and mission for the CoC's geographic area, which includes the City and the County. HIAC's 16 board seats are appointed by the County Commissioners (8 seats) and City Council (8 seats).
- **The Housing Authority of the City of Asheville (HACA)** provides safe, quality, and affordable housing through the Housing Choice Voucher and other rental assistance programs. As part of this mission, it collaborates with the community to create affordable housing opportunities. HACA provides preference in its housing placements for qualified households connected to a program providing support. HACA's CEO currently acts as the Chair of HIAC.

- **The Homeless Coalition** is a group of community stakeholders who regularly work together to improve service delivery and coordination across the Asheville-Buncombe CoC.

- **Homeless and Housing Service Providers & Community Stakeholders** include several partner agencies who participate in service delivery in a variety of ways. Providers may offer one service or a wide array of services as part of their commitment to humanely supporting people experiencing homelessness. Community stakeholders include advocates, faith-based organizations, and volunteers that are committed to supporting those on the streets and in shelters. They offer support directly to those experiencing homelessness by holding donation drives and distributing goods to people experiencing homelessness, or by supporting local agencies to accomplish their mission. Each of these participating groups plays a vital role in supporting wellness in the homeless community and can contribute to coordinating efforts to reduce and end homelessness.

Other key partners in the community include: the Department of Veterans Affairs (VA); people with lived experience of homelessness and housing instability; the business community; and other systems of care within the county.

The State of Homelessness and Affordable Housing in Asheville-Buncombe County

Population

The Asheville-Buncombe CoC is one of twelve CoCs located in the state of North Carolina. The U.S. Census Bureau estimated **Buncombe County's population** at just over 271,000 people in 2021 (about 3 percent of the population of North Carolina), with the City of Asheville containing 35 percent of the total population of the County. According to the most recent data, the population of the County of Buncombe is 82.9 percent white (not Hispanic/Latino), 6.2 percent Black or African American, 1.5 percent Asian, 2.3 percent multi-racial, and less than 1 percent American Indian/Alaska Native/Native Hawaiian/Pacific Islander. Latinos make up 7 percent of the population.[2]

Affordability in the City and County

After comparing Fair Market Rents (FMR), Asheville is more expensive than 98 percent of other North Carolina cities and is currently in the midst of an affordable housing crisis. Since the start of the COVID-19 pandemic in March of 2020, rents have risen 41.7 percent, and as of October 2022, the average rent for a one-bedroom apartment in Asheville was $1,319.[3]

The 2020 **Asheville, North Carolina Region Housing Needs Assessment** found that among the Buncombe County renter households, a total of 17,643 (46.1 percent) are cost burdened and 7,439 (19.4 percent) are severely cost burdened. The City of Asheville has a higher share of cost burdened households than the county overall. Cost burdened households pay more than 30 percent of their income towards housing, while severe cost burdened households pay over 50 percent of their income towards housing. Disaggregated data for Asheville was not available in the 2020 Asheville, North Carolina Region Housing Needs Assessment. Based on national data trends, communities of color are typically more disproportionately cost burdened.

National data demonstrates that when households pay more than 30 percent of their income towards housing, **they fall into homelessness at a faster pace**. This is commonly called being "priced out" of housing, in which the households' income or wages are not

[2] U.S. Census Bureau: **https://www.census.gov/quickfacts/fact/table/buncombecountynorthcarolina,ashevillecitynorthcarolina,US/PST045222**

[3] Average one bedroom apartment rental cost according to www.apartments.com in November, 2022

keeping pace with the cost of housing year-after-year.[4] The City of Asheville **is the most expensive place to rent** in North Carolina, where it is estimated one would need to make at least $26.50 per hour to make rent for a two bedroom unit while paying no more than 30 percent of their income towards housing. However, the median hourly wage in the City of Asheville in 2022 is $15.87. In other words, the average renter would need to work 1.7 jobs to avoid the cost burden of housing.[5] Additionally, the 2020 Asheville, North Carolina Region Housing Needs Assessment found that in 2019, the highest share of renters in Buncombe County (17.6%) made between $10,000-$19,999 and 25.7 percent made below $19,999 annually (see Figure 2).[6]

The **increasing prices** of housing in the community are a key factor in recent challenges with securing housing for those that are in possession of a Housing Choice Voucher or other rental assistance. Because the HUD-determined **FMR in Asheville** for a one-bedroom apartment ($1,298 for FY2023) is significantly lower than what landlords are able to charge in the open market, there are not enough landlords willing to participate in these programs.

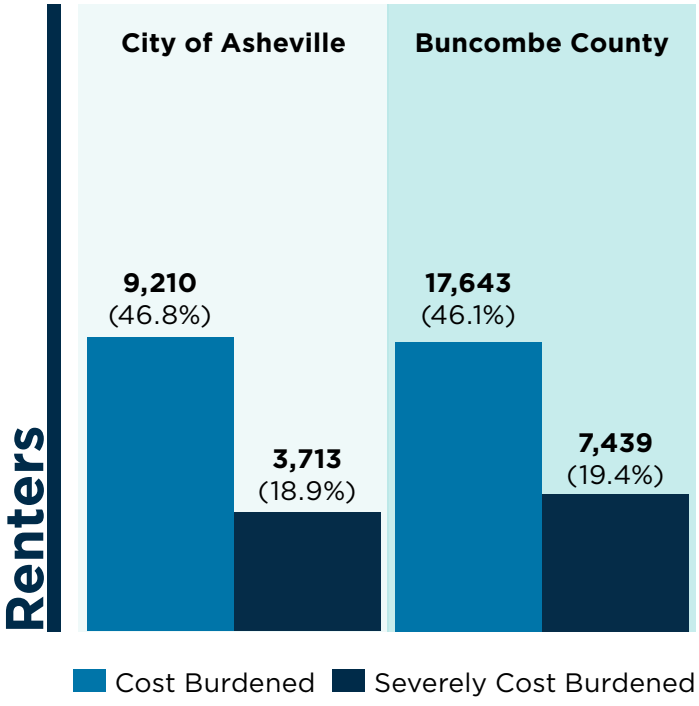

Figure 1: 2020 Asheville, North Carolina Region Housing Needs Assessment, pg. 6

"[To end homelessness in Asheville-Buncombe, we need] more affordable housing, more resources to reduce wait times for housing" — Anonymous Community Survey Response

Renter Households by Income

Region	City of Asheville	Buncombe County
<$10,000	1,866 (8.2%)	3,572 (8.1%)
$10,000 - $19,999	3,908 (17.2%)	7,788 (17.6%)
$20,000 - $29,999	3,201 (14.1%)	6,794 (15.4%)
$30,000 - $39,999	3,091 (13.6%)	6,238 (14.1%)
$40,000 - $49,999	2,934 (12.9%)	5,594 (12.7%)
$50,000 - $59,999	1,586 (7.0%)	2,950 (6.7%)
$60,000 - $99,999	3,572 (15.7%)	6,777 (15.3%)
$100,000+	2,547 (11.2%)	4,490 (10.2%)

Figure 2: 2020 Asheville, North Carolina Region Housing Needs Assessment, pg. 277

[4] Chris Glynn - Alexander Casey on Dec. 11, 2018. 2021, February 11). Homelessness rises faster where rent exceeds a third of income. Zillow Research. Retrieved November, 2022, from **https://www.zillow.com/research/homelessness-rent-affordability-22247/**

[5] Out of Reach - North Carolina. National Low Income Housing Coalition. (n.d.). Retrieved from **https://nlihc.org/sites/default/files/oor/North_Carolina_2022_OOR.pdf**

[6] Asheville, North Carolina Region Housing Needs Assessment (March 2020). Bowen National Research

Supply of Affordable Housing

There are simply not enough affordable housing options in Asheville-Buncombe CoC.

Multifamily rental housing in Buncombe County shows an overall vacancy rate of 3.5 percent, multifamily rental housing and the City of Asheville shows a 2.8 percent vacancy rate.[7] Even with increased efforts to combat the shortage of housing, the market continues to lack a sufficient inventory of affordable rental properties.

In 2019, there was only a 0.3 percent vacancy rate for tax-credit or government subsidized units in the City of Asheville; Buncombe County had a similar vacancy rate at 0.2 percent vacancy. Long waitlists and high occupancy rates at these projects demonstrate the demand to increase affordable housing stock.[8] The absence of affordable housing stock hampers efforts to reduce homelessness in the following ways:

- It increases inflow into the homeless services system. As people who are cost burdened or severely cost burdened get priced out of their units, more households fall into homelessness.
- It strains the existing homeless response system. The absence of affordable housing creates longer lengths of stay in programs, which affects the ability for those who are unsheltered to access vacant beds.
- It creates negative outcomes for Rapid Re-Housing interventions. When newly housed residents are unable to increase their incomes quickly enough to afford rent independently, they require longer stays with programs or they return to homelessness.
- It strains front line staff. Burnout and high turnover of homeless and housing services staff has increased due to staff's inability to support access to critical housing resources for those they serve.

The facts as stated above were reflected in the remarks from stakeholders in the Asheville-Buncombe community during the engagement process for this report. Many stakeholders pointed to a lack of affordable and supportive housing stock and high rents as a major challenge to help people exit homelessness.

Homelessness in the Asheville-Buncombe CoC

In January 2022, the CoC administered the Point-in-Time (PIT) Count (as required by HUD) to determine the number of people experiencing both sheltered and unsheltered homelessness throughout Asheville-Buncombe County. The data showed an overall 16 percent increase from 2020 to 2022 and an increase of 23 percent since 2010. Both the County and the City of Asheville have seen an increase in the total number of unsheltered people experiencing homelessness. Since 2020, the Asheville-Buncombe community has experienced a 257 percent increase in unsheltered homelessness and an overall increase of 330 percent since 2010 based on the PIT. More than 2,400 people interacted with the CoC's homelessness services over the course of 2021.[9]

While overall trends are important for planning purposes, it is important to understand the needs of various populations and/or subpopulations of people experiencing homelessness in the community so that interventions can be properly designed and scaled.

Persons who are...	2010	2020	2021	2022
Sheltered	462	482	411	405
Unsheltered	54	65	116	232
Total	516	547	527	**637**

*Figure 3: PIT Counts 2010, 2020, 2021, 2022 (Source: **City of Asheville**)*

7 2020 **Bowen Regional Housing Needs Assessment**
8 Bowen, WNC Housing Needs Assessment
9 All increases of homeless percentages are from annual PIT homeless count data overseen by the Asheville-Buncombe CoC. Data can be found here: **https://www.ashevillenc.gov/department/community-economic-development/homeless-initiative/homelessness-data/**

Unsheltered. The ratio of unsheltered to sheltered people in the Asheville-Buncombe CoC is generally aligned with the national ratio: about two-thirds of people are sheltered and one-third are unsheltered. While there are more people experiencing homelessness overall in 2022, there are fewer people in shelter programs as compared to 2020 and 2021. This aligns with national trends throughout the pandemic: quarantine periods, shelter decompression to allow for social distancing, and a loss of staff negatively impacted bed utilization and capacity even in areas where hotels and other emergency shelter programs were created to reduce the spread of COVID-19. However, it is worth noting that sheltered homelessness decreased within the Asheville-Buncombe CoC by 16 percent from 2020 and 2022, even with an increase of 93 beds and an overall increase in homelessness of 16 percent over the same time.

Of the persons who were living unsheltered at the time of the 2022 PIT Count, 167 were male and 63 were female (this represents nearly a tripling of the unsheltered count of females). There were 6 veterans, 12 transition-age youth (18-24), and 2 transgender individuals counted. People experiencing unsheltered homelessness are now remaining homeless longer, and unsheltered chronic homelessness nearly doubled from 2021 to 2022, rising from 59 to 112 people.

Race and Ethnicity. According to the U.S. Census Bureau, the City of Asheville has more than 94,000 residents, which was an increase of about 11,000 people (13 percent) from the 2010 Census count. The Black population, meanwhile, saw no growth, contrary to the trends of multi-racial growth across the U.S. Instead, the Black population in Asheville has declined by 10.7 percent since 2010.[10]

National data show that Black, Indigenous, and People of Color (BIPOC) are overrepresented within the population experiencing homelessness, and HUD publishes a **Racial Equity Analysis Tool** to help communities understand the racial disparities evident in their local homeless services systems. Based on this data (which uses the 2021 PIT), Black residents represent only 6 percent of Buncombe County, although they represent 10 percent of those living in poverty, and 24 percent of the people experiencing homelessness in the Asheville-Buncombe CoC population.

Between October 1, 2020–September 30, 2021, Black individuals represented disproportionally higher percentages of those returning to homelessness (31 percent). They were also disproportionately under-represented among those using transitional housing (10 percent) and emergency shelter (19 percent). Black individuals were slightly over-represented to permanent housing placements from all projects (28 percent).

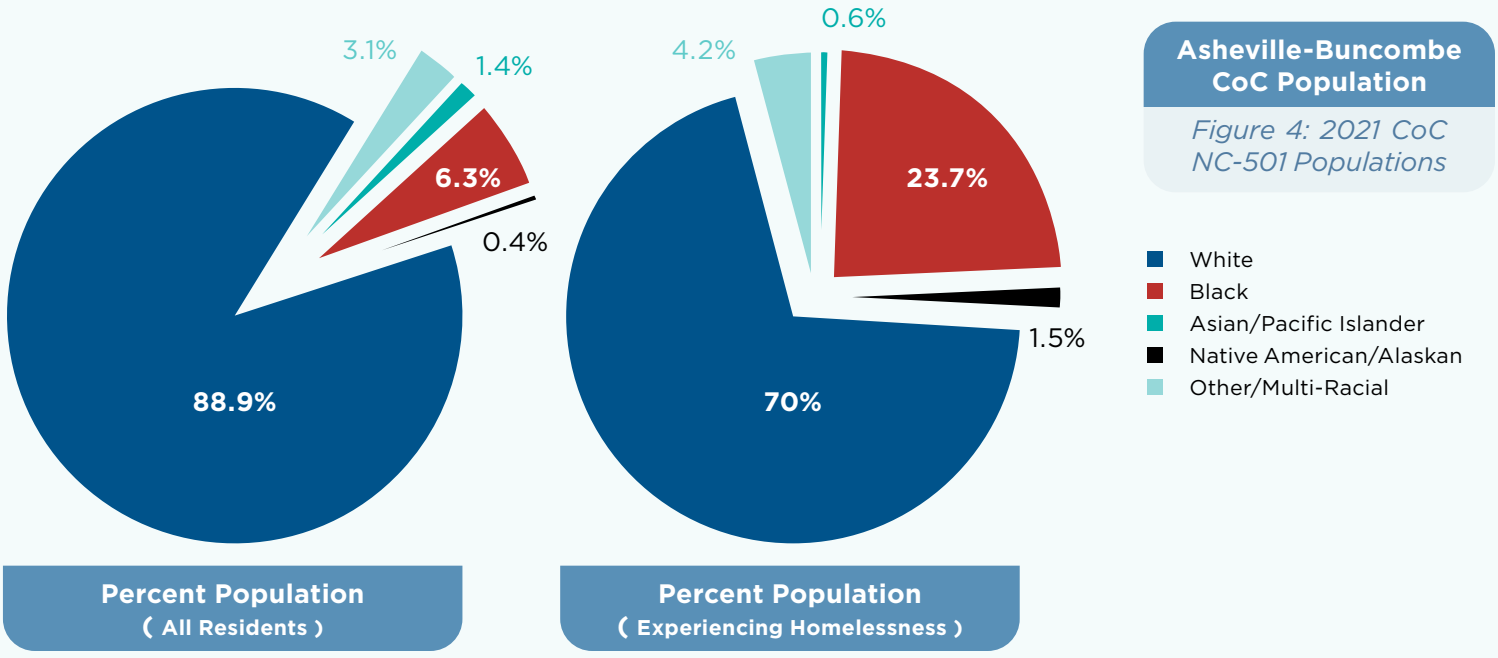

Figure 4: 2021 CoC NC-501 Populations

[10] Burgess, J. T. A. C. T. (2021, August 16). Census: Asheville grows; its Black population shrinks. Asheville Citizen Times. https://eu.citizen-times.com/story/news/2021/08/16/census-asheville-nc-black-population-shrinking-2020-white-grows/118179948/

People Experiencing Homelessness for the First Time. In 2021, the Asheville-Buncombe CoC reported that 684 of the 819 people (or 83.5 percent) entering emergency shelter, transitional housing or permanent housing in the CoC were homeless for the first time, up from 468 of 652 (or 71 percent) the year prior. While this data is only representative of partner agencies that enter data into HMIS, it indicates that affordability seems to be out of reach in the county for an increasing number of households.

Veterans. As discussed in further detail in the next section of this report, a large portion of the transitional and permanent housing resources available in the CoC are dedicated to serving veterans. As a result, Asheville-Buncombe County has shown a 31 percent reduction in veteran homelessness over the last two years. In 2020, veterans accounted for more than 40 percent of the homeless population according to the PIT Count. By 2022, veterans accounted for only 23.5 percent of the homeless population.

Homeless Interventions in the Asheville-Buncombe CoC

The following crisis response and housing interventions are currently available to meet the needs of people experiencing or at risk of homelessness within the CoC:

Crisis Response:

- **Eviction/Homelessness Prevention (HP) and Diversion Assistance**: interventions that provide short-term rental and legal assistance for housing insecure individuals and households so that they can maintain current housing or relocate to new housing and avoid entering the emergency shelter system.
- **Street Outreach (SO)**: an intervention designed to meet the immediate needs of people experiencing homelessness in unsheltered locations by connecting them with emergency shelter, housing, or critical services, and providing them with urgent, non-facility-based care. Component services generally consist of engagement, case management, emergency health and mental health services, and transportation.[11]
- **Emergency Shelter (ES)**: short-term beds without a prescribed length of stay that provide safety, security, and housing navigation/case management services.
- **Transitional Housing (TH)**: a temporary housing intervention partnered with support services to assist the transition to permanent housing. Program participants are required to sign a lease or occupancy agreement and participate in services that will support stability in housing once they transition to permanent housing. Stays are no longer than 24 months.

Permanent Housing:

- **Rapid Re-Housing (RRH)**: short- or medium-term rental assistance (up to 24 months) and services designed to quickly rehouse and stabilize individuals and families.
- **Permanent Supportive Housing (PSH)**: evidence-based housing intervention that provides longer-term rental assistance and intensive supportive services to targeted populations, including people who are chronically homeless.
- **Other Permanent Housing Alternatives**: low-income housing available in the community with or without rental assistance.

[11] Street Outreach. (n.d.). HUD Exchange. Retrieved December 10, 2022, from https://www.hudexchange.info/homelessness-assistance/coc-esg-virtual-binders/esg-program-components/street-outreach/

Shelter Inventory

In addition to the PIT Count, HUD requires each CoC to identify how many beds/units are available for people experiencing homelessness within the CoC. The Asheville-Buncombe CoC Housing Inventory Count (HIC) for 2022[12] includes the following, the majority of which are located in the City of Asheville:

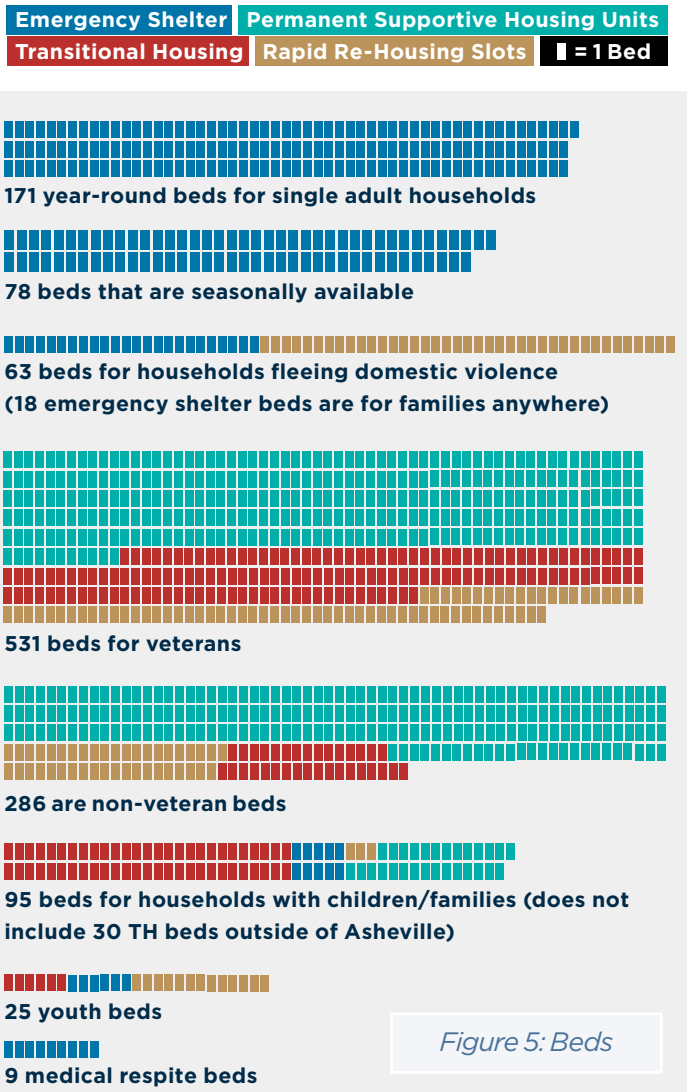

Figure 5: Beds

In addition to these housing/shelter resources, the CoC provides funds for homelessness/eviction prevention and diversion programs that serve about 108 people per year.[13]

Eligibility

Each resource has its own eligibility requirements based on the funding stream for the project. For example, eligibility may be specific to a homeless population (e.g., veterans, families, domestic violence survivors, single adults, etc.), and may include requirements such as disability or chronic homelessness status.

It is important to note that more than half of the transitional and permanent housing interventions listed in **Figure 5** require veteran status. For example, more than 61 percent of permanent supportive housing and 65 percent of transitional housing is available only for veterans, while nearly 43 percent of Rapid Re-Housing slots are dedicated to veterans, according to the 2022 HIC. Additionally, of the 293 total year-round emergency shelter beds available in the CoC for single individuals,[14] only 105 can be accessed by non-veteran single adults compared to the 232 individuals experiencing unsheltered homelessness.

While ensuring that resources for veterans are robust and can serve the needs of this population, resources for veterans are disproportionally funded in the CoC. This is likely because the federal government invests heavily in programs for veterans experiencing or at-risk of homelessness through programs like HUD-VA Supportive Housing (HUD-VASH), Supportive Services for Veteran Families (SSVF) and the Grant and Per Diem (GPD) program. As a result, other populations like families and single adults do not have the same access to crisis response and permanent housing resources, a contributing factor in the increase of unsheltered and chronic homelessness.

Funding for Dedicated Homelessness Assistance

Homeless programs in the Asheville-Buncombe CoC are supported by a variety of federal, state, county, city and private funds. Funding allocations vary widely – they may be one-time, multi-year, or single-year allocations and a portion of these funds are facilitated, received and/or administered by the City of Asheville and Buncombe County governments.

12 Because the 2022 HIC was created in January 2022, it includes resources funded with pandemic relief funds that are now not available. For example, the 2022 HIC includes 66 non-congregate shelter beds that are no longer available because the funding expired or was expended. The 2023 HIC will be more reflective of the current inventory.

13 Diversion and eviction prevention data not reflected in the overall people served.

14 This does not include 9 medical respite beds and 20 beds for persons fleeing domestic violence.

Not accounting for general County funds that are not specifically designated for people experiencing homelessness (behavioral health services, substance use services, etc.) or private philanthropy, about $3.2 Million per year is spent by key partners on homeless-dedicated projects (see first table below). City and County funding generally support programs including homelessness/eviction prevention and diversion, coordinated entry, outreach, emergency shelters (program and operations), housing navigation, and housing stabilization services. CoC funds generally support permanent housing solutions, including Rapid Re-Housing and permanent supportive housing.

It is important to note that both Buncombe County and the City of Asheville saw a significant increase in funding over the past two years due to the nation's response to the COVID-19 pandemic. Pandemic relief funding far outpaced the community's regular spending, as illustrated in the second table below, and those funds that have not already expired will be sunsetting in the next six to nine months. **Because the need in the CoC is not met even with these additional funds, the loss of resources dedicated to homelessness assistance will create a significant resource gap if replacement funding sources are not identified.**

The funding amounts detailed in **Figure 6** and **Figure 7** (page 14) are estimates based on publicly available data. Further, data on costs associated with, but not directly related to, homelessness are not included (e.g., sanitation, behavioral health, substance use services). This data also does not account for private donations or fundraising at the provider level.

Funding accounted for in Figure 6 also does not include dollars spent by the U.S. Department of Veterans Affairs (VA) on programs serving Veterans experiencing or at-risk of homelessness. As noted in an earlier section of this report, a significant portion of the local resources available are dedicated to Veterans. **The funding for those programs is not coordinated with the funding streams detailed in Figure 6.**

System Performance

Accurate system performance — including the successes, challenges, and throughput from crisis response to housing — is difficult to determine. This is primarily due to differences in tracking program participant intake and exits among providers, and because participation in HMIS is low. Only about 66 percent of service providers in Asheville-Buncombe County provide entry and exit data into the HMIS database, amounting to 59 percent of the total beds available.[16] Further, between August 1, 2020 and September 16, 2021, the Asheville-Buncombe CoC reported that only just over 25 percent of those experiencing homelessness in the community had

Figure 6: Regular Spending across Asheville-Buncombe County[15]

Source	Program	Administering Agency	Total
Federal	Emergency Solutions Grants (Annually Appropriated)	City of Asheville	$127,628
Federal	CoC	City of Asheville	$1,887,699
Federal	HOME/CDBG	City of Asheville	$344,127
City	Emergency/Cold Weather Shelter, Drop-in Center, Outreach	City of Asheville	$192,000
County	Emergency/Cold Weather Shelter, Outreach, SSI/SSDI Outreach Access and Recovery (SOAR), Coordinated Entry, Case Management, CoC	Buncombe County	$707,527
		Regular Annual Spending Total	**$3,258,981**

15 Funding amounts for Program Year 2022 based on publicly available data.

16 Homelessness Data. The City of Asheville. (n.d.). Retrieved November 2022, from https://www.ashevillenc.gov/department/community-economic-development/homeless-initiative/homelessness-data/

Figure 7: Pandemic Response Spending across Asheville-Buncombe County			
Source	**Program**	**Administering Agency**	**Total**
Federal	Emergency Solutions Grants-Covid Response (ESG-CV)	City of Asheville	$2,093,997
Federal	FEMA and ARPA Non-Congregate Shelter (No longer open)	City of Asheville	$6,533,282
Federal	Emergency Housing Vouchers (47 Vouchers, 96% currently leased)	Asheville Housing Authority	$717,110
Federal	Eviction Prevention/Homeless Prevention/Rapid Re-Housing	City of Asheville	$1,505,390
Federal	Days Inn, Ramada, and ABCCM Permanent Supportive Housing Expansion	City of Asheville	$4,499,800
City	Ramada Permanent Supportive Housing Expansion	City of Asheville	$1,000,000
Federal	Youth Homelessness programs	City of Asheville	$473,050
Federal	Helpmate - Domestic Violence Emergency Shelter	City of Asheville	$2,000,000
Federal	Helpmate - Domestic Violence Emergency Shelter	Buncombe County	$2,000,000
Federal	Days Inn Permanent Supportive Housing Expansion	Buncombe County	$3,000,000
		Pandemic Response Spending (2022-2023)	**$23,822,629**[17]

received a referral to a housing intervention (RRH, PSH HP, and/or Emergency Housing Vouchers(EHV) by engaging in an assessment (136 of 527 persons in 2021).[18] The overall amount of completed assessments is unknown. This represents a critical lack of information about those who may want and need housing and services in the community and the lack of available housing interventions. This also represents a lack of information on potential racial and ethnic disparities. Because of the lack of HMIS data, it is difficult to determine the flow patterns of people experiencing homelessness entering the shelter system, the average length of the stay in the shelter system, and the overall percentage of successful exits to housing.

Additionally, there are no clear system-wide policies on how homelessness/eviction prevention and diversion interventions are tracked in HMIS. Therefore, the CoC, City, and County cannot fully understand the outcomes and impact these resources have on decreasing the inflow into the homeless response system. This is a clear gap that adversely impacts the CoC's ability to plan. It reduces the ability to evaluate the performance of interventions meant to support and redirect households from entry to the homeless response system.

The available HMIS data shows that roughly 40 percent of people who exited from shelter, transitional housing, and Rapid Re-Housing programs were successful in returning to and maintaining permanent housing. However, without a more comprehensive data set, it is unclear if this is an accurate picture of the CoC's performance overall.

17 More than half of the spending was in capital dollars.

18 Coordinated Entry data for 2021 reported in the Coordinated Entry System Evaluation from the City of Asheville (September 27, 2021) compared to PIT Homeless Count data for 2021. The City of Asheville. (2021). Coordinated Entry System Evaluation 2021

CHAPTER 2: COMMUNITY ENGAGEMENT

Data about the environment of homelessness in the Asheville-Buncombe County CoC — including the number and characteristics of those experiencing homelessness in the CoC, the interventions available, and the landscape of the affordable housing market – tell only part of the story. The other critical information includes feedback and observations about how the system operates from people who use it, from people who lead or work in the system, and from other people impacted by the system like community members and business leaders.

This chapter summarizes the information gathered through the qualitative part of the Alliance's assessment — the engagement with community members and stakeholders.

Strengths & Actions Underway

The Asheville-Buncombe CoC, its providers, and community stakeholders all show passion, grit, and determination in their desire to end homelessness. Through conversations and surveys with community stakeholders, it was clear there is an eagerness to work together to get the most vulnerable and at-risk members of the community into housing. More than 72 percent of leaders in the homeless service sector believe that homelessness is solvable in the City of Asheville/Buncombe County. The City of Asheville's Community and Economic Development Department (CEDD) has used its position as the Collaborative Applicant and Lead Agency of the CoC to rally the community to end homelessness and work towards setting a strategy to do so.

The Asheville-Buncombe CoC has made strides in coordinating several program components to end homelessness and these strengths demonstrate the perseverance and resiliency of the community to work together. Recently the CoC saw greater coordination and resources provided to the crisis response and permanent housing system. They also saw greater coordination for Code Purple, the cold weather emergency shelter with additional shelter beds added to the system; an increase in supportive housing beds; and the development of Days Inn and Ramada room conversions to add 198 supportive housing units.

Additional positive actions taken include:

- **Increase of staffing and the expansion of divisions** (e.g., Affordable Housing and Homeless Strategy) in the City of Asheville's Community and Economic Development Department to invest in the needed human capital and to help lead the strategies set forth.
- **Increase of affordable housing** with Buncombe County supporting the development of 1,850 units affordable for households under 80 percent Area Median Income (AMI). Of those units, 232 will be dedicated for households under 30 percent AMI.

- **Optimized use of Emergency Housing Vouchers (EHV)** throughout the community. While some communities around the country have had difficulty implementing EHVs, Asheville has found success — utilizing 98 percent of the 47 awarded vouchers.

- **Investment in domestic violence emergency shelter**, as increasing shelter for households fleeing domestic violence was identified as a need in the community. With the investment of City, County, and private funding, a new shelter is underway. This will increase the community beds from 21 to 40.

- **Decrease in veteran homelessness** due to system level collaboration, coordination, and use of evidenced based practices. From 2020–2022 the community has seen a 31 percent decrease in veteran homelessness.

- Understanding the need for **expanding representation in HIAC** to be more inclusive of the stakeholder community — including people with lived experience, racial, ethnic, and LGBTQIA+ representation. These seats will include various systems of care that collaborate with the homeless response system (e.g., education, Healthcare, lived experience). This will help to better plan, coordinate, reduce redundancies, and maximize resources.

- **Coordination of services and geographic space among street outreach** and the implementation of standard outreach practices. This will intentionally bring resources to the streets to engage and support the transition from unsheltered homelessness to being indoors.

- **Implementing diversion and problem-solving interventions** to support safe transitions prior to entering the homeless response system or discovering creative housing alternatives.

- **Efforts to expand HMIS coverage and improve data quality** and collection in outreach and programs serving unsheltered households.

- **Increase in energy and effort**: The amount of energy and effort to address unsheltered homelessness was palpable through our conversations with community stakeholders, City staff, County staff, funders, nonprofits, and others. This is evident by the variety of providers and organizations working to address homelessness or advocate for solutions to address unsheltered homelessness throughout the community.

This demonstrated partnership and the momentum from prior community-level collaborative work creates a strong foundation for setting shared equitable goals and realistic objectives for all providers and community stakeholders who serve people experiencing homelessness in the CoC.

Stakeholder Engagement and Community Perspective

The Alliance invited community members from Asheville-Buncombe County to participate in an online survey, community conversations, and focus groups. Community members identified themselves as part of homeless sector leadership, providers, people with lived experience, and from the community (this included membership related to business, faith-based, advocacy, neighborhood associations, etc.). Most respondents have lived in Asheville for more than 10 years (48 percent) or 5–10 years (16 percent). Of the 1,721 participants in the engagement process, 65 percent of respondents identified as property owners in the City of Asheville and/or Buncombe County, and 14 percent identified as business owners.

Generally, respondents reported overwhelming concerns of mental health and substance use-induced crises within the unsheltered population — and reported **that they do not know what to do about it or who to call**. Only 10 percent of respondents in the community believe there is a clear process for people experiencing homelessness to get assistance or be connected with a home. Even people in organizations that participate in the coordinated entry system are divided on whether their community has a transparent process for prioritizing homelessness resources.

Many of the respondents shared similar sentiments. There is a feeling as if little is being done despite continuing to see increases in unsheltered homelessness and tent communities. Moreover, respondents expressed that the community does not know why the increases are happening year after year. Common themes within the community members' responses reflected a loss of trust in the City, County, and providers due to a lack of transparency about who to call to access services, what service types can or will be provided (e.g., how are behavioral health and substance use disorder issues being addressed on the streets), what progress is being made, and an overall feeling of increased criminal activity and diminished community beautification. Community members report that this is affecting business, tourism, and families moving away from the community.

> *"[To end homelessness we need] A comprehensive plan, which would include all the current nonprofit services and organizations.* **When I see an individual on the street… I do not know who to call.** *We need a qualified response team and a clearly detailed list of the options after evaluation. Social workers, behavioral health providers, access to clinics and medical treatment before an emergency. Developing an infrastructure to coordinate the many needs. And to create proactive programs to stem the flow of a growing population of people who are lacking the basic needs and a way out of the situation." — Anonymous Community Survey Response*

Major themes identified through the Alliance's engagement process include the following:

- **A lack of trust in the system.** Community members reported a loss of trust and belief in the ability of elected officials, city, and county staff to have any real impact on homelessness. Overall, they also reported feeling a lack of transparency or accountability from the City or County on progress being made or how to be part of the solution (e.g., they feel there are no clear pathways to help someone get to the resources).

- **Concern about the effectiveness of the current homeless strategy.** Some community members questioned the credibility of the current homeless strategy, even though it uses best practices that have been proven to work in other communities.

- **Public safety concerns.** Many people expressed concern about public safety decreasing and their families "being afraid" to be out in the community and many individuals experiencing homelessness highlighted safety being a concern as well.

- **High-barrier shelter or limited access to shelter.** People using the system and community members expressed concerns that shelter is not accessible or easy to stay in for those who need and want it.

- **Difficult eligibility criteria for services.** People experiencing homelessness shared similar experiences of not "meeting eligibility" for shelter beds or housing resources and not knowing what to do afterwards.

- **The need for more health/behavioral health services for people experiencing homelessness.** A common theme among engagement participants is the overall sense that substance use is getting out of control (e.g., fentanyl and methamphetamine are changing the landscape). Participants expressed interest in an increase in behavioral health and substance use disorder services to meet the needs of the population in both sheltered and unsheltered settings.

- **Uncoordinated care and services within a cumbersome system.** Participants in the engagement process articulated a lack of coordination of all types of resources that support people experiencing homelessness (including behavioral health, substance use treatment, and outreach/housing services). Staff and volunteers who serve people experiencing homelessness in non-homeless programs (i.e., other social service programs or faith-based efforts) reported challenges in supporting their clients to access services or engage in coordinating activities to help mitigate a client's situation.

- **Insufficient affordable housing.** A clear theme across all respondents was that there is not enough affordable housing stock to get people back into housing (several respondents noted the impact of the lack of regulation of Airbnb units).

- **Need for more employment programs.** Many referenced the need for better employment programs. People with lived experience of homelessness shared challenges to being a desirable candidate for open positions during their job searches.

CHAPTER 3: RECOMMENDATIONS

The Asheville-Buncombe CoC should prioritize equitable, person-centered strategies that yield the highest impact, while balancing short-term and life-saving interventions with medium- and long-term solutions that have been proven to reduce homelessness. While the clear solution is to increase affordable housing options, this is a long-term solution that requires time. Long-term solutions should be worked on in parallel with the implementation of robust, coordinated strategies that support all levels of the homelessness response system and immediately address the needs of those who are on the streets or maintaining long stays in shelters. The CoC must be bold in setting goals and aggressive in its implementation of strategies to meet them. This requires intentionally creating a homelessness response system that can be flexible enough to meet changing needs and circumstances.

This report describes a roadmap that requires the ability to consistently be data-informed, allow for system- and program-level evaluation, and receive regular system- and program-level feedback from a diverse and representative group of people with lived experience (including racial and ethnic diversity, LGBTQIA+ people, people with disabilities, and other populations) who are meaningfully engaged. The system must be nimble enough to shift as the environment and circumstances change, and allow the flexibility needed for the Asheville-Buncombe CoC to pivot and update strategies based on new information or a changing landscape.

The Alliance recommends the implementation of values that reflect the information and priorities shared by community stakeholders during the engagement process, the adoption of a shared goal or "North Star" to guide the community's work, and the implementation of strategies to achieve the goal. Specific recommendations are outlined in detail in this chapter.

> *"People that are experiencing homelessness are not included in the homelessness decision-making." — Anonymous Focus Group Participant*

Community Values

Every effective, efficient, and equitable homelessness response system requires a unified and coordinated commitment to delivering services, housing, and programs so that no one is forced to be without a home.

Through conversations, survey responses and focus groups, stakeholders overwhelmingly expressed hope that the Asheville-Buncombe CoC implement a long-term, effective plan that upholds the values expressed by the community related to system-wide policy, program and funding decisions. The Alliance recommends that the CoC collectively centers its efforts around the following values it heard from these stakeholders:

Be bold: The CoC will remain faithful to the aggressive goals, strategies, and actions it commits to, even when there are tough decisions to be made. The CoC will not settle for half measures that disregard the needs of its most vulnerable citizens.

Create accountable and transparent governance structures: The CoC will advance a vision for a CoC governance structure that is clear, efficient, and set up to effectively and accountably drive the community's work to end homelessness.

Build trust through unity, collaboration, and justice: There will be meaningful communication and collaboration between leadership, providers, systems, people experiencing homelessness, and the community, to create transparency and trust.

Focus on housing solutions: The CoC's system partners will collaborate to maximize all of the current resources and be strategic with new resources to ensure we are bringing on more permanent housing solutions.

Value the voice of people with lived experience: The CoC will invest through coaching, mentoring and leadership development for people with lived experience who work to end homelessness. People experiencing homelessness will be represented at all decision-making tables, where their perspectives and voices will help shape policies and guidelines in the system.

Maintain fidelity to data and evidence: Data will help guide all decisions in program, funding, policy, and system design changes. As part of this commitment, the CoC will employ and train evidence-based approaches including Housing First, trauma-informed care, and harm reduction across the service delivery system.

Politics will not drive policies: The CoC's collective work will not be guided by optics or by short term tactics, but rather by a sustained drive towards the stated goals.

Focus on our future: The CoC will not let the past determine the future. Rather, it commits to staying in the present and the future.

Defining the CoC's "North Star"

It was clear from the community engagement process that stakeholders are unified in their desire to see a significant reduction in unsheltered homelessness in the near term, while also pursuing an end of homelessness and housing instability for all in the long term. For the purposes of this plan, decreasing unsheltered homelessness is the CoC's North Star — its guiding goal around which strategies and actions will orbit.

Achieving short-term goals demonstrates that when the CoC operates as a unit it can achieve its goals. It also helps to align and support a common mission, and supports the capacity building work necessary to align with the CoC's vision to reduce and end homelessness. By building upon successes of the past, the community will create new ways to work together and innovate towards the future it wants to see.

Based on the data available, housing interventions in the pipeline, and the results of the community engagement process, **the Alliance recommends that the Asheville-Buncombe County CoC adopt a goal to reduce unsheltered homelessness by 50 percent in two years as the CoC's North Star.**

Recommended Strategies, Priorities, and Actions

The Asheville-Buncombe CoC has built a solid foundation to implement the recommended strategies that are described below. The CoC has made strides to strengthen capacity and coordination as demonstrated by its coalition-building of partner agencies; increasing the number of providers who enter data into HMIS to measure future progress; strengthening coordination efforts in street outreach to address the increase in unsheltered homelessness; and demonstrating its collaborative nature in coordinating the increase of Code Purple beds during the cold months.

The Alliance recommends that the CoC pursue its North Star of decreasing unsheltered homelessness by 50 percent in two years by taking action to implement five broad strategies:

Create a Strong Foundation: Support Systems-Level Planning and Coordination

Implement Evidence-Based and Inclusive Policy: Create an Equitable, Person-Centered Homeless Response System

Improve System Performance Through Program Design: Decrease Inflow and Increase Outflow in the Homelessness System

Improve Data Quality and Reporting: Increase Homeless Management Information System Coverage and Report System Performance

Invest in the Future: Increase the Production of and Access to Permanent Housing Solutions

A detailed description of each strategy, including the time frame for each item, is included throughout the rest of this chapter.

"19 percent of leaders in the homeless services sector believe that the CoC governance board is representative of the people with lived experience of homelessness in their community (racially, ethnically, LGBTQIA+, people with disabilities, youth, older adults)." — Leadership Survey

STRATEGY #1: CREATE A STRONG FOUNDATION: SUPPORT SYSTEMS-LEVEL PLANNING AND COORDINATION.

Priority 1.A: Improve system governance by creating and implementing a new CoC structure to guide community-wide planning to reduce and end homelessness. This structure includes collaborative partners, systems of care, and people with lived experience.

STEP 1
SHORT TERM

Identify new CoC Board Members and restructure the CoC Board. Update the CoC Charter accordingly. A strong, effective, and representative CoC Board needs members who are invested beyond just trying to please constituents, have shared ownership in seeing outcomes, understand the fundamental issues that cause homelessness, demand accountability, and are representative of the population of people experiencing homelessness in that community.

The Board should not be situated under the City and County, and should have direct and clear decision-making ability. The CoC Board should include partner systems of care, service providers, local government, community stakeholders, and people with lived expertise. The CoC Board should create a membership base where providers, organizations, and individuals commit to CoC goals and visions, which allows for the ability to vote and serve on the board or subcommittees.[19]

STEP 2
SHORT TERM

Clarify roles of the CoC Board, CoC Collaborative Applicant/Lead Agency, County, City, and Homeless Coalition. Ensure priorities of each are clear and set clear outputs and outcomes for each entity. For example, ensure the CoC Board sets policy, makes funding decisions, etc.

STEP 3
SHORT TERM

Identify who is responsible for the coordination of different subcommittee bodies. This role will ensure that there are meeting agendas, meeting notes, and discussion of focus areas. This role can help ensure that the different community partners are working on the appropriate priorities, and it can ensure the greater provider and partner community are aware of changes and any training needs. The Alliance recommends this role be filled by dedicated City and County staff, although the CoC Board may identify alternative coordinators when needed.

<< More steps for Priority 1.A on the next page >>

[19] See Richmond CoC membership as an example: https://www.endhomelessnessrva.org/general-membership

Short Term = 12 months or less | Medium Term = 1-4 years | Long Term = 5+ years

STEP 4
MEDIUM TERM

Establish system- and program-level performance measures, benchmarks and goals. This will set expectations and determine the accountability of funded agencies. By establishing these outcome objectives, the CoC will be better be able to identify gaps that need to be addressed within the system.

STEP 5
MEDIUM TERM

Form subcommittees (where needed) in Board structure to work on specific tasks. Some of the suggested subcommittees of the CoC Board could be performance evaluation and reallocation strategies, funding application priorities, equity, and the Notice of Funding Opportunity (NOFO) application.

Priority 1.B: Increase resources and maximize current investments by developing and maintaining a funding strategy for crisis response and permanent housing solutions.

STEP 1
MEDIUM TERM

Create and maintain a comprehensive matrix of all funding sources used in the CoC to ensure funding is utilized systemically and not funding ad hoc projects. Identify other government funding sources that can be tapped into or set aside to tackle homelessness.

STEP 2
MEDIUM TERM

Create a joint planning and budget effort to develop a CoC-wide funding plan for homeless housing and services. At a minimum, City, County, State, and Federal entities should be included, but this group should include philanthropic commitments as well.

STEP 3
MEDIUM TERM

Work with identified foundations and other private funders to align their investments with the CoC's priorities. Identify new funders to help fill gaps. This process should also help funders understand the need for ongoing investment to ensure long-term sustainability.

STEP 4
MEDIUM TERM

Ensure providers are aware of funding shifts to allow for time to prepare for changes. Giving as much notice as possible will eliminate frustration among providers and will allow for better planning including community-led training opportunities and staff retention leading to increased capacity to serve.

Priority 1.C: Lead system change ensuring transparency, accountability, and equity.

STEP 1 SHORT-MEDIUM TERM	Ensure equity is centered in all system changes by ensuring diversity in system decision-makers. Implement a **targeted universalism** approach to reducing homelessness by promoting a targeted universal reduction strategy based on groups situated within structures, culture, and across geographies to obtain the universal goal of equitably ending homelessness.
STEP 2 MEDIUM TERM	Led by a communications subcommittee of the CoC Board, create a communications plan to educate CoC membership and the wider community on system-level performance goals, disaggregated performance data, funding priorities, best practices, and opportunity for engagement.
STEP 3 MEDIUM TERM	Develop live, up-to-date dashboards that show real time numbers on outreach, diversion, shelter bed utilization, and permanent housing outcomes on the CoC webpage to promote transparency and clarity on progress made.
STEP 4 MEDIUM TERM	Develop a written process that outlines how decisions are being made, who is part of the decision-making and how the community is engaged. This would apply to program standards and evaluation, funding and policy decisions.

Priority 1.D: Build system and program level capacity through process improvement, training, and technical assistance.

STEP 1 SHORT TERM	Develop a written process that outlines how decisions are being made, who is part of the decision making and how the community is engaged. This would apply to program design and implementation, funding and policy decisions.
STEP 2 SHORT TERM	Develop and implement a performance improvement framework and process to support system improvements (for example, solicit feedback via a survey link on the CoC web page, require funded contracted agencies to do exit surveys of participants, etc.).
STEP 3 MEDIUM TERM	Incorporate results into the improvements to be implemented into Coordinated Entry System (CES) policies and practices with a sense of urgency.
STEP 4 MEDIUM TERM	Develop and execute an annual cross system training schedule to build capacity within the provider community. Recommended trainings that should be taken as a part of onboarding include: Housing First principles, harm reduction practices, cultural humility, Fair Housing, trauma-informed care, and de-escalation practices.

Priority 1.E: Increase provider capacity.

STEP 1 MEDIUM TERM	Identify non-traditional partners (e.g., faith/business community, smaller community-based organizations) to build system capacity. By bringing more people to the table, greater opportunities for support will become available at various levels.
STEP 2 MEDIUM TERM	As part of establishing overall system and program level performance measures and goals, include system wide benchmarks for program and services utilization and returns to homelessness by component type (ES, TH, RRH, PSH).
STEP 3 MEDIUM TERM	Establish a technical assistance plan for providers that incentivizes capacity building. Building sophisticated organizations, leaders, and frontline staff will improve outcomes.
STEP 4 MEDIUM TERM	Asheville-Buncombe CoC should establish or re-establish monitoring and evaluation. This should include evaluation of fidelity with CoC established written standards for CoC providers. Reviews should be standardized and include corrective actions. Maintaining accountability to those corrective actions is imperative.
STEP 5 MEDIUM TERM	Creates Standard of Care requirements for all funded shelters or interim housing sites. This will allow for clear expectations and reduce the desire to program hop from provider to provider.

Priority 1.F: Ensure staff working to end homelessness are properly equipped to be successful.

STEP 1 SHORT TERM	Review and set standards in Asheville-Buncombe CoC contracts for living wage for front-line staff. Workforce retention is essential for building institutional knowledge and a high-performing, sophisticated system.
STEP 2 SHORT-MEDIUM TERM	Keep caseloads at a reasonable rate (e.g., caseloads for housing focused case managers/navigators/stabilizers may be 1:15/20 but should never exceed 1:30). Document clear guidelines in the Standards of Care, CoC policies and procedures. This will ensure systemwide staff have the time needed to help clients find and secure housing and/or stabilize in housing. Outreach may be exempt from this standard depending on the level of housing navigation requirements built into job descriptions.
STEP 3 MEDIUM TERM	Monitor system staff turnover rates by provider and program type to inform future plans.

Priority 1.G: Increase partnership and coordination between the City of Asheville and Buncombe County in efforts to end homelessness.

STEP 1 SHORT TERM	Establish one full-time employee as Homeless Coordinator within Buncombe County solely dedicated to coordinate County homeless activities and participation in larger system level and data-driven policy and funding decisions.
STEP 2 MEDIUM TERM	Coordinate performance metrics to align City and County funding sources to reduce confusion, inefficiencies, and duplication of services and be in alignment with Asheville-Buncombe County CoC funding priorities.

Priority 1.H: Clarify roles in the CoC's action plan to implement recommended strategies.

The **CoC Board** should be the focal decision-making body in the CoC made up of partner systems of care, service providers, local government, community stakeholders, and people with lived experience. The board's responsibilities should include providing oversight, governance, funding decisions, membership oversight, and other special projects as needed.

SHORT TERM	**The City of Asheville** is vital in supporting efforts to combat homelessness. It must support the strategies outlined in this report with the resources it controls, including providing administrative support to CoC Board and subcommittees. Additionally, the City should continue to fulfill its responsibilities as the Collaborative Applicant and HMIS Lead (See *Understanding the Continuum of Care* on Page 5). The City should also play a significant role in the CoC membership and should develop policies in response to homelessness that align with the CoC's efforts.
SHORT TERM	**Buncombe County** is essential in supporting efforts to combat homelessness and must support the strategies outlined in this report with the resources they control. It is recommended the County commit to hiring 1 full-time position as Homeless Coordinator to provide direct coordination activities with the City on homeless issues and to support coordination efforts of County mainstream resources with the City of Asheville, CoC Board, and stakeholders. Resources that support the safety net for Asheville-Buncombe residents (e.g., behavioral and physical health services, social services, dependency use services, etc.) should be at the forefront of this coordination to increase access and collaborative care coordination of the homeless community between providers.

<< More roles for Priority 1.H on the next page >>

SHORT TERM	**Homeless Service Providers** should be meaningfully engaged in the CoC membership and the CoC board, and should participate in subcommittees and workgroups on the Board. Providers should all participate and join CES/HMIS. This will support data-driven strategies and evaluation, and it will increase access to the variety of housing resources available.
SHORT TERM	**People with Lived Experience** understand the system's services and housing needs better than anybody else. Their voice is critical in all phases of solving homelessness and we have a responsibility to invest in and uplift their voices at leadership tables across the continuum.
MEDIUM TERM	**Private Sector Funders**, including foundations and businesses, can and should align funding to support overall CoC systemic impact goals instead of ad hoc projects. The private and public sectors can work together to align policies and goals that share common ground with the community's action plan to end homelessness, and to identify and remove unnecessary funding requirements.
MEDIUM TERM	**Community Advocates** can have a voice in the subcommittees and ad hoc committees of the CoC board. Participation with the CoC can help their advocacy efforts and activities align with the overall goals of the CoC and the community action plan. Their feedback and participation can support creative partnerships and inform how funding is aligned and coordinated to support best practices, including improved data practices, in combating homelessness.

STRATEGY #2: IMPLEMENT EVIDENCE-BASED AND INCLUSIVE POLICY: CREATE AN EQUITABLE, PERSON-CENTERED HOMELESS RESPONSE SYSTEM.

Priority 2.A: Establish a Housing Focused System-wide Orientation.

"Less than half of leaders and staff serving the homeless population think that staff believe in Housing First philosophy, that people experiencing homelessness are ready to be placed in housing with the correct support services to assist in housing stability." — Leadership & Provider Surveys

"35 percent of People with Lived Experience believed the various agencies/organizations in the Asheville-Buncombe community work well together." — People with Lived Expertise and Community Surveys

STEP 1 SHORT TERM	Provide clear guidance and capacity building to CoC providers on systems-level Housing First principles and approaches. Training on Housing First will be essential to success.
STEP 2 SHORT TERM	Educate system stakeholders and policy makers on system-level Housing First principles and approach.
STEP 3 MEDIUM TERM	Increase re-housing interventions to reduce the housing placement timeline from 200 days to 100 days.
STEP 4 MEDIUM TERM	Support change management efforts for providers by convening provider feedback sessions, peer learning and coordination opportunities.

Short Term = 12 months or less | Medium Term = 1-4 years | Long Term = 5+ years

Priority 2.B: Integrate the voices and experience of persons with lived experience of homelessness in system and program level decision-making, service delivery, and system policy.

"In my case, Rapid Re-Housing and case management helped get me an apartment that I've had now for 4 and a half years" — Anonymous Person with Lived Experience Respondent

STEP 1 SHORT TERM	Ensure the meaningful participation and compensation of persons with lived experience on the CoC Board and its subcommittees.
STEP 2 SHORT TERM	Require that all organizations funded through the CoC (no matter the funding stream) have meaningful lived experience representation on their Board of Directors and throughout. This can easily be added to funding contracts, and **can avoid tokenism (e.g., it would not be helpful to put one person with lived experience on a Board and not grant them decision-making power).**
STEP 3 MEDIUM TERM	Increase meaningful participation in system and program planning and feedback by people with lived experience. This can be done by **adding dedicated seats** on the CoC Board and by ensuring people with lived experience are a part of the subcommittee workgroups.
STEP 4 MEDIUM TERM	Invest in training, coaching and mentoring of people with lived experience to support them moving into employment and leadership roles within the system of care.

Priority 2.C: Implement cross system training in best practices such as cultural competency, race equity, conflict resolution, Fair Housing, de-escalation, trauma-informed care, and harm reduction.

STEP 1 MEDIUM TERM	Build system and provider capacity to successfully implement client-focused approaches. Identify consultants to provide full system training.
STEP 2 MEDIUM TERM	Revise contracts for system and program funding to include clear requirements for training and holding agencies accountable to practice these approaches.

Priority 2.D: Implement an encampment resolution policy and strategy that reduces negative impacts of enforcement on people experiencing homelessness and displacement and increases engagement to service utilization.

"[Only] 20 percent of staff who provide services to the homeless population believe that emergency shelters have few barriers/preconditions for entry and are accessible to people who need it." — Provider Survey

STEP 1
SHORT TERM

Create a CoC workgroup to include key City and County staff along with identified stakeholders to create a comprehensive encampment resolution policy. This policy must be based on best practices that ensure increased coordination, role clarity, definition of an encampment, realistic timeframes, and resource allocation to support successful resolution practices (e.g., an encampment resolution protocol must include allocated interim and/or permanent housing resources that match the needs of the unsheltered neighbors to agree to and voluntarily move on from the encampment).

Community examples: **King County, WA↗**, **Washington, D.C.↗**

STEP 2
SHORT–MEDIUM TERM

Conduct facilitated discussions with people with lived experience of homelessness, advocates, residents, business owners, and front-line homeless provider staff to review the City and County's policy related to enforcement of encampments. This process should identify necessary changes and set expectations for services provided to those experiencing unsheltered homelessness.

STEP 3
SHORT–MEDIUM TERM

Determine timeframes that allow for relationship- and trust building to make resource linkage successful. Realistic timeframes are necessary to support staff retention, decrease burnout, and maintain client engagement to build trust in accepting services when successfully resolving encampments.

STEP 4
MEDIUM TERM

Identify resources and conditions necessary to link people experiencing unsheltered homelessness to resources and problem-solving techniques that help them voluntarily leave the encampment and connect with safer housing. Convene a work group amongst shelter providers to coordinate and make consistent access to their resources by unsheltered persons. As part of this work, participants should review the program requirements of shelter/interim housing options to identify where barriers exist and what can be updated to improve access and acceptance of shelter resources (e.g., keeping unsheltered neighbors together by allowing an encampment to sleep in the same area, or dorm, of the shelter together or in cases where there are congregate rooms, allowing them to move into those spaces together).

STEP 5
LONG TERM

Develop system performance metrics that support greater flow through emergency shelter and shorter length of time homeless.

Priority 2.E: Have a clear and transparent written process of how to access homeless services on the CoC website.

"Only 31 percent of 236 people with lived experience surveyed understood how and where to receive help when they became homeless. Additionally, only 36 percent of respondents felt like the services received were permanent housing focused." — People with Live Experience & Community Survey

STEP 1 MEDIUM TERM	Structure a clear public-facing process of how to access services if one is to become homeless.
STEP 2 LONG TERM	Ensure funded partner agencies create the same messaging on their respective websites and social media to ensure consistent practices are being followed.

STRATEGY #3: IMPROVE SYSTEM PERFORMANCE THROUGH PROGRAM DESIGN: DECREASE INFLOW AND INCREASE OUTFLOW IN THE HOMELESSNESS SYSTEM.

Priority 3.A: Prevention — Align current homelessness prevention activities with best practices and utilize data to target most vulnerable households.

STEP 1 MEDIUM TERM	Review and analyze current disaggregated prevention data to determine who is being served, which services/activities are provided, what is the cost, who is accountable for ownership, and how it demonstrates effectiveness. This analysis will allow the CoC to determine who should be administering homeless prevention services. In some cases, these services may be better housed outside of the homeless sector. Examples include: • allocating dollars to culturally-responsive behavioral health to support at risk Severe and Persistent Mental Illness (SPMI) populations coupled with the supportive services to maintain housing • identifying at-risk families involved with Child Protective Services (CPS) that can maintain CPS stability services coupled with prevention rental assistance to increase the success of family maintenance interventions, etc.
STEP 2 MEDIUM TERM	Develop written standards for a system wide homelessness prevention strategy based on best practices. This should include the population to serve, allowable activities/services, maximum allowance (time and financial resource), and review processes.
STEP 3 MEDIUM TERM	Identify local, state or private funding to support prevention efforts—perhaps outside of the homeless sector resource allocation.
STEP 4 MEDIUM TERM	Establish a standardized prevention assessment tool that adopts a problem-solving approach to use across populations regardless of funding source (e.g., **SSVF Targeting Tool**↗).
STEP 5 MEDIUM TERM	Establish performance metrics and goals for all homeless prevention programs that can be tracked in HMIS.

Short Term = 12 months or less | Medium Term = 1-4 years | Long Term = 5+ years

Priority 3.B: Diversion — Align current diversion activities with best practices and increase diversion interventions each year.

STEP 1 SHORT TERM	Identify system-wide protocols for conducting diversion at Coordinated Entry access points and during Outreach engagement, and clearly define access points as part of Coordinated Entry realignment. This may include a separate triage tool, or staff trained in motivational interviewing and housing-focused problem solving to determine if there are family, friends, a room for rent, or other alternatives to remaining homeless or in shelter.
STEP 2 MEDIUM TERM	Refine and formalize the CoC/CES written standards for diversion.
STEP 3 MEDIUM TERM	Conduct system-wide training on diversion practices to use when working with people experiencing homelessness. This should include in the homeless services sector: outreach, drop-centers/assessment points, shelter staff, housing navigator/case management staff, and housing stabilization case management staff. Agencies supporting Homeless Services but that do not participate in CoC funded programs should be invited to align practices across agencies to unify this approach for any person experiencing homelessness. Other teams that need to be included in this training: mental health provider staff, emergency response staff (police/fire), hospital social worker staff, faith community, city and county staff. All persons that make regular referrals to the homeless system of care can take advantage of this critical training.
STEP 4 MEDIUM TERM	Establish performance metrics and goals for diversion that can be tracked in HMIS. Review disaggregated data quarterly to determine effectiveness.

Priority 3.C: Outreach — Build the capacity of street outreach to ensure a multi-disciplinary and coordinated approach to meet the needs of people experiencing homelessness.

STEP 1
SHORT TERM

Identify and procure training for street outreach staff to ensure best practices to engage high acuity populations and promote housing-focused case management, culturally responsive services, trauma-informed care, harm reduction, de-escalation, etc. Outreach should be identifying ways to connect individuals in encampments to interim shelter and/or permanent housing solutions.

STEP 2
SHORT-MEDIUM TERM

Continue convening all community entities engaging people experiencing unsheltered homelessness. Establish a stakeholder work group to develop a process and timeframe to create written standards for multidisciplinary street outreach. Standards should include clear guidelines to create a multidisciplinary team (MDT) that has a Mental Health Specialist (MSW or MFT level), Substance Use Disorder Specialist (with credential), Peer Support Specialist (with lived experience), and a Generalist Outreach Specialist (to support CES and housing intervention resource access) to provide a wraparound service approach that supports the unique service and case management needs of the population.

This can be achieved by using dedicated funding **or** by coordinating efforts to create a CoC-wide collaborative approach to bring targeted field-based services to street encampments.

STEP 3
MEDIUM TERM

Create a coordinated outreach strategy:

1. Outreach members should meet regularly to coordinate care and case conference with other systems of care to provide service linkage to mental health, substance use, healthcare, housing navigators/case managers, and access to interim and permanent housing. Outreach convenings should also include prioritizing coordination and collaborative efforts with the MDT for those displaying more complex service needs.

2. Identify and procure tools and technology to better coordinate outreach to people experiencing unsheltered homelessness. This may include:
    - a hotline or website for community members to share encampment locations for follow-up outreach or for self-referrals of unsheltered homeless to request outreach support,
    - geo-location services to inform and coordinate outreach practices (ideally connected to HMIS) and decrease duplication of services, and
    - staff technology to complete CES assessments and other referrals directly in the field (e.g., tablets, cell phones with hot spots, etc.).

Priority 3.D: Shelter Capacity — Increase crisis response capacity to meet 30 percent of the immediate problem solving/shelter needs of unsheltered homelessness.

STEP 1 SHORT TERM	Implement newly funded effective shelter[20] bed capacity by 30 percent. Identify non-congregate site(s) which would significantly improve the number of people accepting shelter placement. Refer to shelter inventory to see the list of current shelter beds. This should happen in conjunction with retooling existing shelter options to be effective.
STEP 2 SHORT TERM	Ensure that interim housing sites are not all concentrated in one region of the County or City.
STEP 3 MEDIUM TERM	Ensure provider and community training on diversion is used both to prevent those that have alternatives to shelter from coming in, and also as a way to encourage shelter participants to continue to identify alternative housing options post-shelter placement. Create flexible funding available to help support reunions with family or friends (e.g., support in paying utility bills, groceries, or other household contributions to support an extra head in the household for 1–3 months).
STEP 4 LONG TERM	Use **Stella M↗** to conduct ongoing analysis of interim solutions (e.g., more crisis/shelter beds) and ensure that all new programs are connected to and utilizing CES.

Priority 3.E: Begin the implementation of system improvements to the CoC and CES systems.

> *"That all of the homeless services agencies work together. Right now not all the agencies that provide services are included with the CoC, even though they don't accept money they are still part of the system and have a specific type of power that is minimizing client's ability to get out of homelessness."*
> *— Anonymous staff at local homeless services agency*

STEP 1 SHORT TERM	Create a CES Policy Committee of the CoC to develop or revise written standards, policies and procedures for CES. The Committee should consist of key partners, other systems of care, people experiencing homelessness, providers, education, funders, etc.

<< More steps for Priority 3.E on the next page >>

[20] Effective shelters embrace a Housing First approach, implements safe and appropriate diversion, offers immediate and low-barrier access to anyone facing a housing crisis, measure shelter performance in order to improve results, practice cultural humility and inclusion, and follow HUD's **Equal Access Rule↗**.

STEP 2 MEDIUM TERM	Identify system metrics to track performance of CES. These should include target of annual assessments completed compared to annual PIT numbers, length of time from assessment to program referral, length of time from program entry to housing placement, equity metrics, and number of placements per month.
STEP 3 MEDIUM TERM	Review and align CES core elements[21] to best practices including: • Establish and define clear access points to CES and close all "side doors" to CES especially as it relates to housing resources and/or shelter placement. • Utilize emerging best practices[22] and considerations to revise current assessment tool and process(es) to ensure equity and transparency. • Use quantitative and qualitative data to establish clear and transparent prioritization criteria. • Utilize a "**dynamic prioritization**" approach to CES to ensure that individuals and families who are document ready can move quickly into housing. • Identify an entity to conduct matches to housing opportunities based on housing intervention type, eligibility criteria for program, and a transparent prioritization methodology (a centralized system matching to resources).
STEP 4 MEDIUM TERM	Ensure that access point staff are trained in diversion/housing problem solving skills and that the second CES element of assessment flows from first implementing a diversion strategy. All people presenting for assistance should be engaged in diversion and problem-solving practices to identify those who can independently self-resolve to safe housing options.
STEP 5 MEDIUM TERM	Ensure that all persons experiencing unsheltered homelessness and/or residing in emergency shelter are connected to CES and assessed for services and/or housing during a specific timeframe. Non-CoC funded emergency shelter should refer to CES no later than 14–30 days after enrollment. All funded CoC entities should have enrollments entered into HMIS within 72 hours of shelter placement, including the CES assessment.
STEP 6 MEDIUM TERM	Expand and coordinate access to detox, residential, intensive outpatient, Medication Assisted Treatment (MAT), and community-based supports though CES.
STEP 7 MEDIUM TERM	Conduct ongoing quarterly technical assistance with the provider community to discuss and assess data and systems coordination quality improvements and quality assurance needs.

21 CES core elements are access, assessment, prioritization and referral. See HUD's **Coordinated Entry Core Elements**.

22 See the Alliance's **Next Generation Assessment Tools Series** for emerging practices.

Priority 3.F: Coordinated Entry System — Expand Coordinated Entry System (CES) training to mainstream systems.

STEP 1
MEDIUM TERM

Clearly define where and which agencies are the CES Access Points for mainstream service partners to refer clients who are experiencing homelessness to access services.

Once CES Access Points are defined, post and regularly update information to the CoC website for reference by mainstream partners and community members when in need of prevention, diversion, or housing services.

STEP 2
LONG TERM

Identify all the mainstream partners (e.g., child welfare, hospitals, treatment facilities, jails or prisons, etc.) within the CoC and develop regular training for those staff to ensure easy access to CES. This may include in-person and live seminars, previously recorded workshops, zoom workshops, etc.

Priority 3.G: Re-Housing — Create a high-utilizer targeted initiative.

STEP 1
SHORT TERM

Develop and implement a **housing-focused pilot program** for 10–20 **high utilizers** of multiple systems of care (e.g., emergency room, jails, shelter). It will be critical to coordinate with Asheville Police and Fire Dept, and Buncombe County Sherriff to establish a **shared by-name list**.

Community example: **Boston, MA**

STEP 2
SHORT TERM

Create a targeted prioritization and exit strategy focused on long stayers in shelter. This will need to include a resource to ensure housing placement is the outcome.

STEP 3
MEDIUM TERM

Monitor data on successes, challenges, barriers to implementation, and funding needs to ensure successful pilots turn into ongoing programs by building from what was learned.

Priority 3.H: Re-Housing — Promote housing surge for individuals who are chronically homeless and are unsheltered.

STEP 1 SHORT TERM	Convene all organization and CoC partners who engage with the unsheltered population to identify timeline for surge (e.g., **100 day challenge**↗), placement outcomes, and housing resources available. Creating a live dashboard for tracking and transparency will be key to buy-in and motivation.
STEP 2 SHORT TERM	Identify a by-name list of the "hot spots" (e.g., well-known areas individuals experiencing homelessness are located) to be housed.
STEP 3 SHORT TERM	Create weekly meetings for check-ins on the surge. This will include the full group, as well as any of the smaller more focused workgroups or subcommittee groups that have specific tasks to help the effort.
STEP 4 SHORT TERM	Ensure there are landlord engagement activities and practices in place for the housing surge. If there are not units available, the surge will surely fail.

Priority 3.I: Employment — Increase income and employment opportunities.

STEP 1 MEDIUM TERM	Include points in CoC and ESG scoring tool/application for connection to mainstream benefits. Set performance benchmarks and include in monitoring and evaluation of providers within funding contracts.
STEP 2 MEDIUM TERM	Increase the number of benefits case managers can access when completing applications for Social Security Income and disability income (e.g., increase number of case managers, in both homeless services and mainstream services, trained in SOAR in addition to referring to Pisgah Legal Services).
STEP 3 MEDIUM TERM	Explore expanding CES to streamline benefit coordination. This should be consistent with prevention and diversion as well.
STEP 4 LONG TERM	Explore ways to formalize relationships between workforce development programs and current Rapid Re-Housing and Permanent Supportive Housing interventions, with the purpose of decreasing returns to homelessness.

Priority 3.J: Maximize Existing Resources — Increase utilization of existing Transitional Housing.

STEP 1 MEDIUM TERM	Review bed utilization data to better understand where technical assistance is needed to ensure the maximum utilization of existing beds.
STEP 2 MEDIUM TERM	Coordinate with CES lead to ensure client referrals are provided in a timely manner. Collect data and analyze average length of time from assessment to referral and referral to housing placement. Performance metrics must be written into all funding contracts. Monitoring and evaluation should be done at minimum once per year. To ensure accountability, bi-annual reviews would be ideal.
STEP 3 MEDIUM TERM	Establish written standards for transitional housing based on best practices modalities. Agencies that are funded should be required to operate via effective harm reduction, trauma-informed care, and Housing First focused principles (e.g., no drug testing at entry, no medication requirements for persons with mental health illness, curfews, if necessary, should be reasonable, etc.). This will help facilitate more willingness for individuals with the most chronic homeless histories in encampments to come indoors.
STEP 4 MEDIUM TERM	Create and post for CoC-wide use a system-wide list of existing housing resources outside of the homeless system (e.g., adult care facilities, recovery housing, and others).

STRATEGY #4: IMPROVE DATA QUALITY AND REPORTING: IMPROVE DATA QUALITY, INCREASE HOMELESS MANAGEMENT INFORMATION SYSTEM COVERAGE, AND REPORT SYSTEM PERFORMANCE.

Priority 4.A: Improve HMIS utilization and reporting.

STEP 1
MEDIUM TERM

Data driven decision-making is critical to improving outcomes within any community. The City of Asheville, Buncombe County, and private funders must mandate HMIS utilization from all funded entities and incentivize (funding, CoC membership or other) non-traditional partners to participate. This will help better understand the needs of the community and help make better programmatic and funding priorities. See **Figure 8** below for more information.

Figure 8: **Having consistent, high-quality HMIS data is key to effective system design and measuring progress towards the CoC's goals.**

The current HMIS:

- Fails to identify system inequities
- Creates duplicative service delivery/ resource waste
- Skews data analytics
- Lacks accountability of what is/is not being done by provider community
- Is unable to identify high-low performers
- Lacks understanding of who is being served
- Limits understanding of the needs of those being served
- Lacks comprehensive HMIS participation
- Risks the ability to increase HUD funding
- Creates transparency issues with community
- Doesn't allow for true gap analysis
- Creates duplication of services due to providers not being able to see past history or active involvement of participants being tracked in HMIS (when tracked in HMIS by a provider)
- Does not communicate with Coordinated Entry to support dynamic prioritization of referrals
- Does not include all providers in the homeless system

The CoC should focus on ensuring that it has comprehensive HMIS data so that it can better understand:

- Racial or ethnic disparities within the homelessness services system and equity of resource allocation
- The number of people experiencing homelessness (both sheltered and unsheltered homelessness)
- The number of people experiencing homelessness for the first time
- The length of time (or average length of time people are homeless)
- The number of people exiting homelessness to permanent housing
- The number of people who return to unsheltered homelessness after exiting shelter
- The number of people who return to homelessness after exiting permanent housing
- Employment and income growth
- The average length of time from assessment of services to housing placement
- Who is being served, who is being housed, who is remaining housed

Short Term = 12 months or less | Medium Term = 1-4 years | Long Term = 5+ years

Priority 4.B: Build system and program level capacity for a greater understanding and commitment to data-driven decision-making.

"I think the community at large needs a better understanding of the causes of homelessness. I think there needs to be a coordinated solution to it." — Anonymous Community Member

"Keep talking about it, making decisions, following through on those decisions, and then evaluating those actions in retrospect." — Anonymous Community Member

STEP 1 MEDIUM TERM	Provide ongoing HMIS training in data collection and data quality to all entities entering data into HMIS. Ensure that service provider staff are educated on the how and why to utilize HMIS correctly to create buy-in and ownership.
STEP 2 MEDIUM TERM	Incentivize accurate data quality from providers (e.g., more points or bonus points in the CoC annual scoring process or financial incentives included in contracts).
STEP 3 MEDIUM TERM	Invest in funding for data positions within the provider community. Having provider-level data staff will allow for regular quality assurance and data quality checks to ensure reports are accurate and representative of the work being provided.
STEP 4 LONG TERM	Develop public-facing data dashboards reporting information that key stakeholders (leadership, providers, people with lived experience or currently homeless, community) have requested.

STRATEGY #5: INVEST IN THE FUTURE: INCREASE THE PRODUCTION OF/ACCESS TO PERMANENT HOUSING SOLUTIONS.

Priority 5.A: Develop pipeline plan for new supportive housing units over the next 10 years.

"Between 13–19 percent of staff in all system levels of the Homeless Response system believe there are sufficient Rapid Re-Housing resources in place to assist people to be rehoused quickly should they become homeless." — Leadership & Provider Survey

STEP 1 LONG TERM	Identify the number of units needed and work with CoC and HACA leaders to create a plan for how funding will be acquired to bring those units online. Each supportive housing project takes typically between 2–5 years from planning to lease-ups. The use of **current infrastructure** (including commercial space) that can be rehabilitated should be included. This may require creating an RFP to bring in a consultant.

Priority 5.B: Develop pipeline plan for new RRH units over the next 12 months to 5 years.

STEP 1 MEDIUM TERM	The Asheville-Buncombe CoC needs to increase RRH funded slots that include all populations to ensure system throughput. Bring all funders together to discuss current programmatic spending and identify duplicative service delivery between each respective system and partner systems to remove wasteful spending. Identify failed programs and repurpose funding to add more RRH slots.
STEP 2 MEDIUM TERM	Identify and apply for philanthropic funding opportunities in order to increase housing navigation and stabilization case management staff.
STEP 3 MEDIUM TERM	Through the annual NOFO scoring and reallocation process, release an RFP for RRH programming. CoC NOFO reallocation can be used for RRH programs.

Short Term = 12 months or less | Medium Term = 1-4 years | Long Term = 5+ years

Priority 5.C: Implement innovative options to bring in more market-rate landlords to be part of the solution in ending homelessness.

STEP 1 MEDIUM TERM	Create master-leasing[23] opportunities to bring on new units and allow for system-level housing placements for some of the harder to place households. Explore the various master leasing options[24] (e.g., triple net vs. MOU without tax, repairs, etc.).
STEP 2 MEDIUM TERM	Create a centralized system-wide housing portal (like **Padmission** in Arizona) where all providers can access units and have negotiated price points. This will reduce housing becoming an auction-block item whereby providers are pinned to outbid each other.
STEP 3 MEDIUM TERM	Identify CoC leaders to engage and build relationships with the local apartment association board. This can lead to an increase in interested property managers/owners and a better understanding of the incentives needed to bring in more landlord groups.
STEP 4 MEDIUM TERM	Hold quarterly housing fairs and engage landlords to take part in these events to do real-time screening of potential renters.
STEP 5 MEDIUM TERM	Centralized housing navigator teams should hold weekly "hot unit" calls to ensure available units in the community are leased up quickly and in a coordinated manner.
STEP 6 LONG TERM	Develop and implement a **Flexible Rent Subsidy Pool** that can provide rental subsidies for undocumented or criminally disqualified households to help increase marketability and create pathways for those who traditionally have barriers to housing.

[23] A master leasing is a type of lease that gives the lessee the right to control and sublease the property during the lease, while the owner retains the legal title. In this case, a housing authority or service provider would be the lessee, allowing them to sublease the property to its clients.

[24] A single net lease requires the tenant to pay only the **property taxes** in addition to rent. With a double net lease, the tenant pays rent plus the property taxes as well as insurance premiums. A triple net lease, also known as a net-net-net lease, requires the tenant to pay rent plus all three additional expenses.

Priority 5.D: Develop and implement a shared housing program within 12 months.

STEP 1 SHORT–MEDIUM TERM	Create written standards and regulations for a shared housing program, in which participants can rent apartments with separate rooms and shared amenities together with split leasing. This will increase access to different types of units and encourage creative ways to think about returning to housing and stability.
STEP 2 SHORT–MEDIUM TERM	Identify RRH and supportive housing scattered site subsidies for people experiencing homelessness who are willing to participate in shared housing opportunities.
STEP 3 SHORT–MEDIUM TERM	Develop strategies to obtain units for shared housing. This can include master leasing or creating meaningful landlord incentives.
STEP 4 MEDIUM TERM	Create a messaging strategy to help re-brand what shared housing is and isn't. Messaging needs to be created for participants and landlords separately, as the driver to participate for each of these groups is different.
STEP 5 MEDIUM TERM	Train providers on shared housing strategies that can help expedite more housing placements. This training should include matching, stabilization, conflict resolution, and using rental subsidies.

Priority 5.E: Implement Moving On strategies for long-term supportive housing residents (as appropriate).

STEP 1 SHORT TERM	Create written standards and regulations for **Moving On strategies** across all providers, programs, and staff members. Outlined in the standards would be the role of providers/HACA, first month/security deposit assistance, systemwide landlord engagement strategies, data collection, moving on criteria, and the utilization of culturally appropriate community supports to ensure housing stabilization occurs.
STEP 2 SHORT TERM	Identify persons with stays longer than three years who may be interested in Move On strategies.
STEP 3 SHORT TERM	Work with HACA to identify permanent subsidies for supportive housing residents who are interested in moving on.

CHAPTER 4: IDENTIFIED NEEDS AND RELATED COSTS

Introduction and Limitations

People currently experiencing homelessness, residents, business owners, leaders, and stakeholders throughout the Asheville-Buncombe CoC are keen to understand what's needed to reduce and end homelessness — especially unsheltered homelessness in the community — and the related costs to do so. This section of the report provides a better understanding of the important considerations for the recommended strategies and the Alliance's best estimates for the related costs, where possible.

The Alliance recommends significant increases in the investment of permanent housing solutions, including continued housing development and rental subsidies. Additionally, the Alliance recommends an increase in temporary crisis response options for highest need populations. These options should be easily accessible, housing-focused, and data-driven to meet the immediate needs and safety of persons already experiencing unsheltered homelessness. The cost per person for shelter is less expensive than permanent housing because each shelter bed serves multiple persons per year.

In some communities, the cost to provide a housing subsidy for a year is nearly the same as the annual investment needed to support a single shelter bed. Therefore, the CoC must balance short- and long-term investments.

As was shared earlier, comprehensive and quality data collection on homelessness in the CoC is currently an area for significant improvement. The Alliance's modeling of the needs and related costs for the CoC's crisis response and permanent housing solutions is based on incomplete homeless system data and conversations with key stakeholders to assist in affirming or clarifying these assumptions. More comprehensive start-up and ongoing operational projections need further research and development. It is important to note that these estimates do not include a refined data analysis of persons who are exiting jails, prisons, institutions, or hospitals who do not access homeless services or may not be entered into HMIS (e.g., until recently not everyone experiencing unsheltered homelessness was entered into HMIS).

Assumptions Used in Analysis

The Alliance utilized several data sources to create the need and cost projections and considerations, including: HMIS data as available; the annual 2022 Point-in-Time (PIT) Count and Housing Inventory Count (HIC) data; 2022 City and County budget documents; local provider data; and data from other communities. The Alliance created overall cost projections based on the source data and reviewed and revised assumptions with key stakeholders in a series of community conversations and focus groups held between June through October 2022. The data in this report is finalized based on this feedback.

The projections show, at a minimum, the needed interventions and resources to serve persons requesting assistance in the CoC. Some numbers were rounded for the purpose of simplified projections. The needs and related costs are described for the homeless response system, including leadership and governance structure, shelter and other temporary housing, permanent housing solutions, support services and outreach efforts, and future need and investment.

Cost Considerations and Projections for Recommended Strategies

Strengthen Asheville-Buncombe CoC Governance and Leadership Structure

The Alliance recommends that the County hire one full-time staff member to coordinate the County's efforts to end homelessness, including funding, behavioral health services and other County resources that interact with homelessness. For the City of Asheville, the Alliance recommends a continued team expansion from one to four people, including personnel dedicated to HMIS management, training and technical assistance, and coordination of substance use and recovery services.

In addition to these newer roles, as described in the recommendation section of this report, the Alliance suggests that the Asheville-Buncombe CoC reimagine the entire governance and leadership structure to more clearly define roles, increase transparency, and broaden the experiences and perspectives of the CoC's advisory and decision-making process. The following costs may be considered to implement the strategies and priorities:

Staffing costs to strengthen cross-system collaboration

To establish one full-time employee as Homeless Coordinator within Buncombe County (Strategy #1 Priority 1.G) the estimated range of cost is $100,000–$125,0000 for salary, benefits and taxes, and overhead costs.

Costs to expand and create subcommittees and workgroups

There are several references in this report to expanding representation for community voices, including people with lived experience, through both standing and ad hoc subcommittees to advise the CoC Board and other leaders. In addition to increased staff capacity through the City (and above recommended County) Homeless Coordinators to help administratively support the subcommittees and workgroups, there are other uncovered costs to be considered for development and implementation. There may be logistics such as physical and or virtual meeting space, material reproduction, purchasing equipment, and paying people with lived experience for their expertise.

As discussed earlier in this report, the best practice to meaningfully engage people with lived experience involves compensation for their time for participation through stipends, transportation support for gas or public transit, or gift cards. As the CoC develops their implementation plan, they should consider the number of meetings needed and determine how many participants will be involved. For example, a Lived Experience Advisory Council (modeled on the **Lived Experience Coalition** in King County, WA) with 10 members that holds monthly two-hour meetings should be budgeted for approximately $24,000. This includes preparation time for each member of 2 hours and an hourly rate of $50. Another example of expanding community engagement to ensure a wide array of voices are heard in **San Diego's plan** to address the overrepresentation of Black people experiencing homelessness.

Community examples: **King County, WA**

Costs to improve HMIS data

In addition to other Alliance recommendations to develop clearer standards and processes to improve the CoC's data accuracy, the first two priorities of Strategy #4 suggest that the Asheville-Buncombe CoC expand access to HMIS to additional programs operated in the CoC to support enhanced coordination. To accomplish this, the CoC would be required to expand the CoC's current coverage by at least 30 percent of its current provider network. The Asheville-Buncombe CoC will need to consider the per user ($968) and other related costs to expand access to HMIS.

Increase the Asheville-Buncombe CoC's Shelter and Other Temporary Housing Capacity

The Alliance recommends that the CoC prioritize development of a plan to significantly increase its temporary housing options for non-veteran single adults and families with children.

There was not sufficient data available to fully understand the range of nightly, monthly, and annual costs across the varied interventions (shelter, transitional housing, etc.). A recent report by Tom Albanese and Emily Carmody for the City of Asheville identified costs related to non-congregate shelter conversion at $25,000 per bed. In addition, as previously mentioned in this report, the available data was not complete to provide a concrete projection of effective beds needed. Based off the limited data, the Alliance recommends a 30 percent increase in the number of temporary shelter or interim housing beds that the CoC should implement in **Figure 9** below (based off of 2022 HIC data).

The Alliance also recommends the CoC examine the existing beds and identify opportunities and resources to create more effective shelter beds. These numbers are based off a conservative goal of effective shelter to rehouse individuals in less than 150 days (with the ultimate goal being 100 days) These beds should be embedded in CES.

Other communities across the country have developed and implemented effective plans to expand person-centered shelter capacity, including Washington, D.C.'s major overhaul of its family shelter system. In 2014 D.C. created the **DC General Replacement Plan** to better meet families' needs through a shelter first approach that included decentralization of a 288-unit facility into smaller single family home type settings. **Open Doors** in Connecticut retooled their shelter to be more effective to meet the needs of all individuals in their community. The Framework for an Equitable Homeless Response recently released the **Reimagining Interim Housing: Transforming our Approaches to Sheltering People** that provides guidance and two primary resources: **Stages and Action Areas for Transforming Approaches to Sheltering People Experiencing Homelessness** and **Tools for Strengthening Current Interim Housing Programs and Services**.

Population	Number of New Beds Needed	Program Type	Shelter Structure
Single adults	60	Effective shelter	Renovated building, single family homes, multi-family units, non-congregate
Single adults	25	Enhanced shelter with mental health and substance use specialists onsite	Single family homes, multi-family units, non-congregate buildings
Families with children	10	Effective shelter serving varied family compositions	Single family homes, multi-family units, non-congregate buildings

Figure 9: Recommended temporary shelter/interim housing beds that the CoC should develop

Increase Permanent Housing Options

The **Asheville City Council's 2036 Vision** includes the goal of creating an abundant amount of quality and affordable housing choices. In addition to developing affordable housing in the county per this plan, the Alliance recommends funding other housing and unit acquisition strategies as a top priority.

Increase Rapid Re-Housing Subsidies

Rapid Re-Housing provides people with wrap-around support through housing navigation case management and linkage support, and financial assistance. The annual household costs for Rapid Re-Housing varies across the country. According to the City of Asheville Community and Economic Development Department, the average cost per person per year to provide permanent housing (with supportive services) is $13,000 per year for single adults. Most Rapid Re-Housing programs commit up to 24 months of rental assistance, which ideally decreases over time.

Based on the data shared earlier in this report and the recommendation to reduce the housing placement timeline from 200 days to 100 days, the Alliance recommends that the Asheville-Buncombe CoC develop a plan to increase their Rapid Re-Housing slots as detailed in the Figure 10. Increased Rapid Re-Housing will provide the resources necessary to increase flow through temporary shelter/interim housing.

See **Figure 10** below.

Recommendation 1.F identifies a reasonable case management ratio of no higher than 1:30. Adhering to the recommended case management ratio may require an increase in the annual cost per household for permanent housing if the cost per household provided by the CoC assumes a higher caseload. The annual salary for a case manager in the Asheville-Buncombe CoC is between $42,000 and $46,000.

For example, Dallas created the **Dallas R.E.A.L. Time Rapid Re-Housing Initiative (DRTRR)** and significantly expanded their Rapid Re-Housing slots with the aim to rehouse 2700 people by October 2023. In Miami Dade County they have significantly increased their permanent housing outcomes through Rapid Re-Housing supported through **Tourist and Restaurant Taxes**. Eighty-five percent of the County's 1 percent restaurant tax goes to homeless programs while the remaining 15 percent is allocated to domestic violence services. In 2017, Los Angeles County voters passed **Measure H** to fund the first revenue stream dedicated to preventing and addressing homelessness countywide. Measure H is a 10-year initiative that provides between $355–$450 million annually to fund Rapid Re-Housing, supportive services for permanent supportive housing shelter, and many other homeless programs.

Population	Number of Recommended New Slots	Annual Cost per Person/Household	Total Annual Amount
Single Adults	200	$13,000	$2,600,000
Families with Children	50	$16,000	$800,000

Figure 10: Recommendations for increasing Rapid Re-Housing slots

Enhance and Improve Coordination for Street-Based Outreach

The CoC has numerous outreach teams who specialize in different areas of focus, including alcohol and other substance use disorders, mental health, physical health, and more. However, there is a gap for outreach teams that are primarily focused on housing solutions. In addition to the training costs, there are two main considerations to improve outreach in the Asheville-Buncombe CoC.

Structured Outreach Coordination Efforts for Existing Teams

In order to strengthen and streamline the various outreach teams currently operating in the CoC, the Alliance recommends that the CoC invest in structured outreach coordination. This model has been implemented in multiple cities across California, (e.g., Los Angeles and Santa Monica) as well as other parts of the country, and has proved to be very effective with improved outcomes for participants. The primary cost associated with implementing strategic outreach coordination in the Asheville-Buncombe CoC is staffing for one to two full-time outreach coordinators, with a baseline salary of $41,219. These staff members act like air traffic control to ensure hotspots are addressed; mitigate duplication of effort; coordinate responses; identify gaps and underserved areas; collect, track and manage data; and facilitate outreach case conferences. The other major cost would be to invest in geo-tracking software to enhance real time tracking of encampments, hotspots, and outreach activity. Other additional costs include communication services and materials, physical and or virtual meeting space, and vehicle purchase or mileage reimbursement as needed.

As detailed in the City of San Diego **Community Action Plan on Homelessness** the municipality has worked extensively to improve coordination of outreach in an effort to improve outcomes for street based engagement.

Community examples: **San Diego**

Establish New Multi-Disciplinary Teams (MDT)

In addition to investing in outreach coordination, the CoC should create housing-focused multi-disciplinary outreach teams, comprising various specialty personnel.[25]

This model has proven to be effective in communities across the nation to both assess and address the whole person and their needs right in the field. The County of **Los Angeles Department of Health Services** implemented this MDT model five years ago and now currently has more than 200 of these teams.[26] According to the **Rand Corporation Evaluation** of the Homeless Street Team (MDTs) for the City of Santa Monica, the cost to establish one team is approximately $600,000 per year. This includes the cost for a program manager, licensed or licensed eligible mental health professional, substance use disorder specialist, case manager, medical professional which is usually a nurse, and a person with lived experience. Similarly, in Los Angeles County has established more than 200 MDTs throughout the region and 19 coordinators to align efforts. Given the high cost of establishing this team, the Alliance recommends reorganizing current personnel into these teams.

[25] Citation for Outreach according to Iain De Jong - Jong, I. de. (2019). Section B: Street Outreach. In The Book on Ending Homelessness (pp. 95-118). Victoria, BC, Canada: FriesenPress

[26] Resource Development Associates, 2019, Los Angeles County Chief Executive Office—Research & Evaluation Services Homeless Initiative Strategy E6: Countywide Outreach System Implementation Evaluation

Next Steps

This plan lays out an aggressive approach to combatting homelessness that will require unprecedented leadership, teamwork, and discipline on the part of the CoC, the City of Asheville, Buncombe County, and community stakeholders. Though the plan outlines a number of immediate short-term goals, it is important to understand that building an efficient, effective, and equitable system will take time, but is within reach. Through a combination of system-level thinking, current system improvement and expansion, implementation of innovative practices and stronger partnerships, the Asheville-Buncombe CoC can fulfill its vision to reduce and end homelessness. This plan requires the community to act with urgency and boldness to address the humane cost that homelessness creates. Enacting this plan will have positive change for those experiencing homelessness, the staff that serve them, and for the community.

It will be important to track progress toward key process milestones and outcomes. Understanding impact with regular data "checks and balances" when implementing this plan will be a tool to address accountability, assess progress over time, and identify gaps immediately. With this approach, the CoC can make updates to the homeless response system to best address the overall needs of the community. Tracking data outcomes of the homeless response system will also allow for transparent communication and reporting clear progress back to the community.

To achieve this, the community will need to commit to identifying ways to share appropriate data and identify benchmarks necessary. This approach will need to be integrated throughout all organizations that serve people experiencing homelessness.

Examples of benchmark data to understand efficiency of the homeless response system and its throughput are:

1. Length of time before exiting a homelessness resource, including different types of exits bundled by component (e.g., all emergency shelter stays are not combined with RRH exits to permanent housing)

2. Returns to homelessness

3. Exits to permanent housing based on enrolled programs prior to lease signing (to understand service utilization and access)

It will be important for the CoC Board to identify realistic data points to capture throughout the community, and to support efforts to obtain the identified benchmark data from all providers — regardless of CoC funding and use of HMIS. The Alliance highly encourages any agency who provides critical services to the homeless population to work with the CoC to identify ways to participate in HMIS input. Tracking this data will help to truly understand and make informed decisions on homeless strategies for the Asheville-Buncombe County and ensure access to resources that will quickly resolve an individual's or family's homelessness.

The preceding steps outlined in the report will allow Asheville-Buncombe CoC to make significant progress towards functionally ending homelessness. **Ending homelessness can't happen without courageous leadership, transparency, buy-in, power sharing, accountability, and the understanding that we can't end homelessness if we don't address the persistent inequities that contribute to it.**

APPENDIX A: COMMON DEFINITIONS

- **Affordable housing**: Housing that costs no more than 30 percent of a household's income is considered affordable.

- **Chronic homelessness (HUD definition)**: A homeless individual (or head of household) with a disability and (1) lives in a place not meant for human habitation, a safe haven, or in an emergency shelter, and (2) has been homeless and living as described for at least 12 months* or on at least four separate occasions in the last three years, as long as the combined occasions equal at least 12 months and each break in homelessness separating the occasions included at least seven consecutive nights of not living as described.

- **Continuum of Care (CoC)**: A local or regional Governance board that is responsible for overseeing HUD CoC funding to support a communitywide commitment towards ending homelessness. It is a local planning body that makes decisions on which nonprofits to provide funding to in order to quickly rehouse homeless individuals and families to minimize trauma and displacement caused with homelessness. This board is mandated to coordinate all services and assistance related to homelessness and approves policies to run the Coordinated Entry System (CES) to provide access to and effective utilization of programs. The board also oversees the Point-in-Time (PIT) Count and manages the use of Homeless Management Information System (HMIS) to evaluate outcomes at both the project and system level.

- **Coordinated Entry System (CES)**: A centralized assessment process that supplements an integrated and community wide system for people experiencing homelessness. Coordinated entry systems allow people experiencing homelessness to access resources that meet their unique needs and help providers make prioritization decisions of resources based upon needs.

- **Cost burdened**: When a household pays more than 30 percent of its income on housing costs. Being cost burdened affects a household's ability to afford other basic needs, like food & clothing, health care, transportation, etc.

- **Diversion**: An intervention designed to immediately address the needs of someone who has just lost their housing and became homeless. It is a client-driven approach with the goal to help the person or household find safe alternative housing immediately, rather than entering shelter or experiencing unsheltered homelessness. It is intended to ensure that the homelessness experience is as brief as possible, to prevent unsheltered homelessness, and to avert stays in shelter.

- **Emergency shelter (ES)**: Short-term beds without a prescribed length of stay that provide safety, security, housing navigation/case management services.

- **Homelessness Management Information System (HMIS)**: A local information technology system used to collect client-level data and data on the provision of housing and services to homeless individuals and families and persons at risk of homelessness. Each Continuum of Care (CoC) is responsible for selecting an HMIS software solution that complies with HUD's data collection, management, and reporting standards. HMIS may be used to also coordinate services for households and assess system performance.

- **Homelessness (HUD definition)**: Households who lack a fixed, regular, and adequate nighttime residence and are living in temporary accommodations such as shelter or in places not meant for human habitation; or families who will imminently lose their primary nighttime residence; or families who are fleeing, or are attempting to flee, domestic violence, dating violence, sexual assault, stalking, or other dangerous or life-threatening conditions that relate to violence against the individual or a family member.

- **Housing First**: A homeless assistance approach that prioritizes providing permanent housing to people experiencing homelessness, thus ending their homelessness and serving as a platform from which they can pursue personal goals and improve their quality of life. This approach is guided by the belief that people need basic necessities like food and a place to live before attending to anything less critical, such as getting a job, budgeting properly, or attending to substance use issues. Additionally, Housing First is based on the understanding that client choice is valuable in housing selection and supportive service participation, and that exercising that choice is likely to make a client more successful in remaining housed and improving their life.

- **Housing Inventory Count (HIC)**: As a HUD mandate, each CoC completes an annual inventory of beds and units dedicated to persons experiencing homelessness.

- **Moving On strategies**: A strategy for tenants in supportive housing who may no longer need or want the intensive services offered but demonstrate continued need for assistance to maintain their housing. Moving On strategies challenge a community to create partnerships between the Continuum of Care (CoC) and mainstream housing programs, such as public housing, the Housing Choice Voucher (HCV) program, and HUD-funded multifamily housing providers.[27]

- **Permanent Supportive Housing (PSH)**: An evidence-based housing intervention that provides longer-term rental assistance coupled with intensive supportive services to targeted populations, including people who are chronically homeless.

- **The Point-in-Time (PIT) Count**: As a HUD mandate, each CoC completes an annual count of sheltered and unsheltered people experiencing homelessness on a single night in January. This coincides with the HIC.

- **Rapid Re-Housing**: An intervention designed to help individuals and families to quickly exit homelessness, return to housing in the community, and not become homeless again in the near term. Core components are housing identification, move-in and short-term rent assistance, and Rapid Re-Housing case management and services.

- **Severely cost burdened**: When a household pays more than 50 percent of its income on housing costs. Being severely cost burdened affects a household's ability to afford other basic needs, like food & clothing, health care, transportation, etc.

- **Shared Housing**: A single housing unit occupied by an assisted family and another resident or residents. The shared unit consists of both common space for use by the occupants of the unit and separate private space for each assisted family. The unit may be a house or an apartment.[28]

- **Targeted universalism**: Setting universal goals pursued by targeted processes to achieve those goals. Within a targeted universalism framework, universal goals are established for all groups concerned. The strategies developed to achieve those goals are targeted, based upon how different groups are situated within structures, culture, and across geographies to obtain the universal goal. Targeted universalism is goal oriented, and the processes are directed in service of the explicit, universal goal.[29]

- **Transitional Housing (TH)**: A temporary housing intervention partnered with support services to assist the transition to permanent housing. Program participants are required to sign a lease or occupancy agreement and participate in services that will support stability in housing once they transition to permanent housing. Stays are no longer than 24 months.

- **Unsheltered homelessness**: Individuals or families who live in "places not meant for human habitation." This includes tents, encampments, makeshift shelters, cars & RVs, abandoned buildings, doorways, sleeping on sidewalks, parks, and other public spaces, etc.

27 Moving On. (n.d.). HUD Exchange. **https://www.hudexchange.info/programs/coc/moving-on/**
28 COVID-19 Homeless System Response: Shared Housing. (n.d.). HUD Exchange. **https://www.hudexchange.info/resource/6337/covid19-homeless-system-response-shared-housing/**
29 Targeted Universalism. Othering & Belonging Institute. (n.d.). Retrieved December 19, 2022, from **https://belonging.berkeley.edu/targeted-universalism**

APPENDIX B: APPROACH ON CONDUCTING NEEDS ASSESSMENT WITH STAKEHOLDER ENGAGEMENT

The Alliance's work was guided by a three-part approach: 1) community engagement including informational interviews, focus groups, and surveys, 2) document review, and 3) data review. It is important to recognize how each element played a role in assessing the needs of the community and informing the action plan. For example, reviewing the data on bed utilization rates will not give the full picture on why beds remain open. Interviewing people who are experiencing homelessness and understanding the barriers they experience in accessing an open bed will supplement the data review.

The Alliance reviewed and analyzed available PIT, HIC, and HMIS data and engaged in document and literature review regarding Asheville-Buncombe County. These documents included CoC written standards, previous homeless strategic plans, housing needs assessments, CoC governance bylaws, and other program-specific documents including policies and procedures, job descriptions, cross program Memoranda of Understandings, and more, to supplement the community engagement process. Utilizing this approach provides a well-rounded picture for the narrative of what is happening within the community, so the action plan and recommendations match the community's needs.

The Alliance spent the most time engaging community stakeholders to participate in focus groups, informational interviews, and a web-based survey to understand their views on the issue of homelessness within Asheville-Buncombe County. This community engagement process included members of all levels of the homeless response system and community members including people with recent or current lived experience who have a stake in reducing and ending homelessness.

Focus Groups

Eight focus groups were conducted between August and October of 2022. These groups included AHOPE participants, the faith community, health care partners, business community leaders, Haywood St participants, neighborhood members, and a two-part session with HIAC.

Community Conversations and Informational Interviews

Between June and October 2022, the Alliance held several community conversations with providers who serve the homeless population, the City of Asheville, Buncombe County, people with lived experience, and several other stakeholder groups that have contact with the homeless population.

The Alliance used a conversation template to guide the informational interviews. For each agency-specific conversation, questions focused on the information around the agency itself (its organizational structure, type of programs and services offered, and type of contact they have with the homeless population); descriptions of how Housing First practices are utilized and how data practices are utilized (when applicable); challenges they experience as providers, people with lived experience, or the organization as a whole; and overall questions around the state of homelessness in the community and the progress being made.

These participants are listed on the next page.

Participants included:

Street Outreach

- Homeward Bound — Street Outreach

Emergency Shelters

- Asheville Buncombe Community Christian Ministry (ABCCM)
- Haywood Street
- Helpmate
- Salvation Army
- Western Carolina Rescue Mission

Transitional Housing

- ABCCM

Rapid Re-Housing

- Helpmate
- Eliada
- Homeward Bound — ESG
- Homeward Bound — SSVF
- ABCCM — SSVF

Permanent Supportive Housing

- VA Medical Center (VAMC) HUD VASH
- Homeward Bound

Drop-In Centers

- Homeward Bound — AHOPE
- Haywood Street

Legal Services

- Pisgah Legal Services (SOAR/EP)

Community Stakeholders

- Thrive Asheville
- Asheville Survival Program
- Housing Authority of the City of Asheville (HACA)
- Asheville Police Department
- Coalition of Asheville Neighborhoods
- Asheville Area Chamber of Commerce
- WNC Bridge Foundation
- Buncombe County
- City of Asheville
- Explore Asheville Convention & Visitors Bureau
- People with Lived Expertise
- Dogwood Health Trust
- Mission Hospital
- Behavioral Health (County of Buncombe)
- Vaya Health
- Sunrise Community for Recovery and Wellness
- Beloved
- Community Paramedics
- Encampment Stakeholder Committee
- Community Shelter Steering Committee

Community Survey

Community members were asked to participate in a web-based survey. The survey included rating scale questions related to perceptions of the state of homelessness in the region, the City and County efforts to address it, and the governance structure and its ability to communicate back to the community. The rating scale options were "Strongly Agree, Agree, Neither Agree or Disagree, Disagree, and Strongly Disagree." Respondents were also asked how long they have been a member of the community and if they were a business owner, and were provided with open-ended questions to provide their opinions to mitigate the homeless situation. Over 1,700 community members participated in this survey and provided valuable feedback that helped inform the strategies outlined in this action plan.

Individuals who identified as 1) a person with lived experience of homelessness; 2) a homeless services provider; and/or 3) in a leadership capacity in the homeless services sector in the community were asked additional questions in the process. Respondents were asked to answer questions related to the experience of providing or receiving services, overall understanding related to access to resources in the county, ability to use Housing First practices and other training/best practice proficiencies, and overall views on the governance structure and its progress on resolving homelessness. Respondents were also given the opportunity to provide open-ended responses on how to resolve homelessness in the community.

APPENDIX C: SURVEYS

Survey Results

This spreadsheet↗ documents the results of the 4 surveys in aggregated table form. The open-ended questions are accessible under the raw data below:

Survey raw data by group

- **Community survey↗** from people residing in or conducting business in Asheville-Buncombe County. The survey asked about individuals' experience, thoughts, and impressions on homelessness in Asheville-Buncombe County. This survey was anonymous.

- **Leadership survey↗** from "System Leadership" defined as persons in the Continuum of Care (CoC) coordinating agency; CoC Governance Board members; federal, state, local homeless grant administrators; executive directors and senior management of homeless service organizations; homeless coalition leadership; advocacy organizations; foundations and/or funders of homelessness assistance; elected officials; directors of partner agencies such as the Housing Authority, Behavioral and Mental Health departments, Child Welfare, Corrections, Law Enforcement, First Responders, Parole and Probation; and local government officials. This survey asks for opinions on the homeless response system. All responses were anonymous.

- **Provider of homeless service survey↗** from individuals serving as intake specialists, outreach workers, day center staff, program managers, case managers, employment specialists, housing locators, Homeless Management Information Systems (HMIS) staff, any other frontline or direct service staff, and staff of organizations providing support to those in need. This survey asked opinions about services provided to those experiencing homelessness in the City of Asheville and Buncombe County, as well as your community's response to homelessness as a whole. This survey was anonymous.

- **People With Lived Experience survey↗** (With additional data from the People with Lived Experience community survey) from people who are currently experiencing homelessness (living in a shelter, transitional housing program, or in a place not meant for human habitation such as a car or outside) or who have recently experienced homelessness in Asheville-Buncombe County. It asked about individuals' experience and impressions of homelessness services in Asheville-Buncombe County. This survey was anonymous.