AK-500 CoC Strategic Plan for Serving Individuals and Families Experiencing Homelessness with Severe Service Needs

Anchorage, Alaska CoC Strategic Plan for Serving Individuals and Families Experiencing Homelessness with Severe Service Needs

Introduction

COVID-19 significantly impacted the Anchorage Homelessness Prevention and Response System (HPRS). Anchorage's sole low-barrier shelter quickly decompressed from over 200 beds to 70, refocusing on elders and people with mobility issues. Many people experiencing homelessness (PEH) lost their informal housing situations such as couch surfing or staying with an acquaintance. Anchorage quickly stood up mass care shelters as an emergency response, including congregate and non-congregate sheltering. At its peak, these mass care facilities sheltered approximately 795 people experiencing homelessness in Anchorage. In 2022, the wind-down of mass care began, with a target date to close all facilities by June 2022. This effort underscored the urgent need for more housing in Anchorage. Using a public-private partnership model allowed Anchorage to jumpstart a variety of efforts, dubbed the Mass Care Exit Plan. This plan leveraged a combination of one-time federal funding, local tax revenue, and philanthropic contributions. Through these efforts, new additional units of housing were created, along with shelter for Anchorage's most vulnerable PEH. Anchorage continues to develop housing capacity accessible to PEH: the last non-congregate facility, which shelters approximately 200 individuals, closed at the end of September 2022. The Anchorage Coalition to End Homelessness (ACEH), the lead agency for AK-500's CoC, has been convening the community to address the wind-down of mass care and the ongoing community challenge to ensure adequate services to support PEH. Currently, approximately 350 individuals are unsheltered with no access to low-barrier shelter or housing. Anchorage has seen a growing crisis of unsheltered homelessness since the closure of its largest congregate shelter on June 30, 2022. With winter approaching, a parallel effort is underway to provide emergency winter shelter, but we know that the real solution lies in continued investment in housing and supports to help people with severe care needs secure and maintain housing.

P-1. Leveraging Housing Resources

P-1a. Development of New Housing Units and Creation of New Housing Opportunities – see attachments

The Anchorage CoC gap analysis for 2021 identified the need for 700 additional units of permanent supportive housing (PSH) and 1,695 rapid rehousing units for single adults, transition-aged youth, and families. The gap analysis showed that single adults account for over 60% of the unmet housing need in Anchorage today. Through several initiatives funded through one-time federal relief monies (CARES Act and ARPA) and local tax revenue, Anchorage has been able to pilot new approaches to increasing available housing units for PEH that leverage access to housing vouchers and emergency rental assistance.

New Housing Units

Guest House. 130 new extremely low-income (ELI) and low-income (LI) integrated housing units with 25 units set aside for PSH. On September 1, 2022, the Guest House Hotel will be fully converted into 130 units of leased housing, shifting its use from transitional housing to permanent housing after the successful purchase of the property by a local faith-based organization using local revenues and philanthropic contributions. These units will have access to supportive services supported by tenant rents. The supportive services provider intends to seek additional funding for supportive services through a variety of sources such as HOME-ARP and CDBG. At least 25 units will be PSH through United Way's Home for Good Program, which targets the highest need PEH. Home for Good is funded through a public-private partnership leveraging local tax revenues and philanthropic investments.

Aviator Housing Units. 80 new units of integrated housing. The Aviator Hotel became a non-congregate mass care sheltering location in response to COVID-19. As the need for permanent housing solutions grew urgent, the owners of the hotel converted a wing of the hotel into 80 integrated supportive housing units.

These units specifically target vulnerable residents from the mass care operation at the same location to provide both housing and supportive services. The rents are paid using Emergency Rental Assistance (ERA) funding targeted specifically to PEH as well as ARPA funding for supportive services. Leases are for one year.

Providence Permanent Supportive Housing. Providence Alaska House is the standalone first phase of a planned multi-phase permanent supportive housing development for chronically homeless seniors located in mid-town Anchorage, Alaska. This first phase consists of a four-story residential building containing 51 studio units as well as support space for the provision of social services, including case management consult rooms, a reception area, administrative and service provider offices, and common space for other supportive services and residential programming. Providence Alaska House will primarily serve homeless seniors who suffer from alcoholism, co-occurring disorders, and have a history of high emergency service utilization. Providence Alaska House has received funding from federal, state, and local governments, as well as private foundations and other philanthropic sources. The 6-acre site has been master planned to accommodate a second phase of 51 permanent supportive housing units.

P1-b. Development of New Units and Creation of Housing Opportunities – PHA Commitment – see attachments

Other New Opportunities for Additional Housing

Additional Capital for Hotel Conversion(s). The Municipality of Anchorage appropriated $11 million from its second tranche of ARPA funds to a hotel conversion that would create more units of ELI and PSH housing. The aim is to quickly identify a hotel, or hotels, that would make suitable housing and could also qualify for Emergency Housing Voucher (EHV) and other voucher subsidies. The aim is to leverage this investment with other one-time and recurring HUD funds (CDBG, HOME, and HOME-ARP) to assist in funding the supportive services.

Community Land Trust. Throughout the process of identifying and working to convert hotels into new housing units, the primary challenge has been identifying an owner for these properties. To continue the work of adding ELI and PSH units to Anchorage, a Community Land Trust (CLT) for purposes of holding and managing these properties is under development, with the target of being in operation by the end of 2022. The CLT will be available to take ownership of any completed project to expand this much-needed housing stock. This effort is funded through philanthropic contributions.

Alaska Housing Trust. The Anchorage CoC and the Balance of State CoC spearheaded an effort in collaboration with the Rasmuson Foundation to create the Alaska Housing Trust in 2022. Before its creation, Alaska was one of three states without a housing trust. During the 2021-22 legislative session, the Alaska Housing Trust received $1 million in planning funds. Those funds will allow for the formation of a board and advisory committee to provide education and technical assistance, and eventually, distribute notice of funding opportunities and make awards to increase housing security and the development of new housing units throughout Alaska, including Anchorage. The first funding opportunity is projected to occur mid-2023.

P-1c. Landlord Recruitment

Landlord Housing Partnership (LHP)

1a. The Landlord Housing Partnership (LHP) project under at the United Way of Anchorage serves as a promising new strategy to help our community identify landlords willing to rent to people exiting homelessness. The program grew out of COVID-19 recovery programs operated by the United Way and several community partners to provide rent and mortgage assistance to persons at risk of losing housing during the pandemic. Over 700 landlords have been contacted to invite participation in the Landlord Housing Partnership.

At the end of September 2022, there were 80 total landlords active with the LHP program after the first seven months of outreach. A centralized data base, Padmission, was implemented to track landlords and units dedicated to the program. There are currently more than 60 properties active on Padmission. Using Padmission to catalogue units across the community allows us to identify where there are gaps in the availability of rental units and to attempt to locate landlords in these areas. This is the first time our community has been able to monitor unit availability at this level.

1b. This program has allowed the CoC and community partners to pool resources around landlord recruitment and has provided new landlords to the social service partners in the project. In the past, several agencies kept separate landlords lists which we generally not shared with other organizations. In the past, landlords may have had units left unfilled or had to turn to general public referrals if the individual organizations did not have a match for an open unit. By using a dedicated database, the program can now identify units across our entire CoC that are open for referrals. The system is much more effective in identifying units across all areas of the community.

2. The Landlord Housing Partnership tested several new strategies to recruit and maintain landlord participation. A strategy to test incentives was supported by the Municipality of Anchorage's Health Department using HUD ESG-COVID-19 funds to test Landlord incentives. Incentives have been used in two ways, 1) at rent-up to help landlords to rent to a tenant through LHP as opposed to general renters, and 2) a retention payment at 3 months has been used to incentivize stability for the tenant. The LHP uses a second Municipal grant to provide a Risk Pool for landlords who have damages over the amount that a security deposit will cover. New strategies are being developed to help landlords who need small infusions of funds to renovate and bring on units that are not currently ready for renting. Intensive Housing Case Management (IHCM) was piloted through a CARES Act grant to expand housing case management services to help wind down mass care facilities. IHCM services help clients and recruit new landlords who have never rented to PEH by providing tenant supports beyond signing a lease. Over time, housing case management services taper down as PEH are successful in maintaining new housing. Expanded IHCM services and the Landlord Housing Partnership have resulted in 69 households accessing housing since April 1, 2022.

3. Outflow measure: This project has been embedded with our community's Coordinated Entry system through the Anchorage Coalition to End Homelessness and serves as a tool for expediting referrals to housing from the CE list. During community efforts to decompress mass shelter and NCS sites, ACEH and the Landlord Housing Partnership program collaborated on streamlining referrals for persons exiting these locations. There was daily monitoring of housing unit availability, coordination of referrals for persons exiting mass care sites and monitoring to ensure referrals were enacted by the social services partners. This activity increased the outflow to housing for the community in the weeks leading up to closure of selected sites. This level of coordination will be continued and measured by outflow data in the coming year. Retention measure: LHP will monitor retention of tenants placed by the LHP. One main feature of this program is a phone line for landlords to call if a landlord experiences a challenge with a tenant. By providing proactive support and problem solving to landlords, this project aims to decrease returns to homelessness for tenants placed using the LHP.

P-2. Leveraging Healthcare Resources – see attachments

Development of New Healthcare Partnerships

Healthcare and Homelessness Pilot. ACEH, as the lead agency for the CoC, was selected to participate in a national Healthcare and Homelessness Pilot Project in 2021 convened by Community Solutions and the

Institute for Healthcare Improvement (IHI). This initiative partnered ACEH with healthcare providers, including Providence Hospital and Anchorage Neighborhood Health Center, to develop projects that integrate healthcare response into the HPRS. Through ACEH, the CoC completed the Built for Zero (BfZ) process prior to being selected as part of this national pilot. The Statement of Purpose for this pilot project, developed by the partnership, is: Expand community-wide connections among whole person health care, housing, and social supports, to equitably increase individual and community well-being for people experiencing and at risk of homelessness, by providing the right care, at the right time, and in the right place. The goals for the pilot were to implement care coordination as part of the mass care wind-down, increase connection to Assisted Living Homes (ALH) and PSH for those in need of additional supports, and increase data sharing with local hospitals and healthcare providers.

Medical Respite Shelter. ACEH led the CoC's participation in a Healthcare and Homelessness collaboration with all local hospitals and publicly funded healthcare providers that successfully developed a medical respite program that provided 10 beds of enhanced shelter at Anchorage's low-barrier shelter for people discharging from hospitals. These beds operated through the pandemic and continue to be funded by local hospitals.

Complex Care Shelter. ACEH supported the CoC's implementation of a new Complex Care Shelter (CCS). This facility is targeted to serve PEH with significant medical and functional health issues and provides care coordination to secure appropriate housing. Partnering with the Alaska Mental Health Trust Authority, Catholic Social Services, Rasmuson Foundation, and Ship Creek Community Assets II, this facility went from concept to operation in six months. Many PEH at the CCS require either personal care attendants (PCA) to help them meet their daily needs or assisted living facility (ALF) care. Both PCA and ALF require significant resources, often accessed through Medicaid eligibility and through assessment and eligibility for one of Alaska's 1915(c) Medicaid waivers. CCS can provide a place for individuals to stabilize and get help accessing an appropriate level of care. This facility is the first in Anchorage designed to address the needs of PEH with complex care needs.

Case Conferencing with ADRC. Concurrent with the development of the CCS, ACEH and AHD's Aging and Disability Resource Center (ADRC) began convening case conferencing for PEH with medical and behavioral health needs to identify those who might quality for one of Alaska's 1915(c) Medicaid waivers, the General Relief program, and/or PCA services. Being enrolled in one of these programs is necessary for many PEH to gain admission to an ALF or to receive in-home supports to help maintain housing. This case conferencing meets every other week. Since its inception in October 2021, 16 individuals successfully secured ALF or independent units.

Healthcare Integration through Street Outreach. Healthcare providers join street outreach teams in Anchorage to assist with Medicaid and SNAP applications. This partnership allows PEH to access necessary healthcare services regardless of housing status. Providence Community Health Workers support street outreach and are also able to assess immediate medical needs such as wound care or referrals for follow up. Similarly, Alaska Behavioral Health often accompanies street outreach and can assist with identifying prior clients to reconnect to services, PEH in immediate need of behavioral health intervention through the Mobile Crisis Team, or connection to behavioral health services.

Healthcare Integration at Emergency Shelters. Southcentral Alaska's Tribal Health Organization, Southcentral Foundation, has operated a health clinic at Anchorage's low barrier shelter for adults, and a separate clinic at the low barrier shelter for youth for many years. At the outset of the pandemic in spring 2020 when mass care began, the low-barrier shelter reduced the number of beds available from over 200 to approximately 70. Southcentral Foundation along with other healthcare providers, ACEH, and the Municipality of Anchorage quickly stood up a health clinic at the main mass care congregate shelter site. Providers shared coverage at the site and offered on-site access to behavioral health care and Medication Assisted Treatment (MAT) through Providence Health System's Breakthrough program. Partners included Southcentral Foundation, Anchorage Neighborhood Health Center, Providence Behavioral Health, and Providence Family Medicine Center. The group developed a logic model and long-term plan to implement at

the end of mass care. The long-term goal of the collaboration is People experiencing homelessness achieve whole person health and wellbeing measured by 1) Self-reported reductions in harm and increased sense of wellness and recovery from trauma among people experiencing homelessness; 2) Increased length of engagement for health care services with one provider or provider organization; 3) Increased number of individuals who have and use a medical and/or comprehensive health home; 4) Increased number of individuals with chronic health conditions managed without the use of inpatient care; 5) Increased retention of frontline health care workforce. The collaboration identified several activities including Develop and sustain whole person health clinics at three emergency shelter sites to provide access to whole person care for PEH in shelter and to connect PEH with long-term health homes at local providers.

Home for Good. In May of 2016, ACEH worked with the Municipality of Anchorage and United Way of Anchorage to secure $1.3m in HUD funding for a Pay for Success Demonstration Project developed to demonstrate the return on investment for public sector partners in increasing linkages to PSH for PEH with repeated involvement in the criminal justice system, high use of emergency healthcare services, and long-term homelessness. Through this funding, United Way of Anchorage led a feasibility study and the development of a social impact funding model, working with national partner Social Finance. This led to a 5-year demonstration project called Home for Good which links housing units, behavioral health and health care supports, and a landlord liaison, supported through integrated data from Department of Corrections, HMIS, and healthcare, to identify those who qualify for the program and enroll them into housing and supports. Southcentral Foundation, the Tribal Health Organization serving southcentral Alaska, developed and implemented an Intensive Case Management program that serves individuals with behavioral health needs. This service is part of Alaska's 1115 Medicaid waiver developed by the Division of Behavioral Health in 2018 that is in renewal this year. The CoC, through ACEH continues to be an active member of this partnership and demonstration project.

New Opportunities to Expand Healthcare Partnerships

Hospital Liaison. Together the CoC and Providence Alaska have identified the need for a liaison between the hospital system and the homelessness prevention and response system. This program will use an existing position within the Providence Community Health Workers (CHW) who will shadow hospital social workers making rounds to patients. Seven clients per month will be identified through conducting rounds and interviews when new patients are admitted to Providence. The CHW will be an access point to Coordinated Entry and attend Case Conferencing and Care Coordination meetings to connect clients to a case manager and advocate for the person's care needs. As the program continues and more Community Health Workers are trained in the process, an additional 5-10 clients will be identified each month.

Walk-In Behavioral Health Clinic. Providence Health & Services Alaska's new Behavioral Health Urgent Health Clinic will be a walk-in clinic that will provide same-day access to urgent behavioral healthcare. The clinic will operate 5 days a week, with a goal of expanding to 7 days a week in the future. The walk-in clinic will provide access to Medication Assisted Treatment and psychiatric urgent care, along with ongoing medication management for those who are unable to find providers. Memoranda of Agreement with primary care providers will ensure warm handoffs for Substance Use Disorder (SUD) treatment and additional healthcare services. The clinic will connect with the homelessness response system, including getting individuals onto the Coordinated Entry list and participating in case conferencing meetings to help identify housing and supports.

Expand Data Sharing between HMIS and Healthcare Providers. Several community programs and partnerships are exploring data sharing between HMIS and healthcare providers. Home for Good, a supportive housing program with a social impact model that serves high-service utilizers, uses limited data sharing with EMS, police, and healthcare providers to get individuals who might be eligible for the program onto Coordinated Entry and to locate individuals once they qualify for an open unit. Recent discussions between housing and healthcare providers have identified opportunities for enhanced data sharing, including better coordination at the time of hospital discharge so that individuals are placed onto Coordinated Entry and connected to services with a warm handoff before leaving the emergency room.

P-3. CoC's Current Strategy to Identify, Shelter, and House Individuals and Families Experiencing Unsheltered Homelessness

P-3a. Current Street Outreach Strategy

1. ACEH in its CoC coordination role uses an organized, data-driven street outreach strategy to connect unsheltered PEH to services. The ACEH Outreach Coordinator manages the scheduling of street outreach staff across various participating provider organizations. ACEH facilitates the sharing of information between street outreach providers, the Anchorage Police Department, and the Anchorage Health Department (AHD) to target outreach efforts to the highest-need areas. ACEH also facilitates weekly or bi-weekly case conferencing meetings
Client data is entered into the Homeless Management Information System (HMIS) and data is reviewed to identify gaps and immediate needs within the community. Aggregate data is shared with the HPRS and local government through regular reporting. Based on this data and prioritization, an outreach schedule is created weekly to target specific zip codes.
Data from the municipality's GIS on reported camps is used to create the map and the outreach schedule for the CoC teams. This ensures outreach teams are coordinated using accurate, current, and community-wide data.

2. The ACEH outreach coordinator is primarily responsible for ensuring that community-wide teams are covering the entire AK-500 geographic area. Outreach is conducted 7 days a week, with the primary focus on Mondays through Fridays.

3. Street Outreach staff travel to meet unsheltered individuals and families where they are, often in or adjacent to local parks or greenbelts. Outreach staff are knowledgeable about system-wide housing, healthcare, and supportive service programs and eligibility requirements for youth, individuals, and families. They work to connect clients to the appropriate resources based on each individual's or household's unique needs.

4. All street outreach staff participate in outreach training that includes training on culturally appropriate strategies. Street outreach works to build trust with PEH and uses a Housing First approach along with Coordinated Entry (CE) to ensure PEH are provided with the opportunity to complete a CE assessment. CE ensures that individuals are prioritized for services based on length of time homeless, vulnerability, and need. Referrals to services are based on prioritizing those with the highest vulnerability and most severe service needs, project eligibility requirements, and client preference only. CE assessments are also the basis for Anchorage's By-Name List, a comprehensive list of every person in a community experiencing homelessness, updated in real-time. Using information collected and shared with their consent, each person on the list has a file that includes their name, homelessness history, health, and housing needs.

5. Referrals are discussed during case conferencing to ensure that eligibility requirements are met and to troubleshoot potential barriers to entry. Clients are referred to appropriate housing programs according to placement on the Prioritization List, client preference, and eligibility requirements of the program.

6. Outreach teams regularly discuss the value of hiring PEH to conduct unsheltered outreach. The strategy of the CoC recognizes that people with lived experience provide a unique perspective and an ability to build strong relationships with those who are currently living unsheltered, because of their depth of understanding. They share a common language and history of the realities of living

unsheltered and therefore are more trusted within that community. Organizations within the CoC prioritize hiring people with lived experience for outreach positions.

P-3b. Current Strategy to Provide Immediate Access to Low-Barrier Shelter and Temporary Housing for Individuals and Families Experiencing Unsheltered Homelessness

1. The current strategy has focused on communicating to the community the need for appropriate low-barrier shelter. The CoC has discovered that when public conversations focus on shelter, there is little capacity to focus on the need to add permanent housing inventory. For a number of months, during the wind-down of the mass care facility that was providing congregate shelter for 300+ individuals, a task force composed of representatives from local government, the CoC, and philanthropy worked together to agree upon a collaborative plan to address the shelter needs in AK-500 and identified non-congregate shelters for specific sub-populations as a part of this plan. During this time HUD Disaster TA also provided on-site response to make recommendations regarding best practices to exit people from mass care into permanent housing solutions.

2. Anchorage currently does not have enough low-barrier shelter and temporary housing beds to shelter those experiencing homelessness; current estimates identify 200+ PEH with no access to low-barrier shelter. During COVID-19, clients could access mass care sites at the large congregate shelter at the Sullivan Area or be referred to a non-congregate site in local hotels. While these facilities were in operation, a hub space was made available providing areas that "for and by organizations" were able to connect with clients. This included such organizations as the Native Justice Center, Southcentral Foundation, and Cook Inlet Tribal Council. These mass care sites have closed or are being wound down currently. The mass care congregate shelter set up at Sullivan Arena (low barrier, high census) was closed by the Municipality of Anchorage on June 30, 2022; the Gospel Rescue Mission (high barrier with sobriety requirements), and Brother Francis (special populations) were the primary shelters available and have now permanently changed eligibility and reduced their number of beds. For the past decade, many families experiencing homelessness have been assisted by the faith-based community and limited to emergency weather shelter, but COVID-19 and a lack of resources and volunteers impacted the ability of the faith-based community to continue to assist families. ACEH convenes the family shelter community bi-weekly to discuss solutions for family shelter in light of this gap. One success in the CoC's current strategy is the opening of an 86-bed non-congregate Complex Care shelter that houses individuals with complex medical needs, to provide an opportunity for healing that they would not have if they were discharged back to unsheltered homelessness. These clients often struggled in physically navigating other shelter locations, and clients have had successful outcomes in this new facility.

3. **Guest House and Alex Hotels Transitional Housing Projects**. These projects used ERA1 housing stability set-asides from the Municipality of Anchorage (MOA) to provide transitional housing to individuals exiting mass care facilities as the MOA ended those operations. 129 units of transitional housing were made available at the Guest House and 67 units were made available at the Alex Hotel. The 67 units at the Alex Hotel were only temporarily available, due to constraints by the property owner. During its operation, 25 people moved into permanent housing, another 26 were transferred to the Guest House, and 9 households went to other transitional housing. The Guest House program ended on September 1 when the building changed ownership and the current PEH in the program were offered leases at the same location.

Emergency Housing Stabilization. ERA funding was made available in the spring of 2022 in partnership with Alaska's Public Housing Authority (PHA), the Alaska Housing Finance Corporation (AHFC). AHFC set up an emergency housing stabilization program that allowed 10 local providers to

move unsheltered PEH or PEH in mass care to transitional housing for up to 90 days while working toward locating and securing a permanent housing unit. A combination of hotel stays and existing transitional housing programs, such as Safe Harbor for families, were used. 334 adults and 87 families were served through this program. PEH are then eligible for up to 12 months of rental assistance upon locating a unit if they have not previously received rental assistance. The program is ongoing subject to funding availability. The Municipality of Anchorage is expected to receive additional rental assistance funds that can be leveraged in this manner to assist with sheltering needs for the upcoming winter and the September 30 closure of the last mass care facility that served just over 200 PEH. The CoC has learned through partners and street outreach that PEH are not seeking shelter, but housing. The lack of shelter and the preferences of PEH present an opportunity: to shift the paradigm away from shelter and toward housing as the next step for unsheltered PEH. Clients also want a choice in housing; they don't want to just be assigned to a place; they want to exercise agency in deciding where they live.

P3-c. Current Strategy to Provide Immediate Access to Low-Barrier Permanent Housing for Individuals and Families Experiencing Unsheltered Homelessness

1. The CoC's current strategy involves the recognition that AK-500 does not have enough low-barrier, affordable and available units to provide the housing solutions necessary in order to exit all individuals and families from homelessness into permanent housing. The CoC worked with government, philanthropy, and direct service providers to take advantage of one-time Covid funding and municipal tax revenues to purchase hotels and convert them to housing. Existing housing programs are supported through CoC grants. Case conferencing with existing housing programs partners provides referrals through CE that align with program openings and eligibility requirements.

1a. The CoC offered technical assistance grounding the entire purchase and planning processes in true Housing First principles. Technical assistance included educating multiple stakeholders about Housing First principles and providing input on strengthening Housing First language and requirements in the RFP and operations agreements. Additional support was offered to all organizations who expressed an interest in applying to operate the facilities. All CoC-funded partners must attest that they are and intend to continue using Housing First practices and procedures.

1b. The current strategy to provide immediate access to low-barrier permanent housing for individuals and families experiencing homelessness has resulted in more than 200 new housing units within the last six months. The urgent need for new housing units for PEH is beginning to be addressed through the acquisition and conversion the Guest House and of one wing of the Aviator. Additional funds are committed through ARPA, Municipal taxes, and philanthropy to continue to provide more new housing once appropriate facilities are identified.

2. ACEH has committed significant resources to assisting PEH with completing housing applications and accessing identification and documentation necessary to enter permanent housing programs. This assistance allows case managers to have more capacity to address needs and move clients into housing faster. ACEH is actively supporting shelter providers to work with clients who are in shelter which allows staff to focus on those individuals with higher barriers, such as those living unsheltered. Additional grant applications from corporate grantors support the detail work, such as document acquisition and transportation that are required to overcome barriers to housing. These funds reduce roadblocks and keep processes moving when there otherwise would be opportunities for caseworkers to lose contact with people who are unsheltered.

3. It is important for both tracks of the current strategy to continue moving forward simultaneously. Filling existing housing programs expeditiously moves people from unsheltered situations into programs where they can stabilize. At the same time, the CoC must continue adding new housing into inventory. The most recent census of unsheltered individuals is approximately 350. The last completed gaps analysis showed a need over 2,000 permanent housing units systemwide. More than 200 new permanent homes have been brought online in the last six months and they are all already occupied. This is evidence of the need for efficient use of existing housing and the need to bring even more online.

4. The new practices that the CoC has implemented mainly relate to communicating and operationalizing the importance of adding new housing as a solution to homelessness, rather than focusing only on shelter. The CoC leadership is centering all discussions regarding ending homelessness on adding housing. Our clients want their own place to live, not shelter; and they want to be able to choose their homes, not have them assigned. In light of this information, the CoC has worked in cooperation with the Alaska Balance of State CoC to develop the Alaska Housing Trust. This is not the first time that efforts were made to establish a Housing Trust, although previous efforts were not successful. At the beginning of 2022, Alaska was one of only three states that did not have a Housing Trust. During the last session, legislation was passed that appropriated funds needed to establish a board of directors and a steering committee that will establish the by-laws and policies of the Trust.

P-4. Updating the CoCs Strategy to Identify, Shelter, and House Individuals Experiencing Unsheltered Homelessness with Data and Performance

1a. Street Outreach uses GIS Maps in coordination with local government to identify current and active camps of unsheltered PEH. This resource allows street outreach to plan and strategize with currently available resources. The GIS Map identifies camps that have been reported in the past 30 days. As the street outreach coordinator, ACEH keeps screenshots of maps to track trends over time. With this information on trends, outreach coordination can be adjusted based on the identified needs of each area to be covered. It also allows us to forecast the number and size of teams that will be needed to meet the needs of each area over time. Pavilion Pop Ups have been identified as a best practice and will create opportunities for PEH to come to them by setting up pop-ups at local parks. These pop-ups will provide an opportunity to sit and talk; offer snacks, dry clothes, and rain gear; and listen to needs and conduct Coordinated Entry assessments onsite. Pavilion Pop Ups are also an opportunity to integrate CE and case management into street outreach. By providing a set schedule of locations and notifying unsheltered PEH of the nearby resource, PEH can know when to make connections with CE and case management staff. Additionally, as the needs of PEH in the vicinity of each Pavilion Pop Up are identified, street outreach can coordinate with other providers, such as mobile health clinics, to coordinate additional services at these locations

1b. There are projects in HMIS for Street Outreach. The HMIS Street Outreach projects allow the CoC to pull reports to identify who is experiencing unsheltered homelessness. Outreach staff includes the zip code and location of the client when they add a street outreach project and when they provide updates/contacts within the project for each individual. This creates a mechanism for ACEH and providers to locate unsheltered PEH when programs and services become available to them. Enhanced Street Outreach will begin in October. ACEH will receive local tax revenue to coordinate enhanced outreach services including transportation and food availability. Additionally, enhanced outreach services will be focused on moving PEH from unsheltered to housed without requiring an

intermediate stay in shelter. This funding source will also support a .25 FTE to complete CE intake assessments.

1c. Enhanced Street Outreach will allow for the expansion of organizations that will be able to field a street outreach team. Applications are currently available on the ACEH website to bring additional partners into this process and increase the reach to all unsheltered populations. The CoC is also reaching out to healthcare providers and behavioral health providers to accompany the street outreach teams. ACEH staff is also partnering with the Anchorage Chamber of Commerce to provide businesses with a toolkit that will help them identify ways in which they can connect individuals experiencing homelessness with HPRS resources.

2a. The CoC Data Committee is tasked with reviewing HMIS data to identify ways in which project and system performance can be improved. As we transition from the crisis created by the Covid-19 pandemic, the committee will begin to focus on evaluation criteria by which we can rate the effectiveness of projects and improve access to low-barrier shelter and temporary accommodations. The current strategy is to ensure that clients are aware of their options for low-barrier shelter and work to ensure that clients interested in that option can go to the shelter of their choice.

2b. Family Emergency Shelter. Family Emergency Shelter (FES) was recently funded by the Municipality of Anchorage through a local dedicated tax. This sheltering is intended to provide additional capacity beyond the established shelter capacity for families, particularly during periods of cold weather. The FES plan was developed in collaboration with multiple family providers, the Anchorage School District liaison, and ACEH. The FES leverages a public-private partnership to layer provider staff on top of a robust volunteer base within the church community to ensure that families have a safe and warm place to stay. Once in FES, families will be connected to a Community Navigator to move from FES into bridge or permanent housing. The organization providing case management for FES will be entering all data into the HMIS, whereas previous church volunteers did not collect this information. The collaborative approach to family shelter will allow the CoC to offer expanded space and services to families. The Municipality of Anchorage, including the Mayor's Administration and the Assembly, CoC leadership, direct service providers, tribal organizations, faith-based entities, individuals with lived experience, philanthropy, and youth service providers continue to work on a plan for emergency cold weather shelter for single adults. Current planning identifies a mix of congregate shelter and non-congregate shelter options to meet the needs. Under Anchorage Health Department guidance, congregate shelter locations will not exceed 150 people. The task force planning has been informed by information in HMIS, most of which was gathered through street outreach over the last three months.

2c. The RurAL CAP Sitka Place project will use performance measures, promote participant choice, and employ coordinated homeless assistance and mainstream housing services to ensure people experiencing homelessness receive assistance quickly, and make homelessness assistance open, inclusive, and transparent. This project will create new capacity for Sitka Place to identify individuals experiencing unsheltered homelessness and connect them with the housing and resources they need to become self-sufficient. RurAL CAP is committed to serving the 'hardest to house' and takes referrals of chronically homeless individuals identified through the Anchorage Coordinated Entry System from the top of the list.

3a. The CoC Data Committee is tasked with reviewing HMIS data to identify ways in which project and system performance can be improved. As we transition from the crisis created by the Covid-19 pandemic, the committee will begin to focus on evaluation criteria by which we can rate the

effectiveness of projects and improve access to low-barrier shelter and temporary accommodations. With the street outreach teams collecting and entering additional data, the system will more accurately track exits to permanent housing directly from unsheltered homelessness.

3b. Housing partners who are using some of the newly created units identified in the Leveraging Housing section are mandated to enter all required data in HMIS. This additional data entry will provide the CoC with data points by which performance will be evaluated. Moving forward, as a best practice, the CoC will continue to work with providers and funders to leverage assets to build a direct pipeline from street outreach to housing.

P-5. Identifying and Prioritizing Households Experiencing or with Histories of Unsheltered Homelessness

1. The CoC strategy for ensuring that the resources provided under this Special NOFO will reduce unsheltered homelessness began with approving project applications in the competition that focused on reducing unsheltered homelessness and serving those individuals. Any project funded through the SNOFO will be required to use the CoC Coordinated Entry (CE) system. The current CE system is based on the length of time homeless. The CoC has identified that those with long lengths of time homeless are often also those who are living unsheltered. The CoC will review data regularly to determine if this structure is effective in moving unsheltered individuals directly into housing. After analyzing the data, if necessary, the CoC will make changes needed to CE prioritization that will allow us to ensure that Special NOFO projects are reducing unsheltered homelessness.

2a. Program eligibility processes that reduce unsheltered homelessness The CoC tailors street outreach engagement to persons experiencing homelessness based on their unique circumstances. Outreach began to host “pop-up” outreach in conjunction with warm beverages, distribution of dry clothing, and an opportunity for people to talk with mental health providers. Having a location set up within close proximity to a camp where people could engage of their own volition proved key to beginning relationships with individuals who had avoided other outreach methods. These events also provided the space and time to conduct initial Coordinated Entry (CE) assessments or update CE information. The CoC will continue to enhance street outreach with these events and will continue to invite mental health, health, housing, and other service providers to engage with individuals and families on-site to provide and further connect them to resources and services to move them toward achieving stable housing. The CoC will review street outreach data regularly and will create and adjust processes as necessary to make improvements to addressing and reducing unsheltered homelessness.

2b. Anchorage CE currently uses length of time homeless as its main prioritization criteria. The CE committee is prepared to propose that the criteria include an unsheltered homelessness component to the prioritization structure. The CE committee, with assistance from HUD Disaster TA, has worked over the last year to strengthen their understanding of the role of CE and the CoC process, which has allowed them to work more efficiently together and be more versatile when it comes to identifying areas in which they can influence system performance. This experience will allow them to adjust as needed to reduce unsheltered homelessness through the projects funded under the Special NOFO.

3. The CoC will use enhanced street outreach to expand the number of organizations that will be able to field a street outreach team by bringing additional partners into this process and increasing the reach to all unsheltered populations. Enhanced outreach services will be focused on moving PEH from unsheltered to housed without requiring an intermediate stay in shelter. Street outreach teams will be trained on all available housing resources.

4a. Enhanced street outreach services will include transportation, document and identification acquisition, and food availability.

4b. ACEH has secured funding for a Housing Transition Coordinator (HTC), which has been identified as a missing resource in the community. The HTC works with service providers; facilitates meetings with landlords, case managers, and clients; supports clients in completing applications and getting documents to meet eligibility requirements; and encourages clients to keep appointments. They will support collaborative efforts to assist households unsheltered, in shelters, and in transitional housing, identifying solutions that lead to stable, permanent housing.

4c. The CoC is reaching out to healthcare providers and behavioral health providers to accompany the street outreach teams. Pavilion Pop Ups will provide an opportunity to sit and talk; offer snacks, dry clothes, and rain gear; listen to needs and conduct Coordinated Entry assessments onsite. Pavilion Pop Ups are also an opportunity to integrate CE and case management into street outreach. Additionally, as the needs of PEH in the vicinity of each Pavilion Pop Up are identified, street outreach can coordinate with other providers, such as mobile health clinics, to coordinate additional services at these locations.

P-6. Involving Individuals with Lived Experience of Homelessness in Decision Making

1. The CoC invites stakeholders from the community to participate in monthly public meetings. Members at these meetings represent local and state government, community stakeholders, non-profits, philanthropic groups, healthcare providers, and community members, individuals with lived experience of homelessness. All communications from the CoC are available in a variety of formats, including virtually and electronically, to be accessible to a broad audience. All communications are shared on the CoC website, Facebook page, and email listserv. The CoC website complies with ADA standards to better reach individuals with disabilities. Each meeting includes the opportunity for public comment. In 2018, ACEH established the Homeless Resource Advisory Council (HRAC), an advisory group comprised of individuals with lived experience, and a representative has served on the Advisory Council. In 2022, the task force developing recommendations for emergency cold weather shelter in Anchorage conducted a survey of individuals with lived experience and held a series of events at provider facilities to gather feedback from those with lived experience to inform task force recommendations. Between the survey and community events, 80 individuals with lived experience weighed in on the planning process. The new Advisory Council Lived Experience Committee will build on this momentum to increase and formalize engagement. Volunteers of America provides young adults opportunities to share their views and voices on houselessness, PSH services, behavioral health challenges through internal interview, survey, radio interview, newsletters, filming, and social media. The CE committee is considering adopting unsheltered homelessness as a prioritization criterion. The SNOFO funding will allow the Advisory Council and the CE committee to explore and implement this change to CE. The HPRS has a renewed focus on using CE community-wide. This renewed focus has allowed the HRPS to support additional investment in the CES.

2. Individuals with lived experience have participated in steering committees within the CoC for years and have collaborated through a series of houseless lived experience advisory groups. A representative from Homelessness Resource Advisory Committee (HRAC) has held a voting seat on the CoC Advisory Council since its inception. In 2022, the Homeless Prevention and Response System (HPRS) Advisory Council voted to establish a new Lived Experience Committee. The purpose of the committee will be to engage and empower individuals with lived experience in

decision-making for the Anchorage's HPRS. Street outreach workers frequently ask clients for their thoughts on the current process and for system improvement recommendations. Several street outreach team members have lived houseless experience, one within the last seven years and one within the last ten years. Street outreach is a collaborative process, and dual leadership/lived experience allows for greater system capacity building. ACEH is committed to advancing equity through a partnership with the Municipality of Anchorage's newly formed Equity Advisory Committee. Members of the committee represent a variety of community and faith-based groups and others who have lived through the experience of being underrepresented and have been subject to systemic inequities. The Committee exists to advance equitable outcomes by advising the Anchorage Assembly's planning, policies, legislative work, budgeting, and programming; engaging individuals with lived experience; and providing a forum for equity leaders to share priorities, resources, and experiences.

3. Alaska Housing Initiatives provides a housing first approach, partners with other housing, health, and service agencies, includes persons with lived experience in decision making and adheres to FAIR housing practices. RurAL CAP engages clients with lived experience in a Tenant Advisory Board, coordinates homeless assistance and mainstream housing, and provides services to ensure that people experiencing homelessness receive open, inclusive, transparent, and effective assistance quickly. TAB includes a minimum of six members: one representative of the community where Supportive Housing operates programs and projects; one who is experiencing homelessness or was formerly homeless. Currently VOA AK PSH includes two staff with lived experiences. Covenant House (CHA) partners with housing, health and services, centers racial equity, improves assistance to LGBTQ+, and includes persons with lived experience. CHA created the Diversity, Equity & Inclusion (DEI). DEI employs a Youth Champion Fellow full-time who is actively in CHA services or who has lived experience of homelessness, who serves as a voting member on their Board of Directors. CHA created a program dedicated to training and development of our staff members with lived experience, called Homeless to Heroes, which is now being considered by Covenant House International (CHI) for potential implementation across all Covenant House sites. CHA's staff with lived experience is 30% of their personnel. AWAIC encourages feedback on their programs and services through surveys to all participants and suggestions for program improvement. They employ several staff members with lived experience.

P-6a. Involving Individuals with Lived Experience of Homelessness in Decision-Making – Letter of Support from Working Group – see attachments

P-7. Supporting Underserved Communities and Supporting Equitable Community Development

1. As part of the mass care exit work, ACEH requested and received HUD Disaster TA. This TA provided ACEH and the CoC an opportunity to re-center equity even during some of its most challenging circumstances. First and foremost, it was important to acknowledge that Indigenous people are heavily overrepresented in the number of individuals in mass care and experiencing unsheltered homelessness in Anchorage. The goal of this TA was to increase ACEH and CoC awareness of inequities within the HPRS and improve strategies to support equitable homelessness response within the processes already in place. The CoC used an equity analysis to determine populations that are underserved and overrepresented in homelessness. The CoC recognizes that Anchorage sees significant over-representation of Alaska Native/ American Indian, LGBTQ+, and individuals experiencing disabilities within the HPRS. Individuals in those categories are more likely to spend more time in homelessness and to return to homelessness after securing housing. ACEH, as the CoC's lead agency, is focused on bringing equity work to the forefront of systems and system-

wide meetings. Equity work continues within many providers throughout the CoC to address overrepresentation and disparities. Finally, the revamp of Coordinated Entry also sought to address some of the known disparities. With these building blocks in place, over the next year, the CoC intends to use this analysis to move the system to focus on equitable outcomes for over-represented and marginalized populations.

2. In compliance with the Fair Housing Act, Section 504 of the Rehabilitation Act, Title VI of the Civil Rights Act, Titles II and III of the Americans with Disabilities Act, HUD's Equal Access Rule, and fair housing provisions found within the CoC Program Interim Rule, all phases of CE are conducted without reference to race, color, religion, sex, national origin, disability, familial status, actual or perceived sexual orientation, gender identity, or marital status. The revamp of CE sought to address some of the known disparities by changing the prioritization criteria. Additionally, the CE committee is considering adding unsheltered status as another area for prioritization within CE.

3. The CoC engages in street outreach and Pavilion Pop Ups have been identified as a best practice and will create opportunities to engage with PEH where they are by setting up pop-ups at local parks. These pop-ups will provide an opportunity to sit and talk; offer snacks, dry clothes, and rain gear; and listen to needs and conduct Coordinated Entry assessments onsite. Pavilion Pop Ups are also an opportunity to integrate CE and case management into street outreach. By providing a set schedule of locations and notifying unsheltered PEH of the nearby resource, PEH can know when to make connections with CE and case management staff. The Housing Transition Coordinator provides an additional layer of support to CE as a liaison between CE and PEH living unsheltered, in shelters, and in transitional housing. By prioritizing length of time homeless, CE addresses those who are unsheltered since they are also often those who have been homeless the longest and addresses identified disparities since those individuals are often those who have had less access to the HPRS and have experienced disparate outcomes.